STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 00 B. WING	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00379484, IN00379008, IN00379801, and IN00380287. Complaint IN00379484 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00379008 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684, F690, F726, and F867. Complaint IN00379801 - Substantiated. Federal/State deficiencies related to the allegations are cited at F 677, F 686, and F695. Complaint IN00380287 - Substantiated. Federal/State deficiencies related to the allegations are cited at F584, F684, and F791. Survey dates: May 16, 17, 18, 19, 20, 23, 24, 25, and 26, 2022 Facility number: 000172 Provider number: 155272 AIM number: 100267130 Census bed type: SNF/NF: 123 Total: 123 Census payor type: Medicare: 5 Medicaid: 102 Other: 16 Total: 123 These deficiencies also reflect State findings cited	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Recertification and State Licensure Survey in conjunction with a Complaint Survey (IN00379008, IN00379484, IN00379801, IN00380287) Survey on May 26, 2022. Please accept this plan of correction as the provider's credible allegation of compliance.	

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

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	in accordance with 410 IAC 16.2. Quality review completed on June 7, 2022			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and 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.			

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	§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure a resident's right to be treated with dignity by not assisting a resident to dress in their own clothes rather than a hospital gown for 1 of 6 residents reviewed for dignity. (Resident 5) Findings include: The clinical record for Resident 5 was reviewed on 5/19/22 at 9:04 a.m. Resident 5's diagnoses included, but not limited to, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting left side, dementia, cerebral infarction, bipolar disorder, and anxiety disorder. Resident 5's quarterly MDS (minimum data set) dated 1/19/22 indicated, Resident 5 was cognitively intact. Resident 5 was totally dependent on the assistance of one person for dressing, bathing, and toileting. Resident 5's annual MDS dated 11/18/21 indicated, it was very important for her to choose the clothes she wears. An interview with Resident 5 was conducted on 5/17/22 at 1:47 p.m. Resident 5 was wearing a hospital gown at the time and indicated, she prefers to be dressed in her own clothes rather than the hospital gown.	F 0550	**F 550** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident 5 care plan was reviewed and updated to reflect preferences in regard to what clothing she prefers to wear. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DON or designee will complete resident interviews regarding clothing preferences and care plans were updated as needed. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Director of Nursing Services or designee will re-educate the nursing staff on the following policy: Routine Resident Care with an emphasis on ensuring resident preferences are met regarding what type of clothing they prefer to wear. **How the corrective measures**	06/27/2022

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	An observation of Resident 5 was made on 5/18/22 at 10:42 a.m. Resident 5 was in her room, lying in her bed and wearing a hospital gown. An observation of Resident 5 was made on 5/19/22 at 12:51 p.m. Resident 5 was in the main dining room sitting in a high back wheelchair. She was wearing a hospital gown and had a sheet over her lap. An observation of Resident 5 was made on 05/20/22 at 9:47 a.m. Resident 5 was in her room, lying in bed and wearing a hospital gown. An observation of Resident 5 was made on 5/20/22 at 1:32 p.m. Resident 5 was in her room, lying in bed and wearing a hospital gown. An observation of Resident 5 was made on 5/23/22 at 10:45 a.m. and 2:27 p.m. During both observations, Resident 5 was wearing a hospital gown. An interview with Resident 5 was conducted on 5/20/22 at 9:47 a.m. She indicated, prefers to wear clothing rather than a hospital gown. She stated, "my dignity is being taken away from me and I'm trying to save what dignity I have left" in reference to being in the dining room the previous day while wearing a hospital gown. An interview with Resident 5 was conducted on 5/23/22 at 2:37 p.m. Resident 5 was wearing a hospital gown and stated no one had asked her if she wanted to get dressed today, but she had requested to get dressed because someone was coming to visit her later. A Routine Resident Care policy was received from DON (Director of Nursing) on 5/23/22 at 9:54 a.m.		**will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the Director of Nursing Services or designee 2 times per week times 8 weeks then monthly x 4 months to ensure compliance: observe / interview residents to ensure preferences are being met regarding what clothing they prefer to wear. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	The policy indicated, "It is the policy of this facility to promote resident centered care by attending to the physical, emotional, social, and spiritual needs and honor resident lifestyle preferences while in the care of this facility...Unlicensed staff...Routine care by nursing assistant includes but is not limited to the following: Assisting or provides for personal care...dressing...." A Resident Rights policy was received from DON on 5/23/22 at 9:54 a.m. The policy indicated, "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...Residents have a choice and a voice in how they will be treated." 3.1-3(a) 3.1-3(t)			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make			

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	choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview and record review, the facility failed to honor a resident's preference for the administration timing of a medication and to provide showers, as preferred, for 2 of 4 residents reviewed for choices. (Residents 5 and 233) Findings include: 1. The clinical record for Resident 233 was reviewed on 5/17/22 at 1:30 p.m. The diagnoses included, but were not limited to: bacteremia, sepsis, pneumonia, endocarditis, and osteomyelitis. He was admitted to the facility on 4/28/22. The care plan, revised 5/18/22, indicated he had bacteremia, sepsis, pneumonia, endocarditis, and osteomyelitis. Interventions were to administer his antibiotics/antimicrobials per medical provider's orders. The care plan, revised 5/4/22, indicated he was currently on IV (intravenous) therapy for bacteremia and pneumonia. The physician's orders indicated for 2 grams of	F 0561	**F 561** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident 233 has been discharged. Resident 5 received a shower and had her hair washed per her preference. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DON or designee will interview residents regarding preferences for bathing and medication timing within the scope of the MD order. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Director of Nursing Services or designee will re-educate the nursing staff on	06/27/2022

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	Ceftriaxone Reconstituted Sodium Solution to be administered every 24 hours, effective 4/28/22 to 6/5/22 and for 10 ml of Sodium Chloride Flush Solution 0.9% to be flushed through his IV every 24 hours before and after IV administration, effective 4/28/22 to 6/5/22. An interview was conducted with Resident 233 on 5/17/22 at 1:48 p.m. He indicated he would like his IV treatments at 7:00 p.m. or 8:00 p.m., but he wasn't getting it until around 10:30 p.m. It took about an hour for the IV treatments, and he didn't like going to bed at almost midnight. He'd like to be in bed by 10:00 p.m. or so. He also received trazadone for insomnia at 7:00 to 8:00 p.m., but by the time he could actually go to bed after his IV treatment, the trazadone had worn off. The May 2022 MAR (medication administration record) indicated the Ceftriaxone administrations were signed off by nursing on the following dates and times: 5/1/22 at 10:35 p.m., 5/6/22 at 11:22 p.m., 5/8/22 at 11:57 p.m., 5/12/22 at 9:47 p.m., 5/16/22 at 10:44 p.m., 5/18/22 at 10:27 p.m., 5/19/22 at 9:58 p.m., 5/20/22 at 10:17 p.m., and 5/22/22 at 1:52 a.m. The administration hour to receive the antibiotic was entered as 24h (hours.) An interview was conducted with Resident 233 on 5/25/22 at 2:48 p.m. He indicated he was not receiving his IV antibiotic any earlier. A few nights ago, he fell asleep waiting for it, woke up at 2:00 a.m., and had to track down the nurse to receive it. He'd told a couple of the nurses and aides that he wanted it sooner. An interview was conducted with UM (Unit Manager) 2 on 5/25/22 at 3:00 p.m. She indicated when he received his antibiotic treatment depended on what time he admitted. She		the following policy: Personal Bathing and Shower with an emphasis on ensuring residents preferences are met regarding the type of bathing they prefer Director of Nursing Services or designee will re-educate the Licensed Nurses and QMAs on the following policy: Liberalized Medication Administration with an emphasis on resident preferences of when they would like to take their medication within the MD ordered time frame. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the Director of Nursing Services or designee 2 times per week times 8 weeks then monthly x 4 months to ensure compliance: ensure preferred bathing preferences and medication timing preferences are being met The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	scheduled it for night, but if he wanted it earlier, she could clarify with the physician to see if he could get it earlier. She was unaware he wanted it sooner. An interview was conducted with UM 2 on 5/26/22 at 10:53 a.m. She indicated she spoke with the nurse practitioner, and they switched his IV antibiotic to mornings, and he already received it today. The 5/25/22, 12:18 p.m. nurse's note, recorded as a late entry on 5/26/22 at 9:22 a.m., read, "Writer spoke with res [resident] regarding his concerns about IV administration time change, notified in house NP to confirm change. Res IV administration time changed per res request." 2. The clinical record for Resident 5 was reviewed on 5/19/22 at 9:04 a.m. Resident 5's diagnoses included, but not limited to, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting left side, dementia, cerebral infarction, bipolar disorder, and anxiety disorder. Resident 5's quarterly MDS (minimum data set) dated 1/19/22 indicated, Resident 5 was cognitively intact. Resident 5 was totally dependent on the assistance of one person for dressing, bathing, and toileting. Resident 5's annual MDS dated 11/18/21 indicated, it was very important for her to choose between tub, shower, bed or sponge bath. An interview with Resident 5 was conducted on 5/17/22 at 1:47 p.m. Resident 5 indicated she hadn't had her hair washed in a couple months nor had she received a bed bath or shower twice weekly. She indicated; she prefers to receive a			

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	shower rather than a bed bath. An interview with Resident 5 was conducted on 5/20/22 at 9:47 a.m. Resident 5 indicated, she had not received nor was asked about a bed bath or shower yesterday. She stated, she has to ask each day if it was her shower day. Resident 5's care plan initiated on 11/23/20 and revised on 5/14/21 and 5/19/22 indicated Resident 5 had an ADL (Activities of Daily Living) deficit and required assistance with ADLs. The interventions included, but not limited to, offer a shower twice a week per resident's choice. The care plan did not indicate which days of the week Resident 5 prefers to bathe. Resident 5's Document Survey Report for March 2022 was received from NC (Nurse Consultant) 3 on 5/20/22 at 9:17 a.m. It indicated; Resident 5 received a bed bath on 3/3/22. No other showers/baths for March were documented. Resident 5's Document Survey Report for April 2022 was received from NC (Nurse Consultant) 3 on 5/20/22 at 9:17 a.m. The Document Survey report for April 2022 indicated the following baths/showers given that month: - 4/9/22, a code "RX" for type of bath/shower given. The legend key did not indicate what "RX" indicated. - 4/21/22, a code "NA" for type of bath/shower given. The legend key did not indicate what "NA" indicated. - 4/23/22, a code "NA" for type of bath/shower given. - 4/28/22, indicated a bed bath was given. - 4/30/22, a code "NA" for type of bath/shower given. No other baths/showers for April were			

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	documented. Resident 5's Document Survey Report for May 2022 was received from NC (Nurse Consultant) 3 on 5/20/22 at 9:17 a.m. Under the section titled Intervention/Task bathing per resident's choice, it indicated, Resident 5 received a bed bath on 5/5/22, 5/7/22 and 5/12/22. No other baths/showers for May were documented. Resident 5's March, April and May shower sheets were received on 5/19/22 at 1:11 a.m. from DON (Director of Nursing). They indicated the Resident 5 received a bed bath on: 3/3/22 3/5/22 3/17/22 3/19/22 4/7/22 4/21/22 4/23/22 4/28/22 A Personal Bathing and Shower policy was received from DON on 5/23/22 at 9:54 a.m. The policy indicated, "Policy...Residents have the right to choose their schedules, consistent with their interests, assessments, and care plans including choice for personal hygiene. This includes, but is not limited, to choices about the schedules and type of activities for bathing that may include a shower, a bed bath or tub bath, or a combination and on different days. The facility will not develop a schedule for care, such as waking or bathing schedules, for staff convenience and without the input of the residents/representatives...Bathing preferences should be care planned including type and schedule."			

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	3.1-3(u)(1) 3.1-3(u)(3)			
F 0568 SS=D Bldg. 00	483.10(f)(10)(iii) Accounting and Records of Personal Funds §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. Based on interview and record review, the facility failed to ensure residents received their personal fund quarterly statements for 2 of 3 residents reviewed for personal funds. (Resident 2 and 8) Findings include: An interview with Resident 2 was conducted on 5/18/22 at 10:11 a.m. Resident 2 indicated; he was not receiving quarterly personal fund statements. An interview with Resident 8 was conducted on 5/16/22 at 11:54 a.m. Resident 8 indicated; she didn't know where her checks were going. An interview with BOM (Business Office Manager) was conducted on 5/24/22 at 9:04 a.m. BOM indicated, Residents 2 and 8 had personal fund accounts. Residents 2 and 8 should have received a quarterly personal fund statement in	F 0568	**F 568** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident # 2 and 8 were provided a copy of their most recent personal funds quarterly statement. A signed copy of receipt was placed in the resident's business office file. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice.	06/27/2022

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	April 2022. She further stated, Resident 2 and 8's quarterly statements get mailed to the facility from the corporate office, she copies them, keeps one copy for her files, the other copy goes into an envelope with the resident's name. She then gave the envelopes with the quarterly statements in them to the activities department who distributes them to the residents. BOM indicated, presently, she cannot provide evidence the residents had received the quarterly personal fund statement but agree they should have a system in place to ensure the statements were received by the residents. A Resident Trust Fund policy was received on 5/24/22 at 10:57 a.m. from BOM. The policy indicated, "Purpose: To hold, safeguard, manage, control and reconcile the personal funds deposited with the facility by the residents, as authorized, in a manner and in compliance with all laws and regulations to provide the resident with accurate and timely information regarding their personal funds...Employee #3 (Recommended Executive Director)...4. Review and approve the quarterly Resident Trust Fund Statements prior to mailing. In addition, sign Certification for Proof of Mailing...9. Quarterly Statement of Account...Quarterly statements are received from RFMS(sic) by the Business Office and then reviewed and approved by the Executive Director and provided to the resident or mailed to the resident's legal representative...the Executive Director is to sign the Certification of Mailing...as proof that the statements were mailed." 3.1-6(g)		All in house residents were provided a copy of their most recent personal funds quarterly statement. A signed copy of receipt was placed in the resident's business office file. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Executive Director or designee will re-educate the Business Office staff on the following policy: Resident Trust Fund, with an emphasis on obtaining the resident's signature on each individual personal funds quarterly statement, providing the resident a copy and placing a signed copy in the business office file. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the Executive Director or designee 2 times per week times 8 weeks then monthly x 4 months to ensure compliance: Residents were provided a copy of their most recent personal funds quarterly statement. A signed copy of receipt was placed in the resident's business office file.	

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	155272	A. BUILDING 00 B. WING	05/26/2022

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			The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each			

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	resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation and interview, the facility failed to maintain a clean, sanitary, homelike environment by having a shower room on the Cambridge unit with dirty towels on the floor, handrails and sink; and shower curtains hanging down and not properly hung by hooks; and a shower room on the Brookshire unit with a pile of hair on the floor with the potential to affect 123 residents residing at the facility. Findings include: A complaint was received by the Indiana Department of Health on 5/16/22. It indicated; the shower rooms were very dirty. An observation was made of the two shower rooms on the Brookshire unit on 5/24/22 at 10:38 a.m. One of the shower rooms had a large pile of dry brown hair on the floor. It appeared as if someone had used clippers to give themselves a haircut and left the pile of brown hair on the floor. The sink in this shower room was also covered with bits of hair clippings. An observation was made of the two shower	F 0584	**F 584** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** The shower room on Brookshire was cleaned. The shower room on Cambridge was cleaned. The shower curtains were hanging, secured with hooks. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: The Director of Nursing or designee will observe all shower rooms in the facility to ensure they present for a clean, sanitary and homelike environment. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Director	06/27/2022

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	rooms on the Cambridge unit on 5/26/22 at 8:42 a.m. One shower room appeared to be used for storage and the other had dirty, used towels and washcloths on the floor, a clear plastic bag with used towels sitting in the sink, a stack of wipes not in a container sitting on a shower chair and some on the floor, a used washcloth was on hanging on the grab bar, and two shower curtains not securely hung from all hooks. An interview with Resident D was conducted on 5/17/22 at 10:42 a.m. They indicated, about a month ago there was feces on the floor for 3 days in the shower room on Brookshire. An interview with CNA (Certified Nursing Assistant) 42, who worked on the Cambridge unit, was conducted on 5/26/22 at 8:47 a.m. She indicated, she cleans the shower rooms before and after a resident uses it but hadn't given anyone a shower yet that day. An interview with CNA 43 was conducted on 5/26/22 at 8:51 a.m. indicated, it is the responsibility of the aides to clean the shower rooms after a resident has used it. She also stated, she had not given any showers yet that day. This Federal tag relates to complaint IN00380287. 3.1-19(f)		of Nursing Services or designee will re-educate the nursing staff on the following expectation: shower rooms are to be cleaned after each use to ensure they present for a clean, sanitary and homelike environment, with emphasis on removing dirty linens, shower curtains and secured and hanging from the hooks, rooms are not used for storage and the floor is kept clean. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following observations for each shower room will be conducted by the Director of Nursing Services or designee 2 times per week times 8 weeks then monthly x 4 months to ensure compliance: shower rooms are to be cleaned after each use to ensure they present for a clean, sanitary and homelike environment, with emphasis on removing dirty linens, shower curtains and secured and hanging from the hooks, rooms are not used for storage and the floor is kept clean. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further	

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			recommendation.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review, the facility failed to ensure a resident was free from verbal abuse for 1 of 5 residents reviewed for abuse. (Resident 2) Findings include: The clinical record for Resident 2 was reviewed on 5/19/22 at 9:27 a.m. Resident 2's diagnoses included, but not limited to, chronic obstructive pulmonary disease, heart failure, and anxiety disorder. Resident 2's quarterly MDS (minimum data set) dated 4/9/22 indicated, Resident 2 was cognitively intact. An interview with Resident 2 was conducted on 5/18/22 at 9:46 a.m. Resident 2 indicated,	F 0600	**Resident 2 has been interviewed and assessed by Social Service and the residents psychosocial wellbeing has remained at baseline.** **All residents had the potential to be affected by the alleged deficient practice. Interviews and investigation were initiated at the time of the incident and no other residents were found to be affected by the alleged deficient practice. The DON/Designee has educated all staff on the facility policy identified as, "Indiana Abuse, Neglect, and Misappropriation" with emphasis on prevention. All**	06/27/2022

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	approximately 3 weeks ago, he had an appointment to go to outside of the facility. He was low on oxygen for his portable oxygen tank and went to have his oxygen tank filled but remembered the unit was out of oxygen the previous day, so he went to the Cambridge unit to fill his tank. When he arrived on the Cambridge unit, a CNA (certified nursing assistant) had come up to him and said, you're not from here (meaning not a resident on the Cambridge unit) and then asked who sent him. The CNA then picked up the phone, called the Brookshire unit and proceeded to ask the person who answered the phone things like: Who sent him over here? Who's your aide? Resident 2 stated, she then started to call him a liar saying that no one sent him over there. Resident 2 asked for the CNA's name, and she had replied "Ashley". He then told "Ashley" that he was going to talk to the DON (Director of Nursing) about her behavior and "Ashley" replied saying, I don't care what you do. Prior to leaving the Cambridge unit, Resident 2 indicated, he was told by another staff member that "Ashley" was not really her name and told him what her real name was. Resident 2 indicated DON said she was sending the CNA home, but she came up front to the nurses' station on the Brookshire unit and was talking about him and that was when SS (social services) 2 came up and escorted her off the unit. The investigation file for Resident 2's incident was received on 5/25/22 at 9:13 a.m. The file contained, but not limited to, the following: 1. A witness statement from CNA 44 indicated, "CNA called on Brookshire demanding to come and get resident cause he needed oxygen in his tank (sic) she wanted to know who told him to come on Cambridge (sic) she was asked to fill his tank she said NO!! She was too busy so she kept		**staff and alert have been educated on the facility's existing process on reporting abuse, including but not limited to what constitutes abuse, when to report abuse, to whom to report abuse to, and the grievance process including where to locate grievance forms. The DON/SSD/Designee will interview 10 random residents weekly x 4 weeks, 5 random residents weekly x 4 weeks, then 5 random residents monthly x 1 months to ensure no incidents have occurred.** **The DON/Designee is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meeting x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.** **="" span="">**	

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	asking resident what was his name and who sent him (sic) so (sic) he was upset and asked the CNA what her name was. So she said nevermind (sic) and hung up the phone." 2. A witness statement from CSM 45 indicated, "I (sic, name of CSM 45) witnessed a CNA speak disrespectfully to a resident and when i (sic) asked her to stop and to walk away, she continued to argue and the social worker walked up and asked her to leave the building because we don't speak to our residents in that manner." 3. A Witness statement from CNA 46 indicated, "Patient came from brookshire to get oxygen, I called Brookshire to confirm where his aid (sic, aide) was.(sic) meanwhile (sic) another aid (sic) from Cambridge was filling his oxygen machine, as I was on the phone asking brookshire why (sic) this young man was by his (sic) self and not with a (sic) aid (sic) they said (sic) they did not (sic) so I said okay (sic) he told a lie and hung up. the (sic) resident was leaving cambridge (sic) asked my name I gave it to him (sic) he said he was going to get me in trouble (sic) i walked away, I went to brookshire 15 min (sic, minutes) later to assist another aid (sic), the resident in question rolled up to me and said I got your name your getting and trouble. I said okay whatever and walked away. I honestly should not have responded and by doing so, it put me and this situation." 4. A Witness statement from SS 2 indicated, "writer was on Brookshire and heard CNA (sic CNA 46's name) argueing (sic) with (sic, Resident 2's name) at nurses station calling Mr (sic, Resident 2's last name) a lier (sic) and raising her voice at him- writer approached (sic, CNA 46's name) and informed her to clock out and go home. (sic, CNA 46's name) said "This is (sic, expletive,			

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	F-----) up believing a crack head over staff" writer informed (sic, CNA 46's name) to clock out. (sic, CNA 46's name) still cursing left the unit. Writer followed her to make sure she left building. (sic, CNA 46's name) turned to go to cambridge and writer again told (sic, CNA 46's name) to clock out (sic, CNA 46's name) turned and gave writer the middle finger and walked into DNS (sic, Director of Nursing Service, a.k.a. DON) office." 5. A Witness Statement from Resident 2 indicated, "i (sic) was out of oxygen and went to cambridge to have my bottle filled. a (sic) staff member did help me but (sic, CNA 46's name) started asking me why I was over there (sic) I said i (sic) came over for oxygen. She started asking why my aid (sic) didn't come over? i (sic) stated (sic) is that really relivent (sic) the girl is filling my portable,(sic, CNA 46's name) then called over to brookshire and while calling(sic) she asked who my aid (sic) was and i (sic) said "why (sic) is the matter" (sic, CNA 46's name) said because your lying, you are a liar. i (sic) said are you calling me a liar (sic) i dont have to lie. When i (sic) asked her name, she told me her name was (name of CNA 46) (sic) "I informed her I was going to the DNS" (sic, CNA 46's name) said i dont give a damn what you do"(sic) (sic, nurses name) the nurse stepped in and made sure i was getting my oxygen, (sic, CNA 46's name) said "Well your welcome" and walked off. i (sic) left and went to talk to DNS (sic). DNS (sic) informed me (sic, CNA 46's name) would be sent home. Then i (sic) went back to Brookshire. when i (sic) got to brookshire (sic, CNA 46's name) was on Brookshire questioning if they told me to go to cambridge. then (sic) (sic, CNA 46's name) spotted me. i (sic) did say she called me a liar when she's the one that told me her name is (name of CNA 46) Its not, its [sic, CNA 46's name] calling me a liar again at this point i (sic) called her			

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	a "[sic, expletive, B____]" An interview with SS 2 was conducted on 5/24/22 at 3:39 p.m. SS 2 indicated, the incident between CNA 46 and Resident 2 started on the Cambridge unit. SS 2 stated, he was walking to the Brookshire unit when he heard some "loud voices". CSM 45 was telling CNA 46 she had to leave. CNA 46 was saying to Resident 2 "you lied on me" then Resident 2 replied, "no you lied on me" and CNA 46 got a little louder. CNA 46 was speaking directly to Resident 2 stating, "he was a liar". SS 2 walked behind CNA 46 as she was leaving the unit when she turned around and flipped SS 2 the "bird". An interview with CSM 45 was conducted on 5/25/22 at 9:48 a.m. She indicated, she was on the Brookshire unit, at the nursing station, when the phone rang, and she answered it. It was a CNA 46 from the Cambridge unit. CNA 46's began the call by saying, "Tell me why you all sent a resident over here to get oxygen by himself". CSM indicated, Resident 2 was prepping for an appointment he was about to go to. Over the weekend, the Brookshire unit had run out of oxygen and Resident 2 knew the other unit probably would have oxygen. CSM 45 stated, Resident 2 hadn't realized the oxygen man was already on the Brookshire unit filling the oxygen when he decided to go to the Cambridge unit on his own accord. CNA 46 continued asking why they didn't send someone with him over there and CSM 45 replied saying, well that shouldn't be a problem. CSM 45 then told CNA 46 just to fill the tank for Resident 2 to which CNA 46 said "no". CSM 45 stated, she could hear CNA 46 saying to Resident 2, "I think your lying" and that is when CSM 45 heard someone over the phone telling CNA 46 not to say things like that to Resident 2.			

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	CSM 46 then hung the phone up. CSM 45 stated, she was still on Brookshire when Resident 2 had returned to the unit. She indicated, it wasn't long after Resident 2 had returned when she saw CNA 46 walking onto the Brookshire unit saying things like: she hated it there, no one helped her, and talking about Resident 2. CSM 45 told CNA 46 she can't talk about residents like that and that was then CNA 46 said "F---[sic, expletive] this job" and "the resident was rude". Resident 2 was nearby and heard what CNA 46 had said so he responded, "how was I rude" to CNA 46. CSM 46 indicated, they continued to go back and forth and that was when she told CNA 46 that she needed to walk away several times. SS 2 walked up and told CNA 46 "you need to walk away now". CSM 45 stated, CNA 46 then mumbled something then said "Santa Claus looking" in reference to Resident 2's appearance. CNA 46 then looked straight at Resident 2 and said, "HO, HO, HO". CSM 45 indicated, after that, Resident 2 locked his wheelchair, stood up, and called CNA 46 a B----(expletive, female dog). An Abuse & Neglect & Misappropriation policy was received on 5/16/22 at 11:03 a.m. The policy indicated, "Verbal abuse: In Indiana, oral, written, and/or gestured language that includes disparaging and/or derogatory terms to the resident or their families, either directly or within their hearing. This may include resident to resident verbal threats of harm but excludes random statements of a cognitively impaired resident such as repetitive name calling or nonsensical language. Verbal abuse includes any staff to resident episodes...Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. It is the intent of this facility to prevent the abuse,			

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	mistreatment, or neglect of residents or the misappropriation of their property, corporal punishment and/or involuntary seclusion and to provide guidance to direct staff to manage any concerns or allegations of abuse, neglect or misappropriation of property...Prevention...2. Staff members are identified by name badges which they are required to wear on duty." 3.1-27(b)			
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law,			

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	including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to report the results of all investigations to the State Survey Agency within 5 working days of the incident for 1 of 5 residents reviewed for abuse. (Resident 2) Findings include: An incident report dated 4/18/22 was submitted to the Indiana State Department of Health. The incident report indicated, an incident between Resident 2 and CNA (certified nursing assistant) 46 occurred on 4/18/22 at 11:30 a.m. The description of the incident was that Resident 2 overheard a staff member talking about him and it offended him. The follow up to the incident was reported on 4/26/2022. It indicated; CNA 46 was overheard by three staff witnesses calling the resident a liar in response to his request for a refill of his oxygen. CNA 46 was witnessed to be cursing in the presence of but not at, the resident stating, "this is f-----(expletive) up". The employee was not returned to employment from suspension for failure to follow the company's code of conduct. The follow up to the incident was not reported within 5 working days of the incident's occurrence. An Abuse & Neglect & Misappropriation policy was received on 5/16/22 at 11:03 a.m. It indicated, "A Suspected Abuse g. By the fifth day, the alleged abuse investigation form is completed and	F 0609	The incident was reported to IDOH on 4/18/2022 and the facility submitted the 5 day follow up to the incident on 4/26/2022 which was 1 working day late. Any resident that had an incident reported to IDOH had the potential to be affected. An audit was conducted on all incidents reported to IDOH in the last 30 days to ensure the 5 day follow up was submitted. Any incident found not to have a 5 day follow up submitted was immediately completed and submitted. The Regional Director of Clinical Operations has educated the Executive Director and Director of Nursing on the Indiana Incident Reporting guidelines with emphasis on the requirement of submitting the findings of the investigation to IDOH within 5 working days from the initial incident reporting date. The Regional Director of Clinical Operations/Designee will audit all incidents reported to IDOH for timely 5 day follow up submission on the following schedule: all incidents reported weekly x 4 weeks, then 5 incidents weekly x	06/27/2022

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	reviewed for completeness and accuracy by the Executive Director or designee and submitted to the state." 3.1-28(e)		4 weeks, then 10 incidents monthly x 1 month. The Executive Director/Designee is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. ="" span="">	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law,			

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	including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse for 1 of 5 residents reviewed for abuse. (Resident 70) Findings include: The clinical record for Resident 70 was reviewed on 5/17/22 at 2:30 p.m. The diagnoses included, but were not limited to, schizoaffective disorder, bipolar disease, and anxiety disorder. An interview was conducted with Resident 70 on 5/17/22 at 2:33 p.m. He indicated a nurse verbally abused him 3 months ago but did not inform anyone of the allegation. He was grabbing for some snacks at the nurse's station, and the nurse told him he knew better than that and fu** your mother. The ED (Executive Director) was informed of the above allegation on 5/17/22 at 2:40 p.m. The ED provided the investigative file into the above allegation on 5/25/22 at 9:10 a.m. It included the 5/24/22 follow up incident report indicating through investigation and after completion of interviews with staff and residents, the facility was unable to substantiate the allegation or identify any staff member in relation to allegation. The file included 14 staff interviews. The staff interviews all indicated they did not recall any incident in which a staff member was verbally inappropriate with a resident, or any resident was	F 0610	Resident 70 was interviewed and monitored by Social Service and determined to be at psychosocial baseline and feels safe at the facility. All other residents had the potential to be affected. Abuse interviews were conducted with all alert and oriented residents to identify any concerns. All staff were interviewed to determine if they were aware of or to identify any potential allegations of abuse or events that require investigation. Any identified events or allegations were reported to IDOH and all other reporting entities. The facility must ensure all allegations of abuse are investigated per the existing facility policy to protect the residents. The Executive Director will ensure all investigations are conducted timely and thoroughly. In the event the Executive Director is unavailable the Director of Nursing will be responsible to ensure all investigations are conducted timely and thoroughly in accordance with facility policy. All allegations of abuse or a concern that may constitute abuse will be reported to the Executive Director immediately.	06/27/2022

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	abusive with another resident in respect to 5/17/22 and 5/18/22. An interview was conducted with the ED on 5/25/22 at 10:43 a.m. He indicated the reason in respect to 5/17/22 and 5/18/22 was asked of staff was because he was trying to use the same staff interviews for Resident 70's investigation as was used in another resident's investigation, even though the initial 5/17/22 incident report specifically stated the alleged incident happened 3 months ago. The Abuse & Neglect & Misappropriation of Property policy was provided by the ED on 5/16/22 at 11:03 a.m. It read, "Statements will be obtained from staff related to the incident...." 3.1-28(d)		DON/Designee educated all staff on the facility's existing policy identified as, "Indiana Abuse, Neglect, and Misappropriation", with emphasis on reporting and investigating, and reinforcing the expectation this policy will be followed including a discussion of the consequences of not following facility policy for both the residents and staff. The Regional Director of Clinical Operations will validate all abuse allegations are reported and investigated per the facility policy on the following schedule: All allegations made weekly x 4 weeks, 10 allegations weekly x 4 weeks, and 10 allegations monthly x 1 month. The Executive Director/ Designee will report the findings of the interviews to the monthly QA Committee meeting for no less than 6 months and the QA Committee will determine how best to conduct on going monitoring so that facility policy is implemented and followed and to reinforce the facility's commitment to abuse prevention, investigation, and reporting.	
F 0622 SS=D	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements			

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Bldg. 00	§483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility.			

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	The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals;			

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	(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. Based on interview and record review, the facility failed to provide evidence that appropriate information had been communicated to the receiving health care institutions when a resident was transferred to the hospital for 1 of 4 residents reviewed for hospitalization. Findings included: The clinical record for Resident 5 was reviewed on 5/19/22 at 9:04 a.m. Resident 5's diagnoses included, but not limited to, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting left side, dementia, cerebral infarction, bipolar disorder, and anxiety disorder. Resident 5's quarterly MDS (minimum data set) dated 1/19/22 indicated, Resident 5 was cognitively intact. Resident 5 was totally dependent on the assistance of one person for dressing, bathing, and toileting. An interview with Resident 5 was conducted on 5/17/22 at 2:04 p.m. Resident 5 indicated, she had recently been admitted to the hospital and was found to be septic (widespread infection). A nursing progress note dated 4/8/2022 at 10:00 a.m. indicated, Resident 5 had vomited three times, loose bowel movements and her abdomen was slightly distended. Resident 5's physician was notified, and an order was placed for Resident 5 to	F 0622	**F 622** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #5 has returned from the hospital **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DON or designee will conduct an audit on all residents that are currently in the hospital to ensure proper documentation was sent to the hospital. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Director of Nursing Services or designee will re-educate the Licensed Nurses on the following policy: Discharge and Transfer Policy with emphasis on with an emphasis on ensuring all required paperwork is sent to receiving	06/27/2022

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	be sent to the emergency room for evaluation and treatment for a possible ileus. The nursing note stated, "Resident send to [sic, name of hospital]. paperwork given." The clinical record did not contain information in regards to what paperwork was given nor to whom it was given to. An e-interact transfer was documented in Resident 5's clinical record regarding the 4/8/22 transfer to the hospital however, in an interview with Nurse Consultant 3 (NC 3) and DON (Director of Nursing) on 5/23/22 at 11:26 a.m., NC 3 indicated, the facility sends a face sheet and a medication list when transferring a resident out of the facility. When asked if the e-interact transfer form is sent as well, NC 3 indicated, the e-interact transfer form was an internal document only and the facility did not require nursing to document what information was sent with the resident to the hospital. An interview with DON was conducted on 5/23/22 at 2:47 p.m. DON indicated, in order to ensure all needed information was provided to the receiving provider she would have to conduct an in-service with staff and possibly create a checklist for nursing to know what information needed to be conveyed when transferring a resident and a detailed note of what was sent. A Transfer and Discharge policy was received on 5/23/22 at 11:46 a.m. from DON. The policy indicated, "VII. Information to the Receiving Provider A. Information provided to the receiving provider must include a minimum of the following: 1. Contact information of the practitioner responsible for the care of the resident. 2. Resident representative information including contact information.		facility when resident is transferred out, including the eInteract Tranfer form. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the Director of Nursing Services or designee as on ongoing practice: will audit any resident sent to the hospital in morning clinical meeting to ensure proper documentation was sent with the resident. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	3. Advance Directive information 4. All special instructions or precautions for ongoing care, as appropriate. 5. Comprehensive care plan goals 6. All other necessary information, including a copy of the residents discharge summary, as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care." 3.1-12(a)(6)(B) 3.1-12(a)(9)(A) 3.1-50(h)(5)			
F 0657 SS=E 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			

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	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 hold care plan meetings, as required, and to timely update the plan of care for a resident with pressure ulcers for 1 of 2 residents reviewed for pressure ulcers and 3 of 4 residents reviewed for care plan meetings. (Resident 2, 5, 49, and 60) Findings include: 1. The clinical record for Resident 49 was reviewed on 5/17/22 at 10:00 a.m. The diagnoses included, but were not limited to, hypertension. An interview was conducted with Resident 49 on 5/17/22 at 10:03 a.m. She indicated she was not having care plan meetings, but she would like to have them and participate in them. The MDS (Minimum Data Set) assessments section of the EHR (electronic health record) indicated she had quarterly assessments completed on 12/23/21 and 3/4/22. An interview was conducted with SS (Social Services) 1 on 5/19/22 at 10:10 a.m. She indicated Resident 49 should be having care plan meetings quarterly, following the MDS schedule. Social services were responsible for inviting residents to the meetings. Normally, they documented care plan meetings in a progress note in the EHR and would look for verification of her last 2 meetings. On 5/19/22 at 10:20 a.m., the DON (Director of Nursing) provided verification of Resident 49's	F 0657	**F 657** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** A care plan meeting was offered / held with residents # 49, 2 and 5. Resident 60's care plan was updated to reflect all current skin conditions. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DON or designee will audit all residents with pressure ulcers to ensure the care plans has been reviewed and revised as necessary to reflect current skin conditions. Social Service Director or designee will audit all residents to determine date of last care plan meeting. Any resident identified as being overdue for a care plan meeting will have one offered and scheduled.	06/27/2022

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	last 2 care plan meetings. They were plan of care notes dated 6/6/19 and 4/22/20. The Plan of Care (POC) Overview policy was provided by the Nurse Consultant on 5/19/22 at 9:16 a.m. It read, "Resident/representative will have the right to participate in the development and implementation of his/her own POC...Review care plans quarterly and/or with significant changes to care...support the residents right to participate in treatment and care planning." 2. The clinical record for Resident 60 was reviewed on 5/18/22 at 10:45 a.m. The Resident's diagnosis included, but were not limited to, open wound of the left ankle and paraplegia. An Admission MDS (Minimum Data Set) Assessment, completed 12/16/21, indicated he was cognitively intact and had one stage 4 pressure ulcer. A care plan, last revised on 12/28/21, indicated he had impaired skin integrity related to a stage 4 pressure ulcer on his right thigh. The goal, revised on 3/14/22, was for him to not exhibit complications from altered skin integrity. A Quarterly MDS Assessment, completed 3/18/22, indicated he was cognitively intact and that he had two stage 3 pressure ulcers and one stage 4 pressure ulcer. On 5/23/22 at 1:05 p.m., Nurse Consultant 3 provided the most recent wound evaluation notes which indicated he had a stage 4 pressure ulcer on his right planter foot (ball of foot), a stage 3 pressure ulcer on his left ankle, and a stage 3 pressure ulcer on his left heel. The clinical record did not contain a care plan for		**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Director of Nursing Services or designee will re-educate the IDT on the following policies: Plan of Care Overview and Skin and Wound Care Management Overview with an emphasis on ensuring care plans are updated with new skin conditions and quarterly care plan meetings are documented as offered and held for all residents. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the Director of Nursing Services or designee 2 times per week times 8 weeks then monthly x 4 months to ensure compliance: resident quarterly care plan meeting has been documented as offered / scheduled / held. The Director of Nursing or designee will audit all new pressure ulcers in the clinical morning meeting to ensure the care plan has been updated timely. This will be an ongoing practice.	

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	the two stage 3 pressure ulcers. On 5/23/22 at 3:45 p.m., the DON (Director of Nursing) indicated the care plan should have been updated to include the stage 3 pressure ulcers. On 5/23/22 at 4:00 p.m., the DON provided the Pressure Ulcer Prevention : High Risk Policy, effective 7/1/2016, which read "...1. Develop a care plan for pressure ulcer prevention...4. Revise interventions and/or goals as indicated..." 3. The clinical record for Resident 2 was reviewed on 5/19/22 at 9:27 a.m. Resident 2's diagnoses included, but not limited to, chronic obstructive pulmonary disease, heart failure, and anxiety disorder. Resident 2's quarterly MDS (minimum data set) dated 4/9/22 indicated, Resident 2 was cognitively intact. An interview with Resident 2 was conducted on 5/18/22 at 10:01 a.m. Resident 2 indicated; his care plan meetings were not happening on a regular basis. A care plan note dated 2/4/2022 at 12:13 p.m. indicated Resident 2 had a care plan meeting with his niece and sisters. A care plan note dated 7/28/2021 at 2:30 p.m. indicated, Resident 2 had a care plan meeting with his sisters. The clinical record did not indicate Resident 2 had any care plan meeting between 7/28/21 and 2/4/22. An interview with SS (social services) 2 was conducted on 5/19/22 at 8:55 a.m. SS 2 indicated, Resident 2 will usually let SS 2 know when he		The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	needs a care plan meeting to occur but, Resident 2 should have a care plan meeting quarterly. 4. The clinical record for Resident 5 was reviewed on 5/19/22 at 9:04 a.m. Resident 5's diagnoses included, but not limited to, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting left side, dementia, cerebral infarction, bipolar disorder, and anxiety disorder. Resident 5's quarterly MDS (minimum data set) dated 1/19/22 indicated, Resident 5 was cognitively intact. Resident 5 was totally dependent on the assistance of one person for dressing, bathing, and toileting. An interview with Resident 5 was conducted on 5/17/22 at 2:06 p.m. Resident 5 indicated, she has only had one care plan meeting and that was two years ago. A Care plan note dated 12/10/20 at 12:29 p.m. indicated, Resident 5 had a care plan meeting with her sisters. Resident 5's clinical record did not indicate any other care plan meetings had occurred since 12/10/20. An interview with SS 2 was conducted on 5/19/22 at 8:50 a.m. SS 2 indicated, he speaks to Resident 5's sisters over the phone quite a bit however, those calls are with just himself and do not include any other members of Resident 5's care team. SS 2 stated, he didn't have an excuse as to why Resident 5 had not had a care plan meeting since 12/10/20. A Plan of Care Overview policy was received on			

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	155272	A. BUILDING 00 B. WING	05/26/2022

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	5/19/22 at 9:16 a.m. from NC (nurse consultant) 2. The policy indicated, "Procedure...c. Resident/representative will have the right to participate in the development and implementation of his/her own PoC[sic, plan of care]...d. The facility will...iii. Review care plan quarterly and or with significant changes in care." 3.1-35(b)(1) 3.1-35(d)(2)(B)			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to provide bathing, as scheduled, dressing, as needed, and nail care for a dependent resident for 3 of 9 residents reviewed for ADL (activities of daily living) care and 1 of 4 residents reviewed for choices. (Residents G, F, 5, and 33) Findings include: 1. The clinical record for Resident 33 was reviewed on 5/18/22 at 11:00 a.m. The diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease) and hemiplegia. The ADL (activities of daily living) care plan, revised 2/28/22, indicated she had an ADL self-care performance deficit related to her COPD and hemiplegia. An intervention was to offer her a shower twice a week per her choice. The unit shower schedule was located in a binder	F 0677	F677 1) Resident 33 was given a shower. Resident 5's care plan was revised to include her preferences regarding what clothing she prefers. Residents G and F could not be identified due to resident confidentiality. Residents were not harmed by the deficient practice. 2) All residents have the potential to be affected. Residents were audited to ensure they had received shower/bath per their preferences, nail care performed, and dressed per their preferences. Care plans were revised as needed accordingly. 3) Nursing staff were educated on facility policies "Routine Resident Care" and "Personal Bathing and Shower" with an	06/27/2022

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	at the nurse's station. Resident 33's shower schedule was during day shift, twice weekly on Tuesday and Friday. An interview was conducted with Resident 33 on 5/18/22 at 11:25 a.m. She indicated her shower day was yesterday, but staff didn't offer or give her a shower. She hadn't had a shower in a month. Staff would give her a washcloth to wash up, but she wanted a shower and did not refuse them. The last 30 days of bathing documentation from the tasks section of the EHR (electronic health record) indicated bathing was provided on the following days: a bed bath on 5/3/22 at 7:37 a.m., a bed bath on 5/6/22 at 2:29 p.m., and a bed bath on 5/20/22 at 2:29 p.m. There were no refusals indicated. An interview was conducted with UM (Unit Manager) 22 on 5/24/22 at 10:50 a.m. She indicated any bathing documented on the shower sheets should also be documented in the tasks section of the electronic health record. Shower sheets for the last 30 days were provided by the DON (Director of Nursing) on 5/24/22 at 2:03 p.m. They indicated showers were provided on the following dates: 4/25/22, 4/30/22, 5/2/22, 5/6/22, 5/10/22, 5/17/22, 5/20/22, 5/21/22, and 5/23/22. An interview was conducted with Resident 33 on 5/24/22 at 9:48 a.m. She indicated the shower sheets for the last 30 days were not accurate, but the 3 documented in the tasks section of the EHR sounded more accurate, "if that." 2. The clinical record for Resident G was reviewed 5/16/22 at 3:05 p.m. The Resident's diagnosis included, but were not limited to, tracheostomy		emphasis on ensuring residents receive showers or baths, fingernail care, and dressed according to their wishes. 4) Director of Nursing or Designee will audit and observe 10 residents per week x 1 month, then 5 residents per week x 1 month, then 3 residents per week x 4 months to ensure residents have received shower or bath per preference, nail care, and dressed according to their wishes. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	and acute respiratory failure. An Admission Initial Evaluation, dated 5/3/22, indicated she was dependent on personal hygiene. On 5/16/22 3:05 p.m., she was observed laying in her bed. She had a splint on her right hand. Her nails were long with chipped purple nail polish on them. On 5/19/22 at 10:46 a.m., she was observed lying in bed. She had a hand splint on her right hand. Her nails continued to be long, and the index fingernail was broken off. They continued to have chipped purple nail polish on them. On 5/24/22 at 11:30 a.m., she was observed laying in her bed. Her nails continued to be chipped and long. LPN (Licensed Practical Nurse) 13 indicated that her fingernails needed to be cut. On 5/25/22 at 10:34 a.m., the DON (Director of Nursing) provided the Nail and Hair Hygiene Services Policy, last reviewed on 2/15/22, which read "...This facility will provide routine care for the resident for hygienic purposes and for the psychosocial well-being of the resident including...nail hygiene services including routine trimming, cleaning, and filing. Routine Nail Hygiene ...may be performed in conjunction with bathing or performed separately..." 3. The clinical record for Resident 5 was reviewed on 5/19/22 at 9:04 a.m. Resident 5's diagnoses included, but not limited to, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting left side, dementia, cerebral infarction, bipolar disorder, and anxiety disorder.			

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	Resident 5's quarterly MDS (minimum data set) dated 1/19/22 indicated, Resident 5 was cognitively intact. Resident 5 was totally dependent on the assistance of one person for dressing, bathing, and toileting. Resident 5's annual MDS dated 11/18/21 indicated, it was very important for her to choose the clothes she wears. An interview with Resident 5 was conducted on 5/17/22 at 1:47 p.m. Resident 5 was wearing a hospital gown at the time and indicated, she prefers to be dressed in her own clothes rather than the hospital gown. An observation of Resident 5 was made on 5/18/22 at 10:42 a.m. Resident 5 was in her room, lying in her bed and wearing a hospital gown. An observation of Resident 5 was made on 5/19/22 at 12:51 p.m. Resident 5 was in the main dining room sitting in a high back wheelchair. She was wearing a hospital gown and had a sheet over her lap. An observation of Resident 5 was made on 05/20/22 at 9:47 a.m. Resident 5 was in her room, lying in bed and wearing a hospital gown. An observation of Resident 5 was made on 5/20/22 at 1:32 p.m. Resident 5 was in her room, lying in bed and wearing a hospital gown. An observation of Resident 5 was made on 5/23/22 at 10:45 a.m. and 2:27 p.m. During both observations, Resident 5 was wearing a hospital gown. An interview with Resident 5 was conducted on			

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	5/20/22 at 9:47 a.m. She indicated, prefers to wear clothing rather than a hospital gown. She stated, "my dignity is being taken away from me and I'm trying to save what dignity I have left" in reference to being in the dining room the previous day while wearing a hospital gown. An interview with Resident 5 was conducted on 5/23/22 at 2:37 p.m. Resident 5 was wearing a hospital gown and stated no one had asked her if she wanted to get dressed today, but she had requested to get dressed because someone was coming to visit her later. 4. The clinical record for Resident F was reviewed on 5/19/22 at 3:44 p.m. Resident F's diagnoses included, but not limited to, end stage renal disease, cerebral infarction, and chronic obstruction pulmonary disease. Resident F's annual MDS (Minimum Data Set) dated 3/9/22 indicated, Resident F was cognitively intact. It also indicated, the choice between a bed bath or shower was very important to them. An interview with Resident F was conducted on 5/17/22 at 9:41 a.m. They indicated, they had to fight to get a shower. They stated, they were supposed to get a shower last weekend on Saturday, 5/14/22, but it didn't happen, and no one even asked them if they wanted a shower. They indicated, they don't like to use the sink in their room because the sink was used to clean up their roommate after an incontinent episode and the staff didn't clean the sink afterward. They further stated, they prefer showers and only need someone to prep the room and help them into the shower room since they were in a wheelchair. An interview with Resident F was conducted on			

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	5/19/22 at 3:01 p.m. They indicated, they had received a shower today but, had not received one in a week prior to this one. A copy of Resident F's Documentation Survey Report was received on 5/20/22 at 9:17 a.m. from NC (Nurse Consultant) 2. Under the section listed as "Bathing per residents choice", it indicated Resident F received bed baths/showers on the following days: 3/1/22 bed bath 3/8/22 bed bath 3/17/22 bed bath 3/22/22 bed bath 3/26/22 bed bath 3/29/22 bed bath 4/14/22 bed bath 4/19/22 bed bath 4/26/22 bed bath 4/28/22 shower 4/30/22 bed bath 5/3/22 bed bath 5/5/22 shower 5/7/22 bed bath 5/10/22 "NA" code- code legend does not contain a code "NA" 5/12/22 shower 5/14/22 bed bath 5/17/22 bed bath 5/19/22 shower The DON (Director of Nursing) provided Resident F's shower sheets on 5/19/22 at 1:11 p.m. The shower/bed bath sheets for 5/14/22 nor the 5/17/22 bed baths were not located. The Brookshire unit's shower sheet binder was observed on 5/19/22 at 10:11 a.m. The only shower sheets found for Resident F were for the following dates: 4/28, 5/3, 5/5, and 5/12/22			

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An interview with Resident F was conducted on 5/19/22 at 3:17 p.m. Resident F indicated, they did not receive a bed bath or shower on 5/17/22 nor does she ever take bed baths. They again stated, they had not received a shower for a week.

A Routine Resident Care policy was received from DON (Director of Nursing) on 5/23/22 at 9:54 a.m. The policy indicated, "It is the policy of this facility to promote resident centered care by attending to the physical, emotional, social, and spiritual needs and honor resident lifestyle preferences while in the care of this facility...Unlicensed staff...Routine care by nursing assistant includes but is not limited to the following: Assisting or provides for personal care...dressing..."

A Personal Bathing and Shower policy was received on 5/23/22 at 9:54 a.m. from DON. The policy indicated, "Resident have the right to choose their schedules, consistent with their interests, assessments, and care plans including choice for personal hygiene. This includes, but is not limited to, choices about the schedules and type of activities for bathing that may include a shower, a bed-bath or tub bath, or a combination and on different days...Bathing preference should be care planned including type and schedule."

This Federal tag relates to complaints IN00379801 and IN00379484.

3.1-38(a)(3)(A)
3.1-38(a)(3)(B)
3.1-38(a)(3)(E)
3.1-38(b)(2)

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F 0684 SS=G 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 interview and record review, the facility failed to administer residents' medications as ordered, timely address skin conditions, provide wound care as ordered, and administer treatments as ordered, resulting in debridement and delayed surgery for wound closure; for 3 of 3 residents reviewed for skin conditions, 1 of 3 residents reviewed for hospitalization, and 3 of 8 residents reviewed for unnecessary medications. (Residents B, F, 37, 82, 103, 229, and 233) Findings include: 1. The clinical record for Resident B was reviewed on 5/20/22 at 10:00 a.m. The diagnoses included, but were not limited to, neurogenic bladder. He was admitted to the facility from the hospital on 3/10/22. He discharged from the facility on 4/27/22 for a planned surgery for wound closure. The 3/10/22 hospital discharge summary read, "Condition on Discharge/Disposition: Stable condition will require extensive wound care and working with PT [Physical Therapy] and OT [Occupational Therapy.]" The 3/10/22, 5:54 p.m. nurse's note indicated his	F 0684	**F684** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident B is confidential as part of the complaint survey. Resident 229 medication orders were reviewed to ensure all medications were available for administration. Resident 233 is discharged from the facility. Resident 37 is discharged from the facility. Resident 82 dressings are correct. Resident 103: The resident was assessed by the NP for the need of Elidel Cream. Resident F is confidential as part of the complaint survey. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by the same deficient practices. 1.) Residents with	06/27/2022

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	wound vac was removed before being transported to the facility and had instructions to leave the wound vac off until Monday 3/14/22, as it would be put back on after his visit to the hospital wound clinic at 7:45am. He was currently using a wet to dry dressing. The 3/11/22, 5:11 p.m. Skin/Wound Note, written by the facility Wound Nurse, indicated Resident B had a surgical incision wound\line separation that went from his buttocks, perineum and left thigh region. The Wound Nurse was notified by the hospital emergency room nurse and EMT (emergency medical technicians) and family at bedside that resident's wound vac (vacuum) would be off until his 3/14/22, 7:45 a.m. hospital wound clinic appointment. The physician's orders indicated to cleanse buttock/perineum/incision/wound with normal saline, pat dry, apply wet-to-moist dressing/border gauze daily and as needed every day shift for surgical incision/line separation wound, effective 3/11/22. The March 2022 TAR (treatment administration record indicated this was not done on 3/12/22, 3/13/22, or 3/14/22. An interview was conducted with the Wound Nurse in the presence of the DON on 5/23 at 3:57 p.m. She indicated Resident B was supposed to admit to the facility with a wound vac, but didn't, so they got an order for the wet to dry dressing daily. She was unsure why it wasn't completed his first couple days in the facility. If they were completed, they should have been signed off on the TAR. There were no 3/14/22 hospital wound clinic		wound orders were audited to ensure the current treatment orders in place match the plan of care. 2.) New Admissions were reviewed to ensure their medications were available for administration, this will be an ongoing practice. 3.) All residents were audited to ensure that a weekly skin assessment is triggering in the E.H.R. 4.) All residents receiving insulin E.M.A.R will be audited to ensure insulin is being administered per order. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** 1.) Licensed clinical staff were educated on the policy on dressing changes. 2.) Licensed clinical staff were educated on the Medication Administration policy to include but not limited to administering insulin per MD order. 3.) Licensed clinical staff were educated on MD notifications. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the Director of Nursing Services or designee 2 times per week times 8 weeks, then monthly times 4	

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	notes. An interview was conducted with the facility Wound Nurse on 5/20/22 at 11:21 a.m. She indicated she was the wound nurse in March 2022 when Resident B admitted to the facility. They had issues with transportation getting him to his weekly wound appointments. The 3/16/22 hospital wound clinic note indicated it was his initial evaluation and treatment of sacral and perineal wound. The note indicated Resident B was accompanied by his parents for the visit. Resident B and his parents were very concerned about the wound healing prognosis and had multiple questions. The wound assessment was described as a chronic full thickness necrotizing fasciitis. The measurements were 32 cm X 40 cm X 9 Cm, with an area of 1280 sq cm and a volume of 11520 cubic cm. There was a moderate amount of sero-sanguineous drainage noted. The wound pain level was 4/10. The wound margin was not attached to wound base. The wound bed had 11-20% slough and 81-90% granulation. The periwound skin color was normal, and the periwound skin exhibited maceration. The wound clinic attempted to call the facility and left a voicemail for the DON (Director of Nursing) at the time to discuss the patient's plan of care and scheduling, detailed instructions for the wound vac application, and activity limitations. They were going to fax this note to the facility. It read, "Will see pt [patient] weekly in collaboration with SNF [skilled nursing facility] for wound care, next appointment Monday 3/21/22 at 10:30 a.m. Pt was given appointment card to give to the facility to arrange for transportation." The plan was for his NPWT (negative pressure wound therapy) to be changed twice a week or when soiled, once at the wound clinic on Mondays and once at the facility		months to ensure compliance: 1.) Wound care orders will be validated with emphasis on residents that are provided wound care at an outside facility. 2.) Observation to ensure dressing changes are being changed per MD orders. 3.) Validate that reporting on shower sheets have been reported to MD. 4.) Observation of residents to ensure areas of skin concern are reported to MD. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	on Thursdays. An interview was conducted with the DON on 5/24/22 at 2:02 p.m. She indicated Resident B did not go to his wound clinic appointment on 3/21/22, due to transportation. The scheduled transportation canceled. The March 2022 TAR indicated the above order for his wound vac was completed every Thursday beginning 3/17/22, but it also indicated the previous order of wet to moist dressing continued to be done daily. An interview was conducted with the Wound Nurse in the presence of the DON on 5/23/22 at 3:57 p.m. She indicated she knew they were doing the wound vac treatments on Thursdays, as ordered, and was unsure why the daily wet to dry dressings continued to be signed off on the TAR. There was no 3/29/22 weekly wound clinic note. The 4/5/22 hospital wound clinic note indicated his wound was ready for combination of excision and complex closure as well as skin grafting. He could have his wound vac reapplied. They recommended a nonstick contact layer such as Adaptic or silver layer such as a product called UrgoTul which was like Adaptic with silver impregnated. They were going to place his order for surgery. In the meantime, they recommended continuing the wound vac dressing. The April 2022 TAR did not indicate the addition of a nonstick contact layer as recommended on 4/5/22, rather it indicated a continuing of the previous order of normal saline, pat dry, wet to moist dressing and border gauze from his admission.			

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	There was no 4/12/22 weekly wound clinic note. The 4/19/22 weekly wound clinic note indicated Resident B had not been getting regular dressing changes and the facility took him off the wound vac because there was bone present in the wound and the facility claimed bone in the wound was contraindicated to a vac. Resident B educated facility that is was not a contraindication; however the size of the wound with the location made it difficult on a non-hospital vac which was a more likely reason for doing the wet to dry dressings. Resident B's mother informed the dressings hadn't been changed for some time, then were changed at 12:30 a.m. and the dressings had thick yellow/green drainage. The note indicated there was no change noted in the wound progression. Surgery for wound closure was scheduled for 4/27/22. It read, "Patient is in a facility; however, will be at [name of hospital] for urology appointment so would like to keep wound appointment next week prior to surgery. Pt sated that would be fine. Patient and family nervous about anything messing up surgery." The 4/25/22 weekly wound clinic note indicated he was 2 days in advance of his anticipated procedure for complex closure of his wound. On presentation, he had strikethrough green drainage from his wound. Acetic acid was started. Instructions were issued to parent to bring to facility, and they would be faxed there. It stated, "Do not anticipate further treatment is indicated at this time given plan for closure with [name of surgeon] on Wednesday." The plan read, "Dressings: ... Please change dressing twice per day at a minimum. Dressing was changed at 11:00 on 4/25, please change again in the evening. Apply acetic acid moistened gauze (acetic acid			

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	issued to patient) to wound and cover with ABD pads, secure with medipore tape. Again, change twice per day at a minimum, and more often if needed with strikethrough drainage." The 4/25/22 wound clinic orders for twice daily dressing changes were not added to the facility physician's orders until 4/27/22, after discharging from the facility. The April 2022 TAR indicated a second dressing change was not completed the evening of 4/25/22, nor was it completed twice daily on 4/26/22, as instructed in the 4/25/22 wound clinic note. The 4/26/22, 4:00 p.m., nurses note, written as a late entry on 5/6/22, read, "Res father presented writer with wound dressing concerns, writer then went in and completed res wound [sic] dressing, wound shows no s/s [signs/symptoms] of bleeding or foul odor, no drainage. Res given clean linen, placed in comfortable position. Denies pain/discomfort. Father at bedside, thanked and appreciated writer." The 4/27/22, 5:00 a.m. nurse's note, written as a late entry on 5/9/22, read, "writer and CNA [Certified Nursing Assistant] entered room together to meet patients needs before his scheduled transfer out. nurse offered drsg [dressing] change and pt declined, drsg still present and intact. offered colostomy bag empty/change, pt declined d/t [due to] not needed at the time. CNA emptied f/c [foley catheter] bag and pt did allow nurse to irrigate the cath [catheter.] CNA and nurse offered to change linens on bed, pt declined , pt was on clean linens with a lift sheet on it from shoulders to feet so that he could be transferred to cot. pt took his AM med with sips of water. pt declined getting a bed bath or washed up before he went."			

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4/27/22, 6:25 a.m. nurses note read, "pt sent out per ambulance, stretcher, for scheduled surgery. mother and father at bedside."

An interview was conducted with Family Member 33, Resident B's mother, on 5/23/22 at 2:50 p.m. She indicated
Resident B's wound was so infected when he discharged the facility on 4/27/22 that he couldn't get the surgery for wound closure. The surgeon said he could not close the wound. He needed it debrided. It was delayed 2 days. It was infected. It had green drainage. She was concerned it was infected prior to leaving. They went to wound care on Monday, 4/25/22, and it was green then and they said that wasn't good. They were going to get it all cleaned up for surgery. By Wednesday, 4/27/22, it was all green again. The wound care center said they wanted the dressing changed twice daily, but the facility said no, they were only going to do it once daily. The nurse at the facility said he was the only nurse there and couldn't do it twice. It was truly, truly horrible."

The 4/27/22-5/17/22 hospital notes indicated the planned procedure was debridement and skin graft plus complex closure on 4/27/22. The notes read, "A tissue biopsy was obtained 4/25/2022 that was polymicrobial w/Acinetobacter baumannii, Group A strep, Pseudomonas aeruginosa, Corynebacterium, and 1 colony of Staph aureus. He was admitted 4/27/2022 for planned surgery which ended up being a debridement only as his mother states his wound was not taken care of at [name of facility] and he presented with purulence. Following his debridement yesterday [4/27/22,] he has remained on IV Cefepime....CT scan also revealed a concern for osteomyelitis of the ischium. There are plans

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	for him to return to the OR [operating room] tomorrow for possible wound coverage...Surgical History Internal 04/29/2022 [name and title of surgeon] Skin Graft Split Thickness. 02/27/2022 [name and title of surgeon] Wound Debridement." 2. The clinical record for Resident 229 was reviewed on 5/17/22 at 9:45 a.m. The diagnoses included, but were not limited to: hyperlipidemia, edema, ventricular arrhythmias, heart failure, and hypertension. He was admitted to the facility from the hospital on 5/12/22. An interview was conducted with Resident 229 on 5/17/22 at 9:52 a.m. He indicated he did not receive any his medication for the first 2 days after admission. The 5/12/22 hospital discharge medication list indicated to start taking one 150 mg capsule of mexiletine every 8 hours, and the last dose was given on 5/11/22 at 12:40 p.m.; one 75mg tablet of clopidogrel daily, and the last dose was given on 5/11/22 at 10:03 a.m.; one 81mg tablet of aspirin daily, and the last dose given was on 5/11/22 at 10:01 a.m.; one 10 mg tablet of ezetimibe daily, and the last time it was given was 5/11/22 at 10:02 a.m.; one 21 mg nicotine patch to be applied daily, and the last time it was applied was 5/11/22 at 10:08 a.m.; one multivitamin tablet daily; one 60 mg tablet of torsemide daily; and one 400 mg tablet of amiodarone twice daily. The May, 2022 MAR (medication administration record) indicated the mexiletine was given only twice on 5/13/22 and twice on 5/14/22; the clopidogrel was not given at the facility for the first time until 5/14/22; the aspirin was not given at the facility for the first time until 5/14/22; the ezetimibe was not given for the first time until			

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	5/14/22; the nicotine patch was not applied for the first time at the facility until 5/15/22; the multivitamin tablet was not administered for the first time at the facility until 5/14/22; the torsemide was not given at the facility for the first time until 5/14/22; and the amiodarone was given at the facility only once on 5/13/22. The 5/13/22 physician note read, "Patient is being admitted following a COPD [chronic obstructive pulmonary disease] exacerbation and bronchitis. Patient is being admitted for continued medical care and therapy. Patient has some peripheral edema. Patient has not gotten his torsemide 20mg PO daily. Patient denies any other complaints or concerns...." An interview was conducted with UM (Unit Manager) 22 on 5/18/22 at 3:40 p.m. She indicated upon admission, the medication orders are faxed to the nurse practitioner on call, who enters the orders into the computer, which went straight to the pharmacy. Normally, Resident 229's medications would have been delivered to the facility the morning of 5/13/22, around 6:00 or 7:00 a.m. Some of the Resident 229's admission medications were in the emergency drug kit, like the Aspirin, but he should have received all of his medications on 5/13/22. The Medication Administration policy was provided by the DON (Director of Nursing) on 5/19/22 at 9:05 a.m. It read, "Medication will be administered as prescribed." 3. The clinical record for Resident 233 was reviewed on 5/17/22 at 1:30 p.m. The diagnoses included, but were not limited to, sciatica and osteomyelitis of vertebra. He was admitted to the facility on 4/28/22.			

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	The skin integrity care plan, revised 5/18/22, indicated he was at risk for altered skin integrity related to his disease process with an intervention to complete weekly skin checks. An interview was conducted with Resident 233 on 5/17/22 at 2:01 p.m. He indicated he found a knot on his stomach, on the lower left side. It was hard and knotty. He informed one of the NPs (nurse practitioners,) and was told he needed to tell his physician. He also had red, splotchy skin and red spots that were popping up on his chest since admission. On 5/17/22 at 2:01 p.m., an observation of Resident 233's upper chest was made when he pulled down the neck of his shirt. There were small, scattered, red, raised bumps. The physician's orders indicated to complete weekly skin assessments on day shift on Thursdays for skin assessments of skin health, starting 5/5/22. The May 2022 TAR (treatment administration record) indicated skin assessments were completed on 5/5/22, 5/11/22, and 5/19/22. There were no corresponding skin assessments in the EHR (electronic health record.) An interview was conducted with Resident 233 on 5/25/22 at 2:51 p.m. He indicated no one had addressed the knot on his stomach or the small red dots on his chest, nor had any nursing staff ever performed a skin assessment on him. An interview was conducted with UM (Unit Manager) 2 on 5/25/22 at 3:10 p.m. She indicated nurses are to physically do a head-to-toe skin			

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	assessment during a weekly skin assessment. She reviewed Resident 233's electronic clinical record and indicated no skin assessments triggered. Upon admission, the EHR is supposed to trigger a skin assessment to be completed and documented under the assessments section of the EHR. An interview was conducted with UM 2 on 5/26/22 at 10:53 a.m. She indicated she went in to see Resident 233, and he did have small pimples on his chest and an area on his stomach that was kind of hard. She informed the NP, who was going to look at him the next time they were in the facility. The 5/25/22, 12:18 p.m. nurse's note, recorded as a late entry on 5/26/22 at 9:22 a.m. read, "...Writer also addressed res [resident] concern regarding his skin, skin assessment completed, notified in house NP. NP will follow up with res. Res complains of no pain/discomfort at this time. Family made aware." On 5/25/22, skin assessments were created under the assessments section of the EHR by UM 2 for 5/5/22, 5/12/22, and 5/19/22. All of the assessments indicated there were no skin conditions, or changes, ulcers, or injuries. 4. The clinical record for Resident 37 was reviewed on 5/16/22 at 2:31 p.m. The Resident's diagnosis included, but were not limited to, chronic kidney disease and hypothyroidism. An Admission MDS (Minimum Data Set) Assessment, completed 2/23/22, indicated she was cognitively intact. She had no skin tears and did not display behaviors such as scratching herself. A care plan, last revised on 3/7/22, indicated she			

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	was at risk for altered skin integrity due to immobility. The goal, last revised on 3/17/22, was for her to be without impaired skin integrity. The interventions, initiated 2/11/22, were for her to have skin at risk assessments quarterly and as needed, weekly skin checks were to be completed and therapy was to evaluate and treat as needed. On 5/24/22 at 10:16 a.m., NC (Nurse Consultant) 3 provided the May shower records for Resident 37. They indicated that on 5/2/22 she had redness and skin tears, 5/7/22 she had an open area, redness, and skin tear, 5/9/22 she had skin tears, 5/14/22 she had an open area, redness and bleeding, and skin tears. The comments section of the shower sheet included that she suffers from severe itching on her body and that lotion was applied and linen changed, 5/16/22 shower record had redness and skin tear recorded and the comment section included that the nurse was aware of the areas. The skin sheets were signed by the Certified Assistant that provided the shower and Unit Manager 2. On 5/16/22 at 2:31 p.m., Resident 37 was observed lying in bed. She was scratching her arms. She had multiple open areas on her arms and legs. She indicated that she had "itchy" skin. On 5/24/22 at 11:00 a.m., she was observed laying in her bed. She had white sleeves present on both arms, which were spotted with blood. She had open, bleeding areas on her right shoulder, left arm and both hands. She was scratching at her skin. Her nails were long and had blood on the nail beds and under the nails. During an interview on 5/24/22 at 11:05 a.m., LPN (Licensed Practical Nurse) 30 indicated she had not noticed any skin areas when she had			

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administered her medication earlier in the morning.

During an interview on 5/24/22 at 12:04 p.m., Unit Manager 2 indicated she had a picking behavior. She would pick at her arms and when she did the staff would apply geri sleeves. There was lotion that was applied for it.

During an interview on 5/24/22 at 12:15 p.m. SS (Social Service) 1 indicated that she was unaware of Resident 37 having a behavior of picking at her skin.

On 5/24/22 at 12:20 p.m., she was observed with SS 1, who indicated she had not looked like that before. She was bleeding from several open areas and had blood on her hands. She would make sure the physician was made aware of the areas.

During an interview on 5/24/22 at 2:10 p.m., NP (Nurse Practitioner) 6 indicated she had not been informed of her itching previously and that she would have wanted to know about the itching and open areas.

5. The clinical record for Resident 82 was reviewed on 5/17/22 at 10:37 a.m. The Resident's diagnosis included, but were not limited to, Parkinson's disease and anxiety.

A physician's order, dated 12/2/21, was for a wet to dry dressing to be applied to the right calf twice daily.

A care plan, last revised on 12/28/21, indicated she had impaired skin integrity due to a wound on her right lower leg. The goal, last revised on 3/17/22, was for her to have no complications to the right leg. An intervention, initiated 12/16/22, was to administer treatments as ordered by the

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	medical provider. A Quarterly MDS Assessment, completed 3/23/22, indicated she was cognitively intact. A physician's order, dated 5/4/22, indicated to cleanse right lower leg and pat dry, apply silver alginate (wound dressing) to wound bed and then apply a border gauze. Change the dressing 3 times weekly and as needed. During an interview on 5/17/22 at 10:24 a.m., she indicated that she had a sore on her right leg that had been "giving her trouble." The dressing did not always get changed. On 5/23/22 at 10:40 a.m., she was observed lying in bed in a hospital gown. She indicated the last time her dressing was changed was Saturday. She removed the sheet from her leg and there was a kerlix (gauze strip) dressing which was labeled with the date of 5/21/22. On 5/23/22 at 10:57 a.m., RN (Registered Nurse) 8 was observed changing her dressing to her right lower leg. The 5/21/22 kerlix dressing had been removed, revealing a boarder gauze dressing, dated 5/19/22. She removed the boarder gauze dressing with her gloved hands. The dressing had two 2 x 2 squares, which were stiff and covered with a dark red substance and had an oblong dark yellow area in the middle. She indicated the dressing was saturated with blood and puss. She then cleansed the area with a dry 4x4 gauze. She then changed her gloves, without performing hand hygiene, and sprayed wound cleanser on the wound. She covered the wound cleanser with silver alginate and applied a new border gauze dressing.			

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	The May 2022 TAR (Treatment Administration Record) indicated that the wet to dry dressing to right calf had been completed at least daily, except for on 5/13 and 5/14/22. The May 2022 TAR indicated the silver alginate dressing was to be changed on Tuesdays, Thursdays, and Saturdays. It had not been initialed as completed on 5/14 and 5/17/22. It had been initialed as completed on 5/21/22, however the silver alginate dressing present on her leg on 5/23/22 had been dated as completed on 5/19/22. During an interview on 5/24/22 at 3:47 p.m., the Wound Nurse indicated that silver alginate dressing to her right lower leg should have been completed as ordered. The order for the wet to dry dressing should have been discontinued. The area on her right calf had been healed for some time. 6. The clinical record for resident 103 was reviewed on 5/16/22 at 3:25 p.m. The Resident's diagnosis included, but were not limited to, congestive heart failure and chronic respiratory failure. A care plan, initiated 12/17/21, indicated he was at risk for impaired skin integrity related to his disease process, immobility, poor nutrition, and poor vascularity. The goal, initiated 12/17/21, was for him to be without impaired skin integrity. The interventions, initiated 12/17/21, included, but were not limited to, complete skin at risk assessments upon admission/ readmission, quarterly and as needed and to complete weekly skin checks. A progress note, dated 1/28/22 at 1:25 p.m., indicated he was re-admitted to the facility and			

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	appeared to have a patch of psoriasis noted on his face. A physician's order, dated 1/28/22, indicated he was to have Elidel Cream 1% (cream used to treat dermatitis) applied to his face every day for treatment of psoriasis patches on face. The order was discontinued on 4/20/22 when he went to the hospital for acute care. A Quarterly MDS Assessment, completed 4/2/22, indicated he was cognitively intact. On 5/16/22 at 3:25 p.m., he was observed sitting on the side of his bed. He had flakey crusts of skin in his right ear and on his forehead. On 5/19/22 at 10:48 a.m., he was observed sitting in his room. Flakey crusts of skin were noted on forehead. On 5/23/22 at 10:54 a.m., he was observed laying sideways on bed. He was dressed in a black tee shirt and had been shaved. He had reddened areas on face. On 5/25/22 at 2:50 p.m., he was observed sitting in his room. He had red and scaly patches on his cheeks, chin, and forehead. He indicated he used to have some cream that the nurses put on his face. During an interview on 5/52/22 at 3:08 p.m., QMA (Qualified Medication Aide) indicated that a physician should have been informed of the red, crusty areas on his face. 7. The clinical record for Resident F was reviewed on 5/19/22 at 3:44 p.m. Resident F's diagnoses included, but not limited to, end stage renal disease, cerebral infarction, and chronic			

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	obstruction pulmonary disease. Resident F's annual MDS (Minimum Data Set) dated 3/9/22 indicated, Resident F was cognitively intact. An interview with Resident F was conducted on 5/17/22 at 10:11 a.m. Resident F indicated; they do not always get their insulin. Resident F's May 2022 MAR (Medication Administration Record) was reviewed on 5/24/22 at 2:05 p.m. from DON (Director of Nursing). The May Mar indicated the following: - Lantus Solo Star pen; give 13 units at bedtime - no administrations recorded for 5/12/22, 5/13/22, and 5/14/22. - Lantus solution; 14 units in morning - no administrations recorded on 5/9/22. On 5/13/22 and 5/18/22 a "NC" was charted. NC was determined by DON to stand for "no coverage" given. - Humalog solution; 7 units three times a day - no administrations recorded on 5/3/22 for p.m. dose, 5/9/22 for morning and afternoon doses, 5/12/22 p.m. dose, 5/13/22 p.m. dose. On 5/15/22, the morning dose was coded "9" for see nurses notes. On 5/18/22, the morning dose was coded as "NC". The clinical record did not contain any additional information regarding the code "9" for 5/15/22 nor the "NC" for 5/18/22. - Humalog solution sliding scale - no administrations or blood sugar readings recorded for 5/3/22 for 6 p.m.; 5/9/22 for 8 a.m. and 1 p.m.; 5/13/22 and 5/14/22 for 6 p.m.			

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	155272	A. BUILDING 00 B. WING	05/26/2022

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	A Medication Administration Policy was received on 5/19/22 at 9:05 a.m. from DON. The policy indicated, "The purpose of this policy is to provide guidance for the process for providing monitoring that all medications are received and administered in a timely manner. Procedure: I. Administration Preparedness a. Medications will be administered as prescribed...If medication is not given, indicate on MAR reason it was withheld and physician notified (if applicable)..." This Federal tag relates to complaints IN00380287 and IN00379008 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on interview and record review, the facility failed to ensure residents received proper treatment and/or assistive devices to maintain vision for 2 of 3 residents reviewed for communication and sensory. (Residents 5 and 8) Findings include:	F 0685	F685 – Social Services 1) Resident 5 and resident 8 were seen by optometry/placed on optometry list for next visit? Residents were not harmed by the deficient practice. 2) All residents with impaired vision have the potential to be	06/27/2022

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	1. The clinical record for Resident 5 was reviewed on 5/19/22 at 9:04 a.m. Resident 5's diagnoses included, but not limited to, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting left side, dementia, cerebral infarction, bipolar disorder, and anxiety disorder. Resident 5's quarterly MDS (minimum data set) dated 1/19/22 indicated, Resident 5 was cognitively intact. Resident 5 was totally dependent on the assistance of one person for dressing, bathing, and toileting. A physician's order for Podiatry, Dental, Optometry or Ophthalmology was received on 4/14/2022. An interview with Resident 5 was conducted on 5/17/22 at 2:24 p.m. Resident 5 indicated, she had a pair of prescription glasses but, they had broken some time ago. She has reading glasses but was having issues with seeing things in the distance. She stated, she has not seen an eye doctor. Resident 5's annual MDS (Minimum Data Set) dated 11/18/21 indicated, her vision is adequate and had corrective lenses. An interview with SS (Social Services) 2 conducted on 5/19/22 at 10:59 a.m. indicate, Resident 5 had not been seen by an eye doctor within the last year. The company the facility has contracted to provide vision care had been given Resident 5's consent to treat. Yet, that company had not ensured residents were seen at least yearly. 2. The clinical record for Resident 8 was reviewed		affected. An audit was performed to ensure that all residents needing/requesting vision services were seen by vision services or scheduled to be seen on upcoming visit. 3) IDT team including social services were educated on ensuring all residents needing and/or requesting to be seen by vision services are seen in a timely manner. 4) Director of Nursing or designee will audit 5 residents per week x 1 month, then 3 residents per week x 1 month, then 5 residents per month x 4 months to ensure they have received vision services if needed and/or requested. 5) =”” b=””>The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	on 5/20/22 at 8:59 a.m. Resident 8's diagnoses included, but not limited to, hemiplegia, congestive heart failure, type II diabetes, and hypertension. An interview with Resident 8 was conducted on 5/16/22 at 11:49 a.m. She indicated; she has some vision issues but hasn't seen an eye doctor. Resident 8's annual MDS dated 9/15/21 indicated, Resident 8 had adequate vision and has corrective lenses. Resident 8's quarterly MDS dated 4/22/22 indicated the same information as the annual. A vision visit document dated 6/9/21 indicated, Resident 8 was seen on that day and the reason for the visit was for an intraocular pressure check. The diagnosis was bilateral pre-glaucoma. The treatment plan was for a vision exam in 6 months. An interview with SS 1 was conducted on 5/19/22 at 10:50 a.m. SS 1 indicated; Resident 8 was not seen by vision services in the 6 months from her last exam. SS 1 indicated, the vision company not the facility was accountable for ensuring required follow-up was scheduled and occurred. She stated, if they (vision services) recommended a follow-up then they need to ensure it happens. A vision services policy was requested however, DON (Director of Nursing) indicated, the facility did not have such a policy. 3.1-39(a)(1)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer			

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	§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to timely treat a stage 2 pressure ulcer for 1 of 2 residents reviewed for pressure ulcers (Resident G). Findings include: The clinical record for Resident G was reviewed 5/16/22 at 3:05 p.m. The Resident's diagnosis included, but were not limited to, tracheostomy and acute respiratory failure. A care plan, initiated 5/4/22, indicated that she had a stage 2 pressure ulcer on her left planter foot (ball of foot). The goal was to have no complications from her altered skin integrity. The interventions included, but were not limited to, administer treatments as ordered, initiated 5/4/22. A Wound Evaluation, dated 5/5/22, indicated she had a blister with serous (clear) fluid on her left planter foot, which was present upon admission to the facility. The dressing to be applied was skin prep (skin protectant).	F 0686	**F 686** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident G is confidential as being identified in a complaint survey. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DON or designee will audit the following: 1). all residents identified with wounds will be reviewed to ensure a current treatment is in place **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Director	06/27/2022

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	The May 2022 TAR (Treatment Administration Record) indicated the left plantar food was to be cleansed and patted dry. Skin prep was to be applied daily and as need to the left planter foot. There were no initials, indicating the treatment has been completed for the following days 5/5, 5/6, 5/7, 5/8, 5/9, 5/10, 5/11, 5/13, and 5/14/22. During an interview on 5/24/22 3:47 p.m., the Wound Nurse indicated the skin prep should have been applied to her left planter foot daily starting on 5/5/22. This Federal tag relates to complaint IN00379801. 3.1-40(a)(2)		of Nursing or designee will re-educate the Licensed Nurses on the following facility policy: Skin Care & Wound Management Overview **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the DON or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance:). Residents identified with wounds will be reviewed to ensure a current treatment is in place. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.			

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	§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to deactivate a resident's AUS (artificial urinary sphincter) prior to catheterizing him, provide catheter care, empty and obtain urine outputs, and administer an antibiotic for a resident with a Urinary Tract Infection (UTI,) as ordered, for 1 of 1 resident reviewed for discharge and 1 of 3 residents reviewed for hospitalization. (Residents B and 127) Findings include:	F 0690	**F 690** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident B is confidential as being identified in a complaint survey. Resident 127 has been discharged. **Identification of other residents**	06/27/2022

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	1. The clinical record for Resident B was reviewed on 5/20/22 at 10:00 a.m. The diagnoses included, but were not limited to, neurogenic bladder. He was admitted to the facility from the hospital on 3/10/22. The 3/11/22 care plan indicated he had a foley catheter related to neurogenic bladder. The 3/10/22 hospital discharge summary read, "3/10 [3/10/22] Patient discharging to [name of facility] skilled nursing facility for ongoing wound management. He is in stable condition. His monti [sic] with foley catheter in place draining without any problems...Neurogenic bladder...16 French catheter anchored in Monti channel. Patient to catheterizing 16 French catheter going forward instead of 14 French. Patient is an at fissure [sic-has an artificial] urinary sphincter. Do not catheterize per urethra. If urethral catheter attempts need to be made in the future the sphincter must be deactivated and 8, 10, or 12 French Foley catheter she [sic] will be utilize [sic] but cannot be anchored in place longer than 24-36 hours. Please page Urology further issues with catheter drainage. Will order scheduled forward flushes of catheter with 60 cc P stump syringe. Urology to schedule outpatient follow-up appointment approximately 4 weeks." The specific orders from the hospital to not catheterize per urethra and to deactivate the artificial urinary sphincter if urethral catheter attempts were needed were nowhere on the facility's physician's orders. The 3/24/22, 9:46 p.m. nurse's note, written by LPN (Licensed Practical Nurse) 23 read, "Resident was complaining of pain on his abdomen. He was complaining about the need to void even though		**having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DON or designee will audit the following: 1). All residents identified with catheters will be reviewed to ensure the catheter care policy is being followed. 2.) Antibiotics are being administered per MD order. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Director of Nursing or designee will re-educate the Licensed Nurses on the following facility policies: 1.) The Catheter Care Policy 2.) The Male intermittent or straight catheterization policy **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the DON or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Residents identified with catheters will be reviewed to ensure the facility policy related to catheter care is being followed. 2.) Antibiotics are being administered per MD order. The results of the audit observations will be reported,	

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	he has a supra pubic catheter. In his bag the out put was less than 50 ml. Upon assessment, his abdomen appears distended, and tender during palpation. He added that this had happened before while he was in the hospital, and they performed in and out catheterization on him. As he continue to complain of pain/discomfort, staff performed catheterization and got an out put of about 1700 ml. It appears that his supra pubic catheter is not functioning well and a [sic]such a referral to a urologist was advised for further assessment, evaluation and replacement." An interview was conducted with LPN 23 on 5/23/22 at 2:31 p.m. He indicated he did not remember exactly what happened prior to Resident B going to the ED on 3/25/22. He was unaware Resident B had an artificial urinary sphincter. He was unfamiliar with an AUS and couldn't remember ever caring for a resident that had one. The 3/24/22, 10:25 p.m. physician note read, "Minutes spent on case: 4. Comments: Patient reported suprapubic pain. He has a suprapubic catheter that has had very little drainage today. Straight cath [catheterization] was done with 1700 mL output. Recommend follow up with urologist. Straight cath every 6-8 hours depending on symptoms for urinary retention." The 3/25/22, 6:01 a.m. nurse's note read, "in and out cath for 300 ml urine. cloudy urine return at start of procedure, then cleared." On 5/26/22 at 10:55 a.m., an interview was conducted with LPN 24, who signed off on the TAR as having in and out catheterized Resident B on 3/25/22 at 6:00 a.m. prior to Resident B going to the ED. She indicated she in and out catheterized him just before he went to the ED. She went		reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	through his penis and drained his bladder that way. He kept his catheter in. The only way she could do it was to go through his penis. She reported that it didn't look good at the time, that the catheter was blocked. She was told during report that she needed to in and out catheterize him. She questioned why they were doing it, because it was unusual to have and in and out catheter order, as she was used to irrigating him. She didn't do anything differently for him, having an AUS, then she did for someone without one. The 3/25/22, 10:02 a.m. nurse's note read, "call placed to [name of urologist] urologist, [phone number of urologist.] resident has an appointment on 4/21/22, called to see if appointment can be moved up. left a message, the turnaround time is up to 24 hours. MD in house made aware, mom at bedside made aware." The 3/25/22, 1:04 p.m. nurse's note read, "Resident sent to 'name of hospital' per [name and title of NP] via ambulance for decreased urine output." The 3/25/22 Hospital ED (Emergency Department) notes read, "...presenting to ED with/difficulty draining urine from his suprapubic cath X [times] 1 day...has had to in and out cath twice...Assessment/Plan 1. Catheter Problem...Of note, since his urethra was catheterized without deactivating the AUS, we had scoped the urethra with and found no evidence of erosion. We had also scoped the monti channel and found no abnormalities...His parents contacted 911 to transport him to the ED today because they are worried about the quality of care he is receiving there. The parents and patient have adamantly requested that the facility not catheterize his urethra due to his AUS, and the mother presents with documentation from his medicolegal records			

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	there that also document the urethra cannot be catheterized....For the last 2 days the nursing has been catheterizing his urethra despite specific instructions not to do so....Assessment/Plan: Monti channel catheter was due for exchange so I replaced a new catheter into the monti channel, outflow of clear yellow urine confirmed...Old catheter was occluded with hardened mucous. I instructed patient and family today on how to cycle the AUS too allow for drainage of the bladder, if he has recurrent issue with the catheter and the nurses at his facility are not able to assist in an appropriate, timely fashion. Will have ED case manager come down and speak with patient and family. There is clearly concern for frank negligence from this healthcare facility." An interview was conducted with Family Member 33, Resident B's mother, on 5/23/22 at 2:50 p.m. She indicated Resident B had a lot of sediment in his bladder and the catheter kept clogging. Nursing was supposed to irrigate it, but several didn't know how to do it, or were doing it wrong. She saw one nurse try to go through his belly button. They were pushing fluid into the catheter, but not pulling it out. They weren't willing to change the Foley catheter or put a new one in, so they ended up in the ED. The hospital replaced the catheter. They had had been told not to catheterize through his urethra. She assumed the facility knew that, but when she talked to them, they said they did what they had to do to give him relief and were not going to apologize for that. Family Member 33 told nursing they should have deactivated the sphincter to give him relief, and nursing should have addressed the no urine output after 2 hours instead of waiting until after 6 hours. On 5/26/22 at 10:40 a.m., an interview was			

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	conducted with QMA (Qualified Medication Aide) 34, who signed off on the TAR (treatment administration record) as having in and out catheterized Resident B on 3/25/22 at 12:00 p.m. prior to going to the ED. She indicated she did not do his in and out catheter. A lot of times, she would tell nurses she needed stuff done and so she would sign off on it, because they didn't do it. She definitely did not do his in and out catheter. She had never cared for a resident with and AUS before and wouldn't know how to if they did have one. She would need to report it to the nurse and the nurse would have to do it. An interview was conducted with NP 6 on 5/23/22 at 3:04 p.m. She indicated she was unsure if Resident B knew how to cycle his AUS, prior to going to the ED on 3/25/22. She met him on 3/29/22. The only time she'd seen an AUS, nothing needed to be done to it. She was uncertain how to care for it. To her knowledge, the nursing staff wouldn't know how to deactivate an AUS. She didn't think the orders from the 3/10/22 hospital discharge summary made its way onto the facility's orders or MAR. Resident B told her he shouldn't be in and out catheterized, and she informed him they shouldn't be doing it then. She didn't know if she discontinued the order for the in and out catheter every 8 hours or not, but it was discontinued on 3/29/22. She doubted the on-call physician assistant who placed the order would have known about Resident B's AUS. They would have only known what the nurse told them. The Male Intermittent or Straight Catheterization policy was provided by the DON (Director of Nursing) on 5/24/22 at 12:23 p.m. It read, "1. Basic knowledge and skills for intermittent catheterization a. Validate physician/provider order for the specific resident."2. The clinical			

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ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250

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	record for Resident 127 was reviewed on 5/26/22 at 8:30 a.m. The diagnosis included, but were not limited to, sepsis and paraplegia. The resident was admitted to the facility on 12/15/21 and discharged on 2/17/22. A care plan dated 12/16/21 indicated "...The resident has an indwelling foley catheter impaired skin integrity...Interventions: ...observe/record/report to MD [medical doctor] for s/sx [signs and symptoms] UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp [temperature], urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns...provide catheter care every shift and PRN [as needed]..." A physician order dated 12/15/21 indicated Resident 127 staff was to change the resident's 16 French foley catheter monthly and as needed. A physician order dated 12/15/21 indicated the resident's foley catheter bag was to be emptied every shift. A physician order dated 12/15/21 indicated the staff was to provide catheter care to the resident every shift. A physician order dated 1/25/22 indicated the resident was to receive 1 gram of ceftriaxone antibiotic for 7 days due to a diagnosis of UTI. A lab report date collected on 1/25/22, indicated Resident 127 had an abnormal urine culture. It indicated the resident had greater than 100,000 CFU/ml [the number of colonized bacteria] of proteus mirabilis [bacteria] was found in her urine			

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	collection. The January 2022 Medication Administration Record (MAR) indicated Resident 127 had received 6 out of the 7 dosages of ceftriaxone antibiotic. It indicated the staff administered 1 gram of ceftriaxone to the resident on the following days: 1/25/22, 1/26/22, 1/27/22, 1/28/22, 1/29/22, and 1/31/22. The resident had not received the ceftriaxone on 1/30/22 with a reason documented by staff as "possible side effect." The January 2022 Treatment Administration Record (TAR) indicated the following days and shifts the resident's foley catheter urine bag was not drained with recorded urine outputs, and catheter care was not provided: 1/4/22 - night shift, 1/6/22 - night shift, 1/9/22 - days shift, 1/15/22 - evening shift, 1/16/22 - evening shift, 1/21/22 - evening shift, 1/28/22 - day shift, 1/29/22- day shift, and 1/30/22 - evening shift. The February 2022 TAR indicated the following days and shifts the resident's foley catheter urine bag was not drained with recorded urine outputs, and catheter care was not provided: -Drainage of urine bag was not emptied with recorded urine outputs: 2/3/22 - day shift and night shift, 2/4/22 - evening shift, 2/8/22 - day shift, 2/15/22 - evening shift, and 2/16/22 - evening shift. -Catheter care was not provided: 2/3/22 - day shift, 2/4/22 - evening shift, 2/8/22 - day shift, 2/15/22 - evening shift and 2/16/22 - evening shift.			

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	An interview was conducted with the Sister Facility Director of Nursing on 5/26/22 at 12:03 p.m. She indicated she was unsure why the ceftriaxone was not administered for the 7 days as ordered to Resident 127. She was unable to determine why catheter care was not documented as provided nor any urine outputs recorded on those missing days on the January 2022 and February 2022 MARs/TARs as ordered. The Catheter Care policy was provided by the Sister Facility Director of Nursing on 5/26/22 at 11:55 a.m. It indicated "...Policy: It is the policy of this facility to provide resident care that meets the psychosocial, physical, and emotional needs and concerns of the residents. Catheter care is performed at least twice daily on residents that have indwelling catheters, for as long as the catheter is in place. CAUTI (Catheter Associated Urinary Tract Infections) is the most common adverse event associated with indwelling urinary catheters, including those that are asymptomatic...The risk of bacteremia in residents with indwelling catheters is 3-36 times more likely than residents without an indwelling catheter. Biofilm is the most important cause of bacteriuria in residents with catheters. Reducing the biofilm by performing daily care may help prevent symptomatic infections and incorporate and incorporate antibiotic stewardship recommendations to reduce unnecessary drugs and antibiotics to reduce resistant strain of infections, as well as maintain the dignity and hygiene of the resident..." This Federal tag relates to complaint IN00379008. 3.1-41(a)(2)			

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F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to obtain weekly weights, as ordered, and to obtain and document accurate weights, using a mechanical full body lift with a sling, for 1 of 4 residents reviewed for hospitalization and 1 of 2 residents reviewed for nutrition. (Residents 37 and 50) Findings include: 1. The clinical record for Resident 50 was reviewed on 5/17/22 at 2:59 p.m. The diagnoses included, but were not limited to, dysphagia and malnutrition. The 3/3/22 quarterly nutrition assessment	F 0692	**F 692** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident 50 weight has been obtained per MD order. Resident 37 has been discharged. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: Director of Nursing Services or designee will review: 1.) All	06/27/2022

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	indicated her ideal body weight was 105 pounds. She had a nutrition diagnosis of "at risk for decline" as evidenced by an underweight status, low BMI (body mass index,) total dependence, and past medical history. The physician's orders indicated to obtain weekly weights on Mondays in the morning for weight monitoring, starting 12/27/21. The April 2022 and May 2022 TAR (treatment administration record) indicated weekly weights were taken on 4/4/22, 4/11/22, 4/18/22, and 5/16/22, but there were no actual recorded weights. The TAR indicated weights were not taken on 4/25/22, 5/2/22, and 5/9/22 as ordered, as the TAR was blank on those dates. The April 2022 to present weights from the Weights and Vitals section of the EHR (electronic health record indicated only 2 weights were obtained in April 2022 and May 2022. The first was a weight of 80 pounds on 4/12/22, which represented an 11.3% loss over the last 6 months when compared to a weight of 90.2 pounds on 10/4/21. The second weight was also 80 pounds on 5/1/22, which represented a 13.2% loss over the last 6 months when compared to a weight of 92.2 pounds on 11/2/21. An interview was conducted with UM (Unit Manager) 22 on 5/20/22 at 2:34 p.m. She indicated weights were documented in the vitals section of the electronic health record and staff did not document weights in a separate weight book or binder. She reviewed Resident 50's weights from the vitals section and indicated she did not see that weekly weights were done as ordered, just monthly.		residents to ensure weights are being obtained for admission / readmission and as ordered by the MD. 2.) Residents being weighed with a mechanical lift scale. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Director of Nursing Services or designee will re-educate the nursing staff on the following policy: 1.) Resident weight policy 2.) Performance of a weight with mechanical lift scale. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the Director of Nursing Services or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1.) Review residents to ensure weights are being obtained for admission / readmission and as ordered by the MD. 2.) Residents being weighed with a mechanical lift scale. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further	

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	The Resident Height and Weight policy was provided by the Nurse Consultant on 5/24/22 at 3:06 p.m. It read, "Weights will be obtained with changes in condition or as ordered by the physician or practitioner....Document the weight, the scale and any unusual events associated with obtaining the weight in EHR." 2. The clinical record for Resident 37 was reviewed on 5/16/22 at 2:31 p.m. The Resident's diagnosis included, but were not limited to, chronic kidney disease and hypothyroidism. An Admission MDS (Minimum Data Set) Assessment, completed 2/23/22, indicated she was cognitively intact. Her weight was 224 pounds and she received 51% or more of her calories through a tube feeding. A dietary progress note, dated 3/14/22 at 9:11 a.m., indicated she had triggered a significant weight loss of 5% in 30 days. A re-weight was requested to suspicion of March weight being incorrect. A dietary progress note, dated 5/5/22, indicated her weight was 181 pounds. She had a 19.2% weight loss in 90 days. She remained NPO (Nothing Per Mouth) and received 100% of her nutrition through a gastric tube. The change in weight in the last 2 months was due to unknown causes. During an interview on 5/16/22 at 2:33 p.m., she indicated that she had lost weight since she had been at the facility. A dietary progress note, dated 5/17/22 at 4:03 p.m., indicated she had a potential significant weight gain. There was suspicion of the weight's accuracy. A re-weight had been recommended.		recommendation.	

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	During an interview on 5/24/22 at 2:30 p.m., the Registered Dietician indicated she was unsure of how accurate the weights were, especially for those residents who were weighed using the full body lift with a sling. She was receiving the amount of formula needed to meet her needs according to her calculations, based on her weight. She had increased the amount of tube feeding formula she received multiple times. If the weights were inaccurate, it was difficult for her to assure she was getting the right amount of nutrition. The weights had been an ongoing issue. On 5/24/22 at 2:42 p.m., CNA (Certified Nursing Assistant) 4 was observed demonstrating the process she used while obtaining a weight with the full body mechanical lift scale using a sling. She indicated she would put the pad under the resident and may put a pillow behind their head or back if they needed it for comfort. She would then elevate the resident in the sling and weigh them. She would zero out the mechanical lift scale to zero while there was nothing on the lift. She did not zero out the scale with the sling on it. On 5/24/22 at 3:06 p.m., Nurse Consultant 3 provided the Resident Heigh and Weight Policy, last reviewed on 7/16/21, which read "...obtain weight on scales that have been calibrated per the manufacturing recommendations...4) Accurate weight a) unless a compelling reason exists, obtain weight in the morning before meals and post voiding to obtain the most accurate body weight. b) Obtain weight using similar clothing and the same scale if possible...5) Weight procedure...ii) sling scale: (1) follow manufacturer's directions for appropriate positioning of patient in sling to obtain an accurate weight..."			

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	On 5/24/22 at 3:30 p.m., Nurse Consultant 3 provided the Operating Instructions for the mechanical lift scales which read "... Weighing a patient 1. Connect the sling to the spreader bar and press the ON/Zero[sic] pad to zero the scale. Make sure no part of the sling or spreader bar is touching the floor or any surrounding objects. 2. place the sling around the patient. Lift the patient clear of the bed or chair in accordance with the lift manufacturer's instructions..." 3.1-46(a)(1)			
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 use proper technique when providing tracheostomy care to 1 of 1 resident reviewed for tracheostomy care (Resident G). Findings include: The clinical record for Resident G was reviewed 5/16/22 at 3:05 p.m. The Resident's diagnosis included, but were not limited to, tracheostomy and acute respiratory failure.	F 0695	F695 1) Resident G was part of a confidential survey and could not be identified. 2) All residents with tracheostomies have the potential to be affected. An audit was performed on all residents with tracheostomies to ensure tracheostomy care was performed correctly. 3) All respiratory therapists and license nurses were educated	06/27/2022

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	A physician's order, dated 5/3/22, indicated to provide tracheostomy care every day and night shift. A physician's order, dated 5/3/22, indicated the inner cannula was to be changed and/or cleaned daily and as needed. On 5/26/22 at 9:15 a.m., RT (Respiratory Therapist) 15 was observed providing tracheostomy care for her. She entered the room and donned a disposable isolation gown. She put on a pair of non-sterile disposable gloves. She opened the tracheostomy suctioning kit and then donned the sterile gloves from the suctioning kit over her non-sterile gloves. She removed the suction catheter from the kit and turned on the suction machine, using her gloved hands. She placed the suction catheter onto the suction tubing and used her right hand to move the humidity tubing and collar from the tracheostomy area. She then used her right hand to suction the tracheostomy. She removed the suction catheter from the suction tubing and removed the sterile gloves, throwing them away. She then used the non-sterile gloves, had been under the sterile gloves to open the tracheostomy care kit. She removed a bottle of sterile water from the bed side table drawer. The bottle of sterile water had been previously opened and did not have a date open on it. She poured the sterile water into the disposable container from the tracheostomy care kit. She took the brush from the kit and poured sterile water onto it. She then removed the gauze from the tracheostomy site and used the brush to clean around the tracheostomy in a scrubbing motion. She then dried the tracheostomy area with a 4x4 gauze from the kit and removed the inner cannula from the tracheostomy and threw it in the trash. She		on facilities policy “Tracheostomy Care” with competencies completed. Respiratory Manager or designee will observe 5 residents trach care x 4 weeks, then 3 residents trach care x 4 weeks, then 10 residents trach care monthly x 4 months to ensure proper technique and care is provided.. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	removed her non-sterile gloves and donned the sterile gloves from the tracheostomy care kit, without using hand hygiene. She then opened the new inner cannula package and took the inner cannula out of the package, placing it into the tracheostomy and placed a drainage gauze around the tracheostomy. She picked up the disposable water container from the bedside table and went to the bathroom. She dumped the water out, flushed the toilet and then removed her sterile gloves. She came back to the bedside and took a new suction kit out of the drawer. She opened the kit and donned the sterile gloves from the kit. She did not use hand hygiene prior to donning the sterile gloves. She then removed the suction catheter and turned on the suction machine with her right hand. She placed the suction catheter on the suction tubing and used her left hand to move the humidity collar from the tracheostomy site and suctioned the tracheostomy, using her left hand. During an interview on 5/26/22 at 9:40 a.m., RT 15 indicated that was how she normally performed tracheostomy care. When she suctioned her the first time, her right hand was the sterile hand. During the second time she was suctioned, her left hand was the sterile hand. On 5/26/22 at 10:39 a.m., the Sister Facility Director of Nursing provided the Tracheostomy Care Policy, last revised 5/30/19, which read '...Residents with tracheostomies require care to remove thickened secretions around the cannula site to maintain an open and patent airway that is free from infection and skin integrity concerns...The purpose of this policy is to provide guidance for tracheostomy care...During the procedure, one gloved hand will be considered contaminated (non-dominant) and one gloved hand will remain sterile (dominate) during			

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	the procedure...Open packages using no-touch technique; making tube connections and prepare solutions for use in sterile tray or similar sterile container using non touch method... III. Trach care: Prepare the environment...b. perform hand hygiene...d. Don clean gloves...g. remove oxygen source, soiled dressing and suction the tracheostomy as appropriate i. Discard used equipment...i. Remove gloves and perform hand hygiene j. use sterile tracheostomy kit using no-touch method m. don sterile gloves...f. clean stoma under neck plate with circular motion using sterile water or sterile normal saline-soaked cotton tip applicators and other dried secretions of the exposed outer cannula surfaces i. Pat moist areas dry with gauze pads..." This Federal tag relates to complaint IN00379801. 3.1-47(a)(4) 3.1-47(a)(6) 3.1-47(a)(5)			
F 0697 SS=G Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to timely administer pain medications, as ordered by the physician, resulting in severe pain and refusal of wound care due to pain, for 4 of 8 resident reviewed for pain management (Residents 33, 68, 82, and 233).	F 0697	**F 697** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident 68, 82, and 33: Medical records were reviewed	06/27/2022

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	Findings include: 1. The clinical record for Resident 68 was reviewed on 5/18/22 at 9:48 a.m. The Resident's diagnosis included, but were not limited to, peripheral vascular disease and stage 3 pressure ulcer on right thigh. An Admission MDS (Minimum Data Set) Assessment, completed 3/16/22, indicated he was cognitively intact. He received scheduled and as needed pain medications daily and his pain made it hard for him to sleep and limited his daily activities. A care plan, revised on 4/22/22, indicated he had acute and chronic pain related to his peripheral vascular disease. The goal, revised on 4/4/22, was for him to be able to verbalize relief of pain. The interventions included, but were not limited to, notify the medical provider if the interventions were unsuccessful, initiated 3/9/22, and provide medications as ordered, initiated 3/9/22. During an interview on 5/18/22 at 9:48 a.m., Resident 68 indicated he had run out of his scheduled oxycodone (narcotic pain medication). The prescription had needed refilled for a week, and without it his pain was "horrible" and out of control. He had been taking his as needed hydrocodone (narcotic pain medications) which made it a little more bearable. When he ran out of his scheduled oxycodone, it would take a day or two for his pain to get back under control once started receiving it again. The May 2022 MAR (Medication Administration Record) indicated he had not received doses his oxycodone on 5/14, 5/15, 5/16, 5/17, and 5/18.		and appropriately reflects pain assessment, management and plan of care for pain management. Resident 233 is discharged. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents hat are currently on pain management have the potential to be affected by the same deficient practice. DNS or designee completed an audit of all residents on pain management to ensure pain goals are being met, plan of care reflects resident pain management needs, and medications are available per MD order. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** 1.) Licensed clinical staff were educated on the guideline for pain management to include but not limited to adequately assessing and treating a resident's pain. 2.) Licensed clinical staff were educated on the use of the EDK. 3.) Licensed clinical staff were educated on the Medication Administration policy to include but not limited to administering pain medication per MD order. **How the corrective measures**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The controlled drug administration record for his oxycontin (brand name for oxycodone) CR (continuous release) 10 mg (milligram) indicated twenty tablets had been received by the facility on 5/2/22. He was to receive one tablet every 12 hours for chronic pain. On 5/13/22 at 9:00 p.m., he had received the last of the twenty tablets dispensed. A physician's order, dated 5/18/22, indicated he was to receive oxycodone extended-release abuse deterrent 10 mg every 12 hours for pain. The controlled drug administration record for his oxycodone er (extended release) 10 mg indicated fifty-eight tablets had been received by the facility on 5/18/22. He had received the first tablet on 5/18/22 at 9:00 a.m. During an interview on 5/24/22 at 10:35 a.m., Registered Pharmacist 9 indicated the facility had sent an electronic refill request for the oxycodone er 10mg to the pharmacy on 5/15/22 at 8:51 p.m. The pharmacy did not have a prescription authorizing refills, so a refill request had been sent out to the physician on 5/16/22 and 5/17/22. They had received the prescription to refill the medication on 5/18/22 and then sent the medication to the facility. The medication was available in the EDS (Emergency Drug System) but there not been any pulled for him during the dates of 5/13/22 through 5/18/22. A physician's order, dated 5/23/22 with a start date of 5/24/22, indicated he was to receive one hydrocodone- acetaminophen 10-325 mg tablet every 6 hours as needed for pain. A nurses note, dated 5/24/22 at 11:19 a.m., indicated he had been given his pain medication		**will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the Director of Nursing Services or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1.) Audit and interview residents to ensure pain management needs are being met per the residents plan of care. 2.) Interview staff on the use of the EDK 3.) Audit the EMAR to ensure residents are receiving pain medications per MD order. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	155272	A. BUILDING 00 B. WING	05/26/2022

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	as scheduled, but refused his wound care. The controlled drug administration record for his hydrocodone- apap (narcotic pain medication with acetaminophen) 10-325 mg indicated the facility had received thirty-six tablets on 5/14/22. He had received the last of the thirty-six tablets on 5/23/22 at 4:00 p.m. On 5/24/22, the facility received thirty more hydrocodone- apap 10-325 mg tablets. He had received the first of those tablets on 5/24/22 at 4:00 p.m. During an interview on 5/25/22 at 10:59 a.m., Resident 68 indicated he had run out of his hydrocodone (narcotic pain medication) and his pain had been "off the charts". He had refused his wound dressing change because he was out of his hydrocodone medication. He could not imagine how painful his dressing change would have been without receiving his hydrocodone. During an interview on 5/25/22 at 11:10 a.m., LPN (Licensed Practical Nurse) 30 indicated when narcotic pain medication needed refilled, she called the pharmacy, if the resident was out of refills, then she would contact the physician or the nurse practitioner to send a refill prescription to the pharmacy. During an interview on 5/25/22 at 11:20 a.m., Nurse Practitioner 12 indicated she depended on the facility nurses to let her know when the residents needed their pain medications refilled. If a resident had been on narcotic pain medication for a long time, then she normally refilled it for 2 weeks at a time. She had been made aware of Resident 68 needing a refill of his hydrocodone- apap late in the afternoon on 5/23/22 and had sent a prescription to the pharmacy. The resident's receiving narcotics long term were prescribed			

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	them to manage their pain. 2. The clinical record for Resident 82 was reviewed on 5/17/22 at 10:37 a.m. The Resident's diagnosis included, but were not limited to, Parkinson's disease and anxiety. A care plan, revised on 6/14/21, indicated she had acute and chronic pain related to her impaired mobility. The goal, revised on 3/17/22, was for her to be able to verbalize relief of pain. The interventions included, but were not limited to, provide medications as ordered by the physician, initiated 6/14/21. A Quarterly MDS Assessment, completed 3/23/22, indicated she was cognitively intact and received scheduled pain medications. During an interview on 5/17/22 10:24 a.m., she indicated that she had an open area on leg that had been giving her trouble. I get pain medication, but it is not enough sometimes. "It hurts like a toothache." The May 2022 MAR indicated she received one oxycodone er 12-hour abuse- deterrent 10 mg every 12 hours for pain and that doses of the medication had not been given on 5/16, 5/17, and 5/18/22. During an interview on 5/24/22 at 11:16 a.m., Registered Pharmacist 9 indicated that a refill request for the oxycodone er 12-hour abuse-deterrent 10 mg had been electronically sent by the facility on 5/16/22. There were no refills left on the prescription. The physician sent a new prescription on 5/19/22 and it was delivered to the facility on that day.			

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	During an interview on 5/25/22 at 9:24 a.m., Resident 82 indicated she received scheduled pain medication each day when she went to bed and when she woke up. She could notice a difference in her pain level when she did not receive her scheduled pain medication. 3. The clinical record for Resident 33 was reviewed on 5/18/22 at 11:00 a.m. The diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease) and hemiplegia. The pain care plan, revised 2/28/22, indicated she had chronic pain and to administer her medications as ordered. An interview was conducted with Resident 33 on 5/18/22 at 11:25 a.m. She indicated she had back pain and was getting to the point where she had a hard time walking. The physician's orders indicated for her to receive Norco (7.5-325 mg) tablet of hydrocodone-Acetaminophen 4 times a day for pain. The May 2022 MAR (medication administration record) indicated she did not receive the hydrocodone, as ordered, on the following dates and times: 5/18/22 at 9:00 p.m., 5/19/22 at 1:00 p.m., 5/19/22 at 5:00 p.m., 5/19/22 at 9:00 p.m., 5/20/22 at 1:00 p.m., and 5/20/22 at 5:00 p.m. There were 2 administrations, on 5/19/22 at 9:00 a.m. and 5/20/22 at 9:00 a.m. that indicated she received the medication as ordered. An interview was conducted with UM (Unit Manager) 22 on 5/24/22 at 10:26 a.m. She indicated she did not receive her Norco, because she was out of the medication, and didn't have a prescription for more. She was unsure why there			

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	was no prescription, or how Resident 33 would have received the 9:00 a.m. administrations on 5/19/22 and 5/20/22, when the medication was unavailable. The 5/19/22, 11:36 p.m. nurse's note read, "Resident was out of her Norco- (7.5-325 MG). Called pharmacy to verify her refill status but only to be told that she needs a script. Contacted in house NP [nurse practitioner] but was directed to [name of pain physician.] After talking to [name of pain physician] about the patient and the need to send her script to pharm-script pharmacy, he does not seem to have a good recollection of the patient. Consequently, he advised me to sent him a text message regarding this request. After sending a text message to him, I later followed it up with a call, unfortunately the Dr. [doctor] couldn't be reached. Will continue to follow up with resident request." An interview was conducted with the pain physician's NP (Nurse Practitioner,) NP 12, on 5/25/22 at 11:22 a.m. She indicated she did not like to send in a whole month's prescription at a time. She sent in for 2 weeks at a time. She depended on nursing to tell her which residents needed what medications. If a resident was on the same pain medication for a long time, she would send in a prescription for 2 weeks at a time. If a resident was receiving pain medication for a long time, they needed the medication to manage their pain, and if they didn't get it, they could go thru withdrawal symptoms like nausea, vomiting, sweating, and chills, like having a bad flu for 24 to 48 hours. She received a request for a refill of Resident 33's Norco on 5/20/21, and she sent in a prescription on 5/21/21. An interview was conducted with Resident 33 on			

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	5/25/22 at 9:52 a.m. She indicated she did not receive her Norco for 3 days after her original 5/18/22, 11:25 a.m. interview. She felt horrible, when she wasn't getting the medication. She was in bed the whole day, either on 5/19/22 or 5/20/22, but couldn't remember which day. She was hurting in her middle and lower back. She felt like she couldn't stand for very long. She smoked cigarettes, and only went out to smoke once one of those days, as she normally went out to smoke 6 to 8 times a day, and she wasn't able to visit with her boyfriend, like she normally would. 4. The clinical record for Resident 233 was reviewed on 5/17/22 at 1:30 p.m. The diagnoses included, but were not limited to, osteomyelitis. The pain care plan, revised 5/18/22, indicated he had complaints of chronic pain with an intervention to provide medication peer orders. The physician's orders indicated to administer one 15 mg tablet of morphine sulfate extended release every 12 hours for pain, effective 5/13/22. The May 2022 MAR (medication administration record) indicated he was not administered the morphine on once on 5/13/22, twice on 5/14/22, once on 5/15/22, and twice on 5/16/22. The electronic MAR notes indicated the reasons for not administering the above doses were due to the medication being unavailable. An interview was conducted with Resident 233 on 5/17/22 at 1:51 p.m. He indicated he was prescribed morphine last week but did not receive his first dose until 5/17/22. He stated, "It was horrible the whole last week. I couldn't sleep			

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	through the night at all." An interview was conducted with NP (Nurse Practitioner) 12 on 5/25/22 at 11:40 a.m. She indicated the first time she saw him, he said he was having a lot of pain, so she started him on the extended release. Later, the physician changed all of his medication and started him on Methadone. The Medication Administration policy was provided by the DON (Director of Nursing) on 5/19/22 at 9:05 a.m. It read, "Medication will be administered as prescribed." On 5/25/22 at 10:58 a.m.., the Director of Nursing provided the Pain Management and Assessment Policy, last reviewed on 1/18/2022, which read "...It is the purpose of this policy is to provide guidance to the clinical staff to support the intent...that based on the comprehensive assessment of the resident, the facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. There is no objective test that can measure pain. The clinician must accept the resident's report of pain. Clinical observations clarify information from the resident. Site of discomfort may direct the nurse to specific types of pain- relief measures..." 3.1-37(a)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or			

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	maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.			
	Based on interview and record review, the facility failed to ensure nursing staff were competent in catheterizing a resident with an AUS (artificial urinary sphincter) for 1 of 3 residents reviewed for hospitalization. (Resident B) Findings include: The clinical record for Resident B was reviewed on 5/20/22 at 10:00 a.m. The diagnoses included, but were not limited to, neurogenic bladder. He was admitted to the facility from the hospital on	F 0726	1) Resident B no longer resides at facility. 2) All residents with artificial urinary sphincters have the potential to be affected. An audit was completed with no findings as there were no other residents with artificial urinary sphincters. 3) Licensed nursing staff were educated on facilities policies “Male Intermittent or Straight Catheterization” and “Physician	06/27/2022

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	3/10/22. The 3/11/22 care plan indicated he had a foley catheter related to neurogenic bladder. The 3/10/22 hospital discharge summary read, "3/10 [3/10/22] Patient discharging to [name of facility] skilled nursing facility for ongoing wound management. He is in stable condition. His monti [sic] with foley catheter in place draining without any problems...Neurogenic bladder...16 French catheter anchored in Monti channel. Patient to catheterizing 16 French catheter going forward instead of 14 French. Patient is an at fissure [sic-has an artificial] urinary sphincter. Do not catheterize per urethra. If urethral catheter attempts need to be made in the future the sphincter must be deactivated and 8, 10, or 12 French Foley catheter she [sic] will be utilize [sic] but cannot be anchored in place longer than 24-36 hours. Please page Urology further issues with catheter drainage. Will order scheduled forward flushes of catheter with 60 cc P stump syringe. Urology to schedule outpatient follow-up appointment approximately 4 weeks." The specific orders from the hospital to not catheterize per urethra and to deactivate the artificial urinary sphincter if urethral catheter attempts were needed were nowhere on the facility's physician's orders. The 3/24/22, 9:46 p.m. nurse's note, written by LPN (Licensed Practical Nurse) 23 read, "Resident was complaining of pain on his abdomen. He was complaining about the need to void even though he has a supra pubic catheter. In his bag the out put was less than 50 ml. Upon assessment, his abdomen appears distended, and tender during palpation. He added that this had happened		Orders" with an emphasis on understanding what an AUS is and following physician orders. QMA's were educated on not signing off on any procedures that they have not performed. 4) Director of Nursing or designee will audit via observation any resident with an AUS x 6 months to ensure technique is performed properly. ="" b="">The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	before while he was in the hospital, and they performed in and out catheterization on him. As he continue to complain of pain/discomfort, staff performed catheterization and got an out put of about 1700 ml. It appears that his supra pubic catheter is not functioning well and a [sic] such a referral to a urologist was advised for further assessment, evaluation and replacement." An interview was conducted with LPN 23 on 5/23/22 at 2:31 p.m. He indicated he did not remember exactly what happened prior to Resident B going to the ED on 3/25/22. He was unaware Resident B had an artificial urinary sphincter. He was unfamiliar with an AUS and couldn't remember ever caring for a resident that had one. The 3/24/22, 10:25 p.m. physician note read, "Minutes spent on case: 4. Comments: Patient reported suprapubic pain. He has a suprapubic catheter that has had very little drainage today. Straight cath [catheterization] was done with 1700 mL output. Recommend follow up with urologist. Straight cath every 6-8 hours depending on symptoms for urinary retention." The 3/25/22, 6:01 a.m. nurse's note read, "in and out cath for 300 ml urine. cloudy urine return at start of procedure, then cleared." On 5/26/22 at 10:55 a.m., an interview was conducted with LPN 24, who signed off on the TAR as having in and out catheterized Resident B on 3/25/22 at 6:00 a.m. prior to Resident B going to the ED. She indicated she in and out catheterized him just before he went to the ED. She went through his penis and drained his bladder that way. He kept his catheter in. The only way she could do it was to go through his penis. She reported that it didn't look good at the time, that			

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	the catheter was blocked. She was told during report that she needed to in and out catheterize him. She questioned why they were doing it, because it was unusual to have and in and out catheter order, as she was used to irrigating him. She didn't do anything differently for him, having an AUS, then she did for someone without one. The 3/25/22, 10:02 a.m. nurse's note read, "call placed to [name of urologist] urologist, [phone number of urologist.] resident has an appointment on 4/21/22, called to see if appointment can be moved up. left a message, the turnaround time is up to 24 hours. MD in house made aware, mom at bedside made aware." The 3/25/22, 1:04 p.m. nurse's note read, "Resident sent to 'name of hospital' per [name and title of NP] via ambulance for decreased urine output." The 3/25/22 Hospital ED (Emergency Department) notes read, "...presenting to ED with/difficulty draining urine from his suprapubic cath X [times] 1 day...has had to in and out cath twice...Assessment/Plan 1. Catheter Problem...Of note, since his urethra was catheterized without deactivating the AUS, we had scoped the urethra with and found no evidence of erosion. We had also scoped the monti channel and found no abnormalities...His parents contacted 911 to transport him to the ED today because they are worried about the quality of care he is receiving there. The parents and patient have adamantly requested that the facility not catheterize his urethra due to his AUS, and the mother presents with documentation from his medicolegal records there that also document the urethra cannot be catheterized....For the last 2 days the nursing has been catheterizing his urethra despite specific instructions not to do so....Assessment/Plan:			

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	Monti channel catheter was due for exchange so I replaced a new catheter into the monti channel, outflow of clear yellow urine confirmed...Old catheter was occluded with hardened mucous. I instructed patient and family today on how to cycle the AUS too allow for drainage of the bladder, if he has recurrent issue with the catheter and the nurses at his facility are not able to assist in an appropriate, timely fashion. Will have ED case manager come down and speak with patient and family. There is clearly concern for frank negligence from this healthcare facility." An interview was conducted with Family Member 33, Resident B's mother, on 5/23/22 at 2:50 p.m. She indicated Resident B had a lot of sediment in his bladder and the catheter kept clogging. Nursing was supposed to irrigate it, but several didn't know how to do it, or were doing it wrong. She saw one nurse try to go through his belly button. They were pushing fluid into the catheter, but not pulling it out. They weren't willing to change the Foley catheter or put a new one in, so they ended up in the ED. The hospital replaced the catheter. They had had been told not to catheterize through his urethra. She assumed the facility knew that, but when she talked to them, they said they did what they had to do to give him relief and were not going to apologize for that. Family Member 33 told nursing they should have deactivated the sphincter to give him relief, and nursing should have addressed the no urine output after 2 hours instead of waiting until after 6 hours. On 5/26/22 at 10:40 a.m., an interview was conducted with QMA (Qualified Medication Aide) 34, who signed off on the TAR (treatment administration record) as having in and out catheterized Resident B on 3/25/22 at 12:00 p.m.			

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	prior to going to the ED. She indicated she did not do his in and out catheter. A lot of times, she would tell nurses she needed stuff done and so she would sign off on it, because they didn't do it. She definitely did not do his in and out catheter. She had never cared for a resident with and AUS before and wouldn't know how to if they did have one. She would need to report it to the nurse and the nurse would have to do it. An interview was conducted with NP 6 on 5/23/22 at 3:04 p.m. She indicated she was unsure if Resident B knew how to cycle his AUS, prior to going to the ED on 3/25/22. She met him on 3/29/22. The only time she'd seen an AUS, nothing needed to be done to it. She was uncertain how to care for it. To her knowledge, the nursing staff wouldn't know how to deactivate an AUS. She didn't think the orders from the 3/10/22 hospital discharge summary made its way onto the facility's orders or MAR. Resident B told her he shouldn't be in and out catheterized, and she informed him they shouldn't be doing it then. She didn't know if she discontinued the order for the in and out catheter every 8 hours or not, but it was discontinued on 3/29/22. She doubted the on-call physician assistant who placed the order would have known about Resident B's AUS. They would have only known what the nurse told them. The Male Intermittent or Straight Catheterization policy was provided by the DON (Director of Nursing) on 5/24/22 at 12:23 p.m. It read, "1. Basic knowledge and skills for intermittent catheterization a. Validate physician/provider order for the specific resident." This Federal tag relates to complaint IN00379008.			

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F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to have a Registered Nurse working at the facility for 8 consecutive hours for 1 of 11 days reviewed with the potential to affect 123 of 123 residents residing at the facility. Finding include: During an interview on 5/16/22 at 10:30 a.m., the Administrator indicated the facility census was 123 residents. The facility nursing schedule, as worked, were provided by the Staffing Coordinator on 5/26/22 at 1:30 p.m. The schedule for 5/22/22 did not contain a RN (Registered Nurse) who had worked at the facility on that date. On 5/26/22 at 2:50 p.m., the SFDON (Sister Facility Director of Nursing) provided the name of the Director of Nursing as the RN who provided the	F 0727	**F 727** **1) The facility allegedly failed to ensure 8 consecutive hours of RN services 7 days a week.** **2) All residents have the potential to be affected by the alleged deficient practice.** **3) The facility will staff 8 consecutive hours of RN services 7 days a week. The scheduler was educated on the existing facility staffing requirements with emphasis on 8 consecutive hours of RN services 7 days a week. This education emphasized the expectation that the facility would have RN services for 8 consecutive hours 7 days a**	06/27/2022

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	coverage for 5/22/22. There was no other Registered Nurse who worked in the building on that date. During an interview on 5/26/22 at 3:50 p.m., the SFDON indicated facility did have a policy regarding RN coverage but would follow the regulation. 3.1-17(e)		**week and the potential consequences of not staffing in accordance with facility staffing requirements.** **4) The Executive Director, DON, Human Resource manager, and staffing coordinator will review the staffing schedule for each day to confirm that 8 consecutive hours of RN services are scheduled daily. This is an ongoing facility practice that will continue Monday through Friday. The weekend schedule is reviewed in the Friday staffing meeting.** **The ED/Designee is responsible for compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and			

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	§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, interview, and record review, the facility failed to follow through with a dental recommendation for teeth extraction and to ensure residents received routine dental care for 3 of 7 residents reviewed for dental services. (Residents 2, 5, and 49) Findings include: 1. The clinical record for Resident 49 was reviewed on 5/17/22 at 10:00 a.m. The diagnoses included, but were not limited to, hypertension. An interview was conducted with Resident 49 on 5/17/22 at 10:04 a.m. She indicated she had some broken teeth and some loose teeth. No one asked her about seeing the dentist. An observation of Resident 49's oral cavity was made on 5/17/22 at 10:04 a.m. She had some missing and broken mandibular (bottom) teeth. The dental care plan, revised 3/21/22, indicated she had missing/broken teeth and obvious dental caries related to poor oral hygiene and a history of dysphagia. The physician's orders indicated dental consult as needed, effective 8/28/17. The 2/12/21 dental note indicated she was missing 4 teeth on top and 5 teeth on bottom. She had 8 root tips on top and 2 root tips on bottom. It indicated she had natural teeth without dentures	F 0791	F791 1) Residents 2, 5, and 49 had appointments made and/or were placed on the list for dental services. 2) All residents have the potential to be affected. An audit was performed to ensure all residents with dental concerns desiring dental services have been seen by dental services or placed on list to be seen at next visit. 3) IDT team including social services were educated on facility's policy "Dental Services" with an emphasis on ensuring all residents who require/request dental services are seen in a timely manner. 4) Director of Nursing or designee will audit 5 residents per week x 1 month, then 3 residents per week x 1 month, then 5 residents per month x 4 months to ensure they have received dental services if needed and/or requested. ="" b="">The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further	06/27/2022

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	and was interested in information about dentures. She was a candidate for dentures and needed to have all upper teeth extracted by an oral and maxillofacial surgeon, before she was eligible for an upper denture. There was no information in the clinical record to indicate follow up to the 2/12/21 dental recommendation for teeth extraction. An interview was conducted with SS (Social Services) 2 on 5/19/22 at 12:30 p.m. He indicated he was going to contact an oral surgeon to schedule an appointment for teeth extraction. An interview was conducted with Resident 49 on 5/19/22 at 12:33 p.m. She indicated she still wanted dentures and was okay with going out for teeth extraction. The Dental Services policy was provided by the Nurse Consultant on 5/19/22 at 9:15 a.m. It read, "The facility will assist the resident in: ...c. Obtaining services to the resident to meet the needs of each resident...d. Making appointments...e. Arranging for transportation to and from the dental service location."2. The clinical record for Resident 2 was reviewed on 5/19/22 at 9:27 a.m. Resident 2's diagnoses included, but not limited to, chronic obstructive pulmonary disease, heart failure, and anxiety disorder. Resident 2's quarterly MDS (minimum data set) dated 4/9/22 indicated, Resident 2 was cognitively intact. A physician's order for Podiatry, Dental, Optometry or Ophthalmology consults was renewed on 3/31/22.		recommendation.	

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	An interview with Resident 2 conducted on 5/18/22 at 10:07 a.m. indicated, he hadn't seen a dentist in a long time and would like for his teeth to be cleaned. An interview with SS (Social Services) 2 was conducted on 5/18/22 at 2:58 p.m. SS 1 indicated; Resident 2 had not voiced he wanted his teeth cleaned. Resident 2's dental referral was sent to the contracted company at the time of Resident 2's admission. SS 2 reviewed the tracking system he uses to document when residents are seen for vision, dental, or other contracted services. SS 2 indicated; Resident 2 had not been seen by the dentist in the last year. An interview with SS 1 was conducted on 5/19/22 at 10:50 a.m. SS 1 indicated; the contracted company for special services such as vision and dental were accountable for ensuring services for those residents who had signed up were performed. 3. The clinical record for Resident 5 was reviewed on 5/19/22 at 9:04 a.m. Resident 5's diagnoses included, but not limited to, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) affecting left side, dementia, cerebral infarction, bipolar disorder, and anxiety disorder. Resident 5's quarterly MDS (minimum data set) dated 1/19/22 indicated, Resident 5 was cognitively intact. Resident 5 was totally dependent on the assistance of one person for dressing, bathing, and toileting. A physician's order for Podiatry, Dental, Optometry or Ophthalmology consults was			

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	renewed on 4/14/22. An interview with Resident 5 conducted on 5/17/22 at 2:08 p.m. indicated, she had partial dentures and had recently broke when they fell on the floor and would like them replaced. An interview with SS 2 was conducted on 5/18/22 at 2:53 p.m. SS 2 indicated; Resident 5 had not told him she needed services. When asked how he ensures residents receive contracted services at least yearly, he indicated, he keeps an excel spreadsheet to document when contracted services were provided and from time to time would audit the tracker to see if anyone had not received the services they had signed up for. Resident 5 had not had any routine dental services within the last year. A Dental Services policy was received on 5/19/22 at 9:15 a.m. from NC (Nurse Consultant) 3. The policy indicated, under definitions, "Routine dental services for the purpose of this policy, and according to CMS means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures...Procedure: 1. The facility will assist the resident in: a. Obtaining routine Dental Services...d. Making appointments...Charges/Ability to Pay for Services...b. For Medicaid residents: i. the facility must provide all emergency dental services and those routine dental services to the extent covered under the Medicaid state plan." This Federal tag relates to complaint IN00380287.			

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	3.1-24(a)(1) 3.1-24(b)			
F 0810 SS=D Bldg. 00	483.60(g) Assistive Devices - Eating Equipment/Utensils §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. Based on observation, interview, and record review, the facility failed to use a Nosey cup, as ordered, when assisting a resident with her meal for 1 of 2 residents reviewed for nutrition. (Resident 50) Findings include: The clinical record for Resident 50 was reviewed on 5/17/22 at 2:59 p.m. The diagnoses included, but were not limited to, dysphagia and malnutrition. The physician's orders indicated for her to start using a Nosey cup (a cup with a cut out on the non-drinking side so that cup can be tilted without interference by the nose, allowing the drinker to avoid tilting the head back, thus minimizing the chance of liquid entering the respiratory tubes and causing choking) for liquids, every shift, effective 4/19/21. The nutrition care plan, revised 4/14/22, indicated she was unable to self-feed and was to use a Nosey cup. The 3/3/22 nutrition assessment read, "Pt [Patient] needs feeding assistance and a nosey cup at meal	F 0810	1) Resident 50 was not harmed by the deficient practice. 2) All residents requiring assistive devices have the potential to be affected. An audit was completed on all residents requiring assistive devices to ensure devices were in place, care planned, and being used accordingly. 3) Nursing staff were educated on facilities policy “Assistive Eating Devices” with an emphasis on ensuring assistive devices are utilized at all necessary times per residents plan of care. 4) Director of Nursing or designee will observe 5 residents with assistive devices x 4 weeks, then 3 residents with assistive devices x 4 weeks, then 10 residents with assistive devices monthly x 4 months to ensure assistive devices are being utilized per residents plan of care. The results of the audit observations will be reported, reviewed and trended for	06/27/2022

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	times." An observation of Resident 50 was made on 5/20/22 at 1:47 p.m. during the lunch service. She was being assisted to eat lunch in her lunch by CNA (Certified Nursing Assistant) 20. CNA 20 was not using a Nosey cup when assisting her to drink. An observation of Resident 50's bedside table was made on 5/20/22 at 2:14 p.m. She had 2 drinks in regular cups, not Nosey cups, on the table. An interview was conducted with CNA 20 on 5/20/22 at 2:33 p.m. She indicated at some point in time, Resident 50 was using a Nosey cup. She was unsure how long it'd been since she used one, as she hadn't seen one used for her in a few months. She stated, "She's just using regular cups now." An interview was conducted with CNA 21 on 5/20/22 at 2:07 p.m. She indicated she'd worked at the facility for several years. Resident 50 used to use a Nosey cup but didn't anymore. She leaned forward when she drank, and the Nosey cup would assist her to drink by preventing her from having her nose in the cup. An interview was conducted with UM (Unit Manager) 22 on 5/20/22 at 2:34 p.m. She indicated she was unsure why a Nosey cup wasn't being used for Resident 50. The Assistive Eating Devices policy was provided by 5/23/22 at 9:15 a.m. It read, "Definitions: Assistive eating devices: special adaptive eating and drinking utensils for those with low dexterity or other disabilities that prevents residents from otherwise eating and drinking independently - may include bowls, cups,		compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	plates, spoons and forks - usually recommended by therapy or nursing for individualized care needs....Procedure ...3. Educate staff for placement and use to assist resident." 3.1-21(h)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure meals were served with proper hand hygiene and under sanitary conditions, potentially affecting 109 of 123 residents residing at the facility. Findings include:	F 0812	1) 1) The facility allegedly failed to ensure meals were served with proper hand hygiene and under sanitary condition. 2) 109 residents had the potential to be affected by alleged deficient practice. 3) The Regional Dietary	06/27/2022

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	On 5/19/22 at 11:50 a.m., the lunch meal service was observed. DA (Dietary Aide) 31 was putting trays placing food trays on the tray line and putting silver wear and drinks onto the trays. She picked up a pallet warmer, which had dried food debris on it, from the shelf beneath the tray line and placed it onto the line directly next to a tray that had been prepared with silver wear and drinks. Cook 11 began serving the food from the steam table. She was wearing disposable gloves while serving the food. She left the steam table and went to get hamburger buns. She brought 2 packages of the buns back to the steam table and opened them with her gloved hands. She then left the steam table again and went to a cabinet to retrieve a pair of tongs. She opened the drawer with her gloved hands and picked up the tongs. She then returned to the steam table. She did not wash her hands or change her gloves. She began serving the food again, placing two hamburger buns on the plate with her gloved hands. Using tongs, she placed hamburger patties on the buns and then picked up cheese slices with her gloved hands and placed them on the hamburger patties. She continued to serve the tray line. As the tray line was continuing, DA 31 placed new food trays onto the line as the food cart was loaded. The trays placed on the line had water drops on them. DA 31 left the tray line and got a towel from a drawer. She dried the trays with the towel as they were being placed onto the tray line to be used. During an interview on 5/19/22 at 2:52 p.m., the Dietary Manager indicated the pallet warmer should be cleaned and that Cook 11 should have washed her hands and changed her gloves after retrieving the tongs and prior to serving the food. The trays should have air dried instead of being stacked for storage while still wet.		consultant has educated the Dietary Manager and staff on ensuring meals are served with proper hand hygiene and under sanitary condition. 4) The Dietary Manager/Designee will audit via observation the dietary staff during meal serving times to ensure meals are served with proper hand hygiene and under sanitary condition on the following schedule: 10 meals weekly x 4 weeks, then 5 meals weekly x 4 weeks, then 10 meals monthly x 4 weeks. 5) The Dietary Manager/Designee is responsible for the compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5) 5)	

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	On 5/20/22 at 1:36 p.m., the Executive Director provided the Food: Preparation Policy, last revised September 2017, which read "...All Foods are prepared in accordance with the FDA Food Code. Procedures 1. All staff will practice proper hand washing techniques and glove use..." On 5/20/22 at 1:36 p.m., the Executive Director provided the Warewashing Policy, last revised September 2017, which read "...4. All dishware will be air dried and properly stored..." 3.1-21(i)(3)			
F 0839 SS=F Bldg. 00	483.70(f)(1)(2) Staff Qualifications §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. Based on interview and record review, the facility failed to provide evidence of licensure, certification or registration of professional staff for 15 of 143 staff members who continue to work at the facility. Findings include: A list of current employees was provided on 5/19/22 at 12:30 p.m. by ED (Executive Director) The staff licenses and certifications were provided by the Executive Director (ED) on 5/24/22 at 9:00	F 0839	**F 839** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Licensure, certifications or registration for current professional staff is on file. **Identification of other residents having the potential to be affected by the same alleged deficient practice and**	06/27/2022

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	a.m. A review of the facility's professional staff's licenses and certifications was conducted on 5/25/22. The facility was unable to provide evidence of license or certification for the following professional staff members included are their hire dates: 1. CNA(Certified Nursing Assistant) 63; Date of hire: 8/26/20 2. CMA (Certified Medication Assistant) 65; Date of hire: 4/18/06 3. Clinical Liaison RN (Registered Nurse) 64; Date of hire: 2/20/06 4. QMA (Qualified Medication Assistant)10; Date of hire 11/29/18 5. CNA 67; Date of hire: 10/30/90 6. CNA 68; Date of hire 5/20/20 7. Speech Therapist 69; Date of hire 5/21/19 8. CMA 70; Date of hire: 2/8/22 9. CMA 71; Date of hire 2/17/22 10. CNA 72; Date of hire: 3/8/22 11. LPN (Licensed Practical Nurse) 73; Date of hire: 4/7/22 12. CNA 74; Date of hire: 4/7/22 13. CMA 75; Date of hire: 4/14/22 14. Physical Therapist 76; Date of hire: 5/6/22 15. Respiratory Therapist 77; Date of hire: 4/28/22 An interview with ED conducted on 5/26/22 at 4:30 p.m. indicated, he was unable to provide evidence of professional staff's licenses or certifications at the time of exit. He indicated, the missing licenses and/or certifications would be provided by email by 5/27/22 however, as of 5/31/22 at 3:52 p.m. no other evidence had been provided. 3.1-14(q)(5)		**corrective actions taken**: Executive Director or designee will audit all professional staff files to ensure a license, certification or registration is in place. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Executive Director or designee will re-educate the Human Resource department or designees on the following policy: Licensure, Certification and Registration, with an emphasis on the procedure to obtain a current copy of the employee's credentials will be obtained during the hiring process and placed in the employee's personnel file **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits for all new hires will be conducted by the Executive Director or designee 2 times per week times 8 weeks then monthly x 4 months to ensure compliance: audit new hire professional staff files to ensure a license, certification or registration is in place The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then	

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

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	proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview and record review, the facility failed to ensure residents medical records were complete and accurately documented for showers/bed baths for 3 of 8 residents reviewed for ADLs (Activities of Daily Living). (Residents 5, 8, and F)	F 0842	F842 1) Residents 5, 8, and F were not harmed by the deficient practice. 2) All residents have the potential to be affected. An audit was performed on residents	06/27/2022

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	Findings include: 1. Resident 5's Document Survey Report for March 2022 was received from NC (Nurse Consultant) 3 on 5/20/22 at 9:17 a.m. It indicated, Resident 5 received a bed bath on 3/3/22. No other showers/baths for March were documented. Resident 5's Document Survey Report for April 2022 was received from NC (Nurse Consultant) 3 on 5/20/22 at 9:17 a.m. The Document Survey report for April 2022 indicated the following baths/showers given that month: - 4/9/22, a code "RX" for type of bath/shower given. The legend key did not indicate what "RX" indicated. - 4/21/22, a code "NA" for type of bath/shower given. The legend key did not indicate what "NA" indicated. - 4/23/22, a code "NA" for type of bath/shower given. - 4/28/22, indicated a bed bath was given. - 4/30/22, a code "NA" for type of bath/shower given. No other baths/showers for April were documented. Resident 5's Document Survey Report for May 2022 was received from NC (Nurse Consultant) 3 on 5/20/22 at 9:17 a.m. Under the section titled Intervention/Task bathing per resident's choice, it indicated, Resident 5 received a bed bath on 5/5/22, 5/7/22 and 5/12/22. No other baths/showers for May were documented. Resident 5's March, April and May shower sheets were received on 5/19/22 at 1:11 a.m. from DON (Director of Nursing). They indicated the Resident 5 received a bed bath on:		medical record for the last 7 days to ensure bathing was documented as performed. 3) Nursing staff were educated on ensuring proper documentation is completed in residents medical records for type of bathing performed. 4) Director of nursing or designee will audit 10 residents per week x 4 weeks to ensure accurate bathing documentation has occurred, then 5 residents per week x 4 weeks, then 3 residents per week x 4 months. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	3/3/22 3/5/22 3/17/22 3/19/22 4/7/22 4/21/22 4/23/22 4/28/22 The electronic health record and shower sheets did not reflect the same information whether it was date or type of bath received in all instances documented. 2. Resident 8's Document Survey Report for March 2022 was received from NC (Nurse Consultant) 3 on 5/20/22 at 9:17 a.m. It indicated, Resident 8 received a bed bath on 3/14/22 and 3/21/22. On 3/25/22, for shower/bed bath type, it was documented as "NA". No further showers/bed baths were documented that month on the report. Resident 8's Document Survey Report for April 2022 was received from NC (Nurse Consultant) 3 on 5/20/22 at 9:17 a.m. It indicated, Resident 8 received a bed bath on 4/25 and 4/29. No further showers/bed baths were documented that month on the report. Resident 8's Document Survey Report for May 2022 was received from NC (Nurse Consultant) 3 on 5/20/22 at 9:17 a.m. It indicated, Resident 8 received a bed bath on 5/2, 5/6, 5/9, and 5/16. On 5/13, for shower/bed bath type, it was documented as "NA". No further showers/bed baths were documented that month on the report. Resident 8's March, April and May shower sheets were received on 5/19/22 at 1:11 a.m. from DON (Director of Nursing). They indicated the			

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	Resident 8 received bed baths or showers on the following dates: 3/3/22; shower 3/7/22; shower 3/10/22; bed bath 3/14/22; shower 3/17/22; bed bath 3/21/22; shower 3/24/22; bed bath 3/28/22; shower 4/1/22; shower 4/4/22; shower 4/7/22; bed bath 4/11/22; shower 4/14/22; bed bath 4/18/22; bed bath 4/22/22; bed bath 4/25/22; bed bath 4/28/22; bed bath 5/2/22; shower 5/5/22; shower 5/9/22; shower 5/12/22; bed bath 5/16/22; bed bath The electronic health record and shower sheets did not reflect the same information whether it was date or type of bath received in all instances documented. 3. A copy of Resident F's March, April, and May Documentation Survey Report was received on 5/20/22 at 9:17 a.m. from NC (Nurse Consultant) 2. Under the section listed as "Bathing per residents choice", it indicated Resident F received bed baths/showers on the following days: 3/1/22 bed bath 3/8/22 bed bath 3/17/22 bed bath 3/22/22 bed bath			

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	3/26/22 bed bath 3/29/22 bed bath 4/14/22 bed bath 4/19/22 bed bath 4/26/22 bed bath 4/28/22 shower 4/30/22 bed bath 5/3/22 bed bath 5/5/22 shower 5/7/22 bed bath 5/10/22 "NA" code- code legend does not contain a code "NA" 5/12/22 shower 5/14/22 bed bath 5/17/22 bed bath 5/19/22 shower The DON (Director of Nursing) provided Resident F's shower sheets on 5/19/22 at 1:11 p.m. The shower/bed bath sheets for 5/14/22 nor the 5/17/22 bed baths were not located. The Brookshire unit's shower sheet binder was observed on 5/19/22 at 10:11 a.m. They indicated the Resident F received bed baths or showers on the following dates: 3/1/22; shower 3/4/22; shower 3/5/22; shower 3/8/22; shower 3/10/22; shower 3/13/22; shower 3/15/22; shower 3/17/22; shower 3/18/22; shower 3/19/22; shower 3/21/22; shower 3/24/22; shower 3/26/22; shower 3/27/22; shower			

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	3/29/22; shower 3/31/22; shower 4/2/22; shower 4/5/22; shower 4/7/22; shower 4/9/22; shower 4/12/22; shower 4/14/22; shower 4/16/22; shower 4/19/22; shower 4/20/22; shower 4/23/22; shower 4/26/22; shower 4/28/22; shower 4/30/22; shower 5/3/22; shower 5/5/22; shower 5/12/22; shower The electronic health record and shower sheets did not reflect the same information whether it was date or type of bath received in all instances documented. 3.1-50(a) 3.1-38(a)(3)			
F 0867 SS=E Bldg. 00	483.75(g)(2)(ii) QAPI/QAA Improvement Activities §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; Based on interview and record review, the facility's QA [Quality Assurance] committee failed to identify quality deficiencies and develop action	F 0867	A Resident 68's pain medication has been ordered and administered	06/27/2022

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	plans to address them regarding wound care and pain management. This affected 6 of 123 residents in the facility. (Residents B, 33, 68, 82, 103, 233) Findings include: 1. The clinical record for Resident 68 was reviewed on 5/18/22 at 9:48 a.m. The Resident's diagnosis included, but were not limited to, peripheral vascular disease and stage 3 pressure ulcer on right thigh. An Admission MDS (Minimum Data Set) Assessment, completed 3/16/22, indicated he was cognitively intact. He received scheduled and as needed pain medications daily and his pain made it hard for him to sleep and limited his daily activities. A care plan, revised on 4/22/22, indicated he had acute and chronic pain related to his peripheral vascular disease. The goal, revised on 4/4/22, was for him to be able to verbalize relief of pain. The interventions included, but were not limited to, notify the medical provider if the interventions were unsuccessful, initiated 3/9/22, and provide medications as ordered, initiated 3/9/22. During an interview on 5/18/22 at 9:48 a.m., Resident 68 indicated he had run out of his scheduled oxycodone (narcotic pain medication). The prescription had needed refilled for a week, and without it his pain was "horrible" and out of control. He had been taking his as needed hydrocodone (narcotic pain medications) which made it a little more bearable. When he ran out of his scheduled oxycodone, it would take a day or two for his pain to get back under control once started receiving it again.		appropriately to control their pain. Wound treatments are offered as ordered and performed with resident's consent. Resident 82's scheduled pain medication has been ordered and administered appropriately to control their pain. Wound treatments are offered as ordered and performed with resident's consent. Resident 233 was discharged to home on 06/07/2022 Resident B's identity was kept confidential as the source of a complaint to the state Resident 103's psoriasis has been treated as ordered and offered with resident's consent B All residents have the potential to be affected. A 100% audit will be conducted concerning the skin integrity of the residents. Those residents identified with skin conditions will be placed on wound rounds and appropriate treatments reviewed and documented A 100 % audit will be conducted concerning pain and pain management of the residents. Those residents identified with pain issues will be placed on rounds for pain and appropriate treatments reviewed. C All licensed nurses and IDT team were educated on the facilities'	

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	The May 2022 MAR (Medication Administration Record) indicated he had not received doses his oxycodone on 5/14, 5/15, 5/16, 5/17, and 5/18. The controlled drug administration record for his oxycontin (brand name for oxycodone) CR (continuous release) 10 mg (milligram) indicated twenty tablets had been received by the facility on 5/2/22. He was to receive one tablet every 12 hours for chronic pain. On 5/13/22 at 9:00 p.m., he had received the last of the twenty tablets dispensed. A physician's order, dated 5/18/22, indicated he was to receive oxycodone extended-release abuse deterrent 10 mg every 12 hours for pain. The controlled drug administration record for his oxycodone ER (extended release) 10 mg indicated fifty-eight tablets had been received by the facility on 5/18/22. He had received the first tablet on 5/18/22 at 9:00 a.m. During an interview on 5/24/22 at 10:35 a.m., Registered Pharmacist 9 indicated the facility had sent an electronic refill request for the oxycodone er 10mg to the pharmacy on 5/15/22 at 8:51 p.m. The pharmacy did not have a prescription authorizing refills, so a refill request had been sent out to the physician on 5/16/22 and 5/17/22. They had received the prescription to refill the medication on 5/18/22 and then sent the medication to the facility. The medication was available in the EDS (Emergency Drug System) but there not been any pulled for him during the dates of 5/13/22 through 5/18/22. A physician's order, dated 5/23/22 with a start date of 5/24/22, indicated he was to receive one hydrocodone- acetaminophen 10-325 mg tablet		"skin care and wound management policy" All licensed nurses and IDT team were educated on pain and pain management. D 24 hour report will be utilized 5 days a week to identify residents with compromised skin condition in daily clinical stand-up and in weekly wound rounds. 24 hour report will be utilized 5 days a week to identify residents with pain issues in daily clinical stand-up and in weekly wound rounds. This will be an ongoing facility practice DON or designee will perform resident observations each week to identify compromised skin conditions and/or pain and pain management issues. Results will be reported in monthly QA which will track and trend the results through a developed plan which identifies quality deficiencies concerning wounds and pain.	

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	every 6 hours as needed for pain. A nurses note, dated 5/24/22 at 11:19 a.m., indicated he had been given his pain medication as scheduled, but refused his wound care. The controlled drug administration record for his hydrocodone- apap (narcotic pain medication with acetaminophen) 10-325 mg indicated the facility had received thirty-six tablets on 5/14/22. He had received the last of the thirty-six tablets on 5/23/22 at 4:00 p.m. On 5/24/22, the facility received thirty more hydrocodone- apap 10-325 mg tablets. He had received the first of those tablets on 5/24/22 at 4:00 p.m. During an interview on 5/25/22 at 10:59 a.m., Resident 68 indicated he had run out of his hydrocodone (narcotic pain medication) and his pain had been "off the charts". He had refused his wound dressing change because he was out of his hydrocodone medication. He could not imagine how painful his dressing change would have been without receiving his hydrocodone. During an interview on 5/25/22 at 11:10 a.m., LPN (Licensed Practical Nurse) 30 indicated when narcotic pain medication needed refilled, she called the pharmacy, if the resident was out of refills, then she would contact the physician or the nurse practitioner to send a refill prescription to the pharmacy. During an interview on 5/25/22 at 11:20 a.m., Nurse Practitioner 12 indicated she depended on the facility nurses to let her know when the residents needed their pain medications refilled. If a resident had been on narcotic pain medication for a long time, then she normally refilled it for 2 weeks at a time. She had been made aware of Resident 68			

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	needing a refill of his hydrocodone- apap late in the afternoon on 5/23/22 and had sent a prescription to the pharmacy. The resident's receiving narcotics long term were prescribed them to manage their pain. 2a. The clinical record for Resident 82 was reviewed on 5/17/22 at 10:37 a.m. The Resident's diagnosis included, but were not limited to, Parkinson's disease and anxiety. A care plan, revised on 6/14/21, indicated she had acute and chronic pain related to her impaired mobility. The goal, revised on 3/17/22, was for her to be able to verbalize relief of pain. The interventions included, but were not limited to, provide medications as ordered by the physician, initiated 6/14/21. A Quarterly MDS Assessment, completed 3/23/22, indicated she was cognitively intact and received scheduled pain medications. During an interview on 5/17/22 10:24 a.m., she indicated that she had an open area on leg that had been giving her trouble. I get pain medication, but it is not enough sometimes. "It hurts like a toothache." The May 2022 MAR indicated she received one oxycodone er 12-hour abuse- deterrent 10 mg every 12 hours for pain and that doses of the medication had not been given on 5/16, 5/17, and 5/18/22. During an interview on 5/24/22 at 11:16 a.m., Registered Pharmacist 9 indicated that a refill request for the oxycodone er 12-hour abuse-deterrent 10 mg had been electronically sent by the facility on 5/16/22. There were no			

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	refills left on the prescription. The physician sent a new prescription on 5/19/22 and it was delivered to the facility on that day. During an interview on 5/25/22 at 9:24 a.m., Resident 82 indicated she received scheduled pain medication each day when she went to bed and when she woke up. She could notice a difference in her pain level when she did not receive her scheduled pain medication. 2b. A physician's order, dated 12/2/21, was for a wet to dry dressing to be applied to the right calf twice daily. A care plan, last revised on 12/28/21, indicated she had impaired skin integrity due to a wound on her right lower leg. The goal, last revised on 3/17/22, was for her to have no complications to the right leg. An intervention, initiated 12/16/22, was to administer treatments as ordered by the medical provider. A Quarterly MDS Assessment, completed 3/23/22, indicated she was cognitively intact. A physician's order, dated 5/4/22, indicated to cleanse right lower leg and pat dry, apply silver alginate (wound dressing) to wound bed and then apply a border gauze. Change the dressing 3 times weekly and as needed. During an interview on 5/17/22 at 10:24 a.m., she indicated that she had a sore on her right leg that had been "giving her trouble." The dressing did not always get changed. On 5/23/22 at 10:40 a.m., she was observed lying in bed in a hospital gown. She indicated the last time her dressing was changed was Saturday.			

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	She removed the sheet from her leg and there was a kerlix (gauze strip) dressing which was labeled with the date of 5/21/22. On 5/23/22 at 10:57 a.m., RN (Registered Nurse) 8 was observed changing her dressing to her right lower leg. The 5/21/22 kerlix dressing had been removed, revealing a boarder gauze dressing, dated 5/19/22. She removed the boarder gauze dressing with her gloved hands. The dressing had two 2 x 2 squares, which were stiff and covered with a dark red substance and had an oblong dark yellow area in the middle. She indicated the dressing was saturated with blood and puss. She then cleansed the area with a dry 4x4 gauze. She then changed her gloves, without performing hand hygiene, and sprayed wound cleanser on the wound. She covered the wound cleanser with silver alginate and applied a new border gauze dressing. The May 2022 TAR (Treatment Administration Record) indicated that the wet to dry dressing to right calf had been completed at least daily, except for on 5/13 and 5/14/22. The May 2022 TAR indicated the silver alginate dressing was to be changed on Tuesdays, Thursdays, and Saturdays. It had not been initialed as completed on 5/14 and 5/17/22. It had been initialed as completed on 5/21/22, however the silver alginate dressing present on her leg on 5/23/22 had been dated as completed on 5/19/22. During an interview on 5/24/22 at 3:47 p.m., the Wound Nurse indicated that silver alginate dressing to her right lower leg should have been completed as ordered. The order for the wet to dry dressing should have been discontinued. The area on her right calf had been healed for some			

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	time. 3. The clinical record for Resident 33 was reviewed on 5/18/22 at 11:00 a.m. The diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease) and hemiplegia. The pain care plan, revised 2/28/22, indicated she had chronic pain and to administer her medications as ordered. An interview was conducted with Resident 33 on 5/18/22 at 11:25 a.m. She indicated she had back pain and was getting to the point where she had a hard time walking. The physician's orders indicated for her to receive Norco (7.5-325 mg) tablet of hydrocodone-Acetaminophen 4 times a day for pain. The May 2022 MAR (medication administration record) indicated she did not receive the hydrocodone, as ordered, on the following dates and times: 5/18/22 at 9:00 p.m., 5/19/22 at 1:00 p.m., 5/19/22 at 5:00 p.m., 5/19/22 at 9:00 p.m., 5/20/22 at 1:00 p.m., and 5/20/22 at 5:00 p.m. There were 2 administrations, on 5/19/22 at 9:00 a.m. and 5/20/22 at 9:00 a.m. that indicated she received the medication as ordered. An interview was conducted with UM (Unit Manager) 22 on 5/24/22 at 10:26 a.m. She indicated she did not receive her Norco, because she was out of the medication, and didn't have a prescription for more. She was unsure why there was no prescription, or how Resident 33 would have received the 9:00 a.m. administrations on 5/19/22 and 5/20/22, when the medication was unavailable.			

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	The 5/19/22, 11:36 p.m. nurse's note read, "Resident was out of her Norco- (7.5-325 MG). Called pharmacy to verify her refill status but only to be told that she needs a script. Contacted in house NP [nurse practitioner] but was directed to [name of pain physician.] After talking to [name of pain physician] about the patient and the need to send her script to pharm-script pharmacy, he does not seem to have a good recollection of the patient. Consequently, he advised me to sent him a text message regarding this request. After sending a text message to him, I later followed it up with a call, unfortunately the Dr. [doctor] couldn't be reached. Will continue to follow up with resident request." An interview was conducted with the pain physician's NP (Nurse Practitioner,) NP 12, on 5/25/22 at 11:22 a.m. She indicated she did not like to send in a whole month's prescription at a time. She sent in for 2 weeks at a time. She depended on nursing to tell her which residents needed what medications. If a resident was on the same pain medication for a long time, she would send in a prescription for 2 weeks at a time. If a resident was receiving pain medication for a long time, they needed the medication to manage their pain, and if they didn't get it, they could go thru withdrawal symptoms like nausea, vomiting, sweating, and chills, like having a bad flu for 24 to 48 hours. She received a request for a refill of Resident 33's Norco on 5/20/21, and she sent in a prescription on 5/21/21. An interview was conducted with Resident 33 on 5/25/22 at 9:52 a.m. She indicated she did not receive her Norco for 3 days after her original 5/18/22, 11:25 a.m. interview. She felt horrible, when she wasn't getting the medication. She was			

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	in bed the whole day, either on 5/19/22 or 5/20/22, but couldn't remember which day. She was hurting in her middle and lower back. She felt like she couldn't stand for very long. She smoked cigarettes, and only went out to smoke once one of those days, as she normally went out to smoke 6 to 8 times a day, and she wasn't able to visit with her boyfriend, like she normally would. 4. The clinical record for Resident 233 was reviewed on 5/17/22 at 1:30 p.m. The diagnoses included, but were not limited to, osteomyelitis. The pain care plan, revised 5/18/22, indicated he had complaints of chronic pain with an intervention to provide medication peer orders. The physician's orders indicated to administer one 15 mg tablet of morphine sulfate extended release every 12 hours for pain, effective 5/13/22. The May 2022 MAR (medication administration record) indicated he was not administered the morphine on once on 5/13/22, twice on 5/14/22, once on 5/15/22, and twice on 5/16/22. The electronic MAR notes indicated the reasons for not administering the above doses were due to the medication being unavailable. An interview was conducted with Resident 233 on 5/17/22 at 1:51 p.m. He indicated he was prescribed morphine last week but did not receive his first dose until 5/17/22. He stated, "It was horrible the whole last week. I couldn't sleep through the night at all." An interview was conducted with NP (Nurse Practitioner) 12 on 5/25/22 at 11:40 a.m. She indicated the first time she saw him, he said he			

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	was having a lot of pain, so she started him on the extended release. Later, the physician changed all of his medication and started him on Methadone. The Medication Administration policy was provided by the DON (Director of Nursing) on 5/19/22 at 9:05 a.m. It read, "Medication will be administered as prescribed." On 5/25/22 at 10:58 a.m.., the Director of Nursing provided the Pain Management and Assessment Policy, last reviewed on 1/18/2022, which read "...It is the purpose of this policy is to provide guidance to the clinical staff to support the intent...that based on the comprehensive assessment of the resident, the facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. There is no objective test that can measure pain. The clinician must accept the resident's report of pain. Clinical observations clarify information from the resident. Site of discomfort may direct the nurse to specific types of pain- relief measures..." 5. The clinical record for Resident B was reviewed on 5/20/22 at 10:00 a.m. The diagnoses included, but were not limited to, neurogenic bladder. He was admitted to the facility from the hospital on 3/10/22. He discharged from the facility on 4/27/22 for a planned surgery for wound closure. The 3/10/22 hospital discharge summary read, "Condition on Discharge/Disposition: Stable condition will require extensive wound care and working with PT [Physical Therapy] and OT [Occupational Therapy.]" The 3/10/22, 5:54 p.m. nurse's note indicated his			

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	wound vac was removed before being transported to the facility and had instructions to leave the wound vac off until Monday 3/14/22, as it would be put back on after his visit to the hospital wound clinic at 7:45am. He was currently using a wet to dry dressing. The 3/11/22, 5:11 p.m. Skin/Wound Note, written by the facility Wound Nurse, indicated Resident B had a surgical incision wound\line separation that went from his buttocks, perineum and left thigh region. The Wound Nurse was notified by the hospital emergency room nurse and EMT (emergency medical technicians) and family at bedside that resident's wound vac (vacuum) would be off until his 3/14/22, 7:45 a.m. hospital wound clinic appointment. The physician's orders indicated to cleanse buttock/perineum/incision/wound with normal saline, pat dry, apply wet-to-moist dressing/border gauze daily and as needed every day shift for surgical incision/line separation wound, effective 3/11/22. The March 2022 TAR (treatment administration record indicated this was not done on 3/12/22, 3/13/22, or 3/14/22. An interview was conducted with the Wound Nurse in the presence of the DON on 5/23 at 3:57 p.m. She indicated Resident B was supposed to admit to the facility with a wound vac, but didn't, so they got an order for the wet to dry dressing daily. She was unsure why it wasn't completed his first couple days in the facility. If they were completed, they should have been signed off on the TAR. There were no 3/14/22 hospital wound clinic			

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	notes. An interview was conducted with the facility Wound Nurse on 5/20/22 at 11:21 a.m. She indicated she was the wound nurse in March 2022 when Resident B admitted to the facility. They had issues with transportation getting him to his weekly wound appointments. The 3/16/22 hospital wound clinic note indicated it was his initial evaluation and treatment of sacral and perineal wound. The note indicated Resident B was accompanied by his parents for the visit. Resident B and his parents were very concerned about the wound healing prognosis and had multiple questions. The wound assessment was described as a chronic full thickness necrotizing fasciitis. The measurements were 32 cm X 40 cm X 9 Cm, with an area of 1280 sq cm and a volume of 11520 cubic cm. There was a moderate amount of sero-sanguineous drainage noted. The wound pain level was 4/10. The wound margin was not attached to wound base. The wound bed had 11-20% slough and 81-90% granulation. The periwound skin color was normal, and the periwound skin exhibited maceration. The wound clinic attempted to call the facility and left a voicemail for the DON (Director of Nursing) at the time to discuss the patient's plan of care and scheduling, detailed instructions for the wound vac application, and activity limitations. They were going to fax this note to the facility. It read, "Will see pt [patient] weekly in collaboration with SNF [skilled nursing facility] for wound care, next appointment Monday 3/21/22 at 10:30 a.m. Pt was given appointment card to give to the facility to arrange for transportation." The plan was for his NPWT (negative pressure wound therapy) to be changed twice a week or when soiled, once at the wound clinic on Mondays and once at the facility			

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	on Thursdays. An interview was conducted with the DON on 5/24/22 at 2:02 p.m. She indicated Resident B did not go to his wound clinic appointment on 3/21/22, due to transportation. The scheduled transportation canceled. The March 2022 TAR indicated the above order for his wound vac was completed every Thursday beginning 3/17/22, but it also indicated the previous order of wet to moist dressing continued to be done daily. An interview was conducted with the Wound Nurse in the presence of the DON on 5/23 at 3:57 p.m. She indicated she knew they were doing the wound vac treatments on Thursdays, as ordered, and was unsure why the daily wet to dry dressings continued to be signed off on the TAR. There was no 3/29/22 weekly wound clinic note. The 4/5/22 hospital wound clinic note indicated his wound was ready for combination of excision and complex closure as well as skin grafting. He could have his wound vac reapplied. They recommended a nonstick contact layer such as Adaptic or silver layer such as a product called UrgoTul which was like Adaptic with silver impregnated. They were going to place his order for surgery. In the meantime, they recommended continuing the wound vac dressing. The April 2022 TAR did not indicate the addition of a nonstick contact layer as recommended on 4/5/22, rather it indicated a continuing of the previous order of normal saline, pat dry, wet to moist dressing and border gauze from his admission.			

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	There was no 4/12/22 weekly wound clinic note. The 4/19/22 weekly wound clinic note indicated Resident B had not been getting regular dressing changes and the facility took him off the wound vac because there was bone present in the wound and the facility claimed bone in the wound was contraindicated to a vac. Resident B educated facility that is was not a contraindication; however the size of the wound with the location made it difficult on a non-hospital vac which was a more likely reason for doing the wet to dry dressings. Resident B's mother informed the dressings hadn't been changed for some time, then were changed at 12:30 a.m. and the dressings had thick yellow/green drainage. The note indicated there was no change noted in the wound progression. Surgery for wound closure was scheduled for 4/27/22. It read, "Patient is in a facility; however, will be at [name of hospital] for urology appointment so would like to keep wound appointment next week prior to surgery. Pt sated that would be fine. Patient and family nervous about anything messing up surgery." The 4/25/22 weekly wound clinic note indicated he was 2 days in advance of his anticipated procedure for complex closure of his wound. On presentation, he had strikethrough green drainage from his wound. Acetic acid was started. Instructions were issued to parent to bring to facility, and they would be faxed there. It stated, "Do not anticipate further treatment is indicated at this time given plan for closure with [name of surgeon] on Wednesday." The plan read, "Dressings: ... Please change dressing twice per day at a minimum. Dressing was changed at 11:00 on 4/25, please change again in the evening. Apply acetic acid moistened gauze (acetic acid			

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	issued to patient) to wound and cover with ABD pads, secure with medipore tape. Again, change twice per day at a minimum, and more often if needed with strikethrough drainage." The 4/25/22 wound clinic orders for twice daily dressing changes were not added to the facility physician's orders until 4/27/22, after discharging from the facility. The April 2022 TAR indicated a second dressing change was not completed the evening of 4/25/22, nor was it completed twice daily on 4/26/22, as instructed in the 4/25/22 wound clinic note. The 4/26/22, 4:00 p.m., nurses note, written as a late entry on 5/6/22, read, "Res father presented writer with wound dressing concerns, writer then went in and completed res wound [sic] dressing, wound shows no s/s [signs/symptoms] of bleeding or foul odor, no drainage. Res given clean linen, placed in comfortable position. Denies pain/discomfort. Father at bedside, thanked and appreciated writer." The 4/27/22, 5:00 a.m. nurse's note, written as a late entry on 5/9/22, read, "writer and CNA [Certified Nursing Assistant] entered room together to meet patients needs before his scheduled transfer out. nurse offered drsg [dressing] change and pt declined, drsg still present and intact. offered colostomy bag empty/change, pt declined d/t [due to] not needed at the time. CNA emptied f/c [foley catheter] bag and pt did allow nurse to irrigate the cath [catheter.] CNA and nurse offered to change linens on bed, pt declined , pt was on clean linens with a lift sheet on it from shoulders to feet so that he could be transferred to cot. pt took his AM med with sips of water. pt declined getting a bed bath or washed up before he went."			

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4/27/22, 6:25 a.m. nurses note read, "pt sent out per ambulance, stretcher, for scheduled surgery. mother and father at bedside."

An interview was conducted with Family Member 33, Resident B's mother, on 5/23/22 at 2:50 p.m. She indicated
Resident B's wound was so infected when he discharged the facility on 4/27/22 that he couldn't get the surgery for wound closure. The surgeon said he could not close the wound. He needed it debrided. It was delayed 2 days. It was infected. It had green drainage. She was concerned it was infected prior to leaving. They went to wound care on Monday, 4/25/22, and it was green then and they said that wasn't good. They were going to get it all cleaned up for surgery. By Wednesday, 4/27/22, it was all green again. The wound care center said they wanted the dressing changed twice daily, but the facility said no, they were only going to do it once daily. The nurse at the facility said he was the only nurse there and couldn't do it twice. It was truly, truly horrible."

The 4/27/22-5/17/22 hospital notes indicated the planned procedure was debridement and skin graft plus complex closure on 4/27/22. The notes read, "A tissue biopsy was obtained 4/25/2022 that was polymicrobial w/Acinetobacter baumannii, Group A strep, Pseudomonas aeruginosa, Corynebacterium, and 1 colony of Staph aureus. He was admitted 4/27/2022 for planned surgery which ended up being a debridement only as his mother states his wound was not taken care of at [name of facility] and he presented with purulence. Following his debridement yesterday [4/27/22,] he has remained on IV Cefepime....CT scan also revealed a concern for osteomyelitis of the ischium. There are plans

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	for him to return to the OR [operating room] tomorrow for possible wound coverage...Surgical History Internal 04/29/2022 [name and title of surgeon] Skin Graft Split Thickness. 02/27/2022 [name and title of surgeon] Wound Debridement." 6. The clinical record for resident 103 was reviewed on 5/16/22 at 3:25 p.m. The Resident's diagnosis included, but were not limited to, congestive heart failure and chronic respiratory failure. A care plan, initiated 12/17/21, indicated he was at risk for impaired skin integrity related to his disease process, immobility, poor nutrition, and poor vascularity. The goal, initiated 12/17/21, was for him to be without impaired skin integrity. The interventions, initiated 12/17/21, included, but were not limited to, complete skin at risk assessments upon admission/ readmission, quarterly and as needed and to complete weekly skin checks. A progress note, dated 1/28/22 at 1:25 p.m., indicated he was re-admitted to the facility and appeared to have a patch of psoriasis noted on his face. A physician's order, dated 1/28/22, indicated he was to have Elidel Cream 1% (cream used to treat dermatitis) applied to his face every day for treatment of psoriasis patches on face. The order was discontinued on 4/20/22 when he went to the hospital for acute care. A Quarterly MDS Assessment, completed 4/2/22, indicated he was cognitively intact. On 5/16/22 at 3:25 p.m., he was observed sitting on the side of his bed. He had flakey crusts of			

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	skin in his right ear and on his forehead. On 5/19/22 at 10:48 a.m., he was observed sitting in his room. Flakey crusts of skin were noted on forehead. On 5/23/22 at 10:54 a.m., he was observed laying sideways on bed. He was dressed in a black tee shirt and had been shaved. He had reddened areas on face. On 5/25/22 at 2:50 p.m., he was observed sitting in his room. He had red and scaly patches on his cheeks, chin, and forehead. He indicated he used to have some cream that the nurses put on his face. During an interview on 5/52/22 at 3:08 p.m., QMA (Qualified Medication Aide) indicated that a physician should have been informed of the red, crusty areas on his face. 7. The ED (Executive Director) provided the most recent QAPI [Quality Assurance and Performance Improvement] Meeting Agenda and Minutes on 5/26/22 at 1:49 p.m. They included the 3/18/22 minutes, the 4/22/22 minutes, the 4/28/22 minutes, the 5/16/22 minutes, and the 5/20/22 minutes. None of the minutes referenced wound care or pain management. An interview was conducted with the ED, Interim DON (Director of Nursing,) and a Sister Facility DON on 5/26/22 at 1:25 p.m. The ED indicated they'd discussed that there was no Wound Care Director at meetings but did not have a specific plan in place to address wound care in the facility. It was only recently that they realized they needed to tighten up on some things in regards to wound care, but more so in morning meetings format, not			

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	during QAPI meetings. He did not recall discussing or identifying pain management as an area of concern during QAPI meetings. In terms of a trend, there was no QAPI plan in place for pain management. The QAPI Plan was provided by the ED on 5/26/22 at 3:01 p.m. It read, "QAPI is data-driven. QAPI is a proactive approach to improving quality of life, care and services. The activities of QAPI involve members at all levels of the organization to: identify opportunities for improvement, address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions. This Federal tag relates to complaint IN00379008. 3.1-52(b)(1) 3.1-52(b)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing,			

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	identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.			

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	§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to don an isolation gown when entering and to wash hands with soap and water prior to leaving an Enteric Contact Precaution Isolation room, to perform hand hygiene when changing gloves, and to properly prevent and/or contain COVID-19 for 1 of 7 residents reviewed for infection control during medication administration, 1 of 1 resident reviewed for tracheostomy care, and 1 of 3 residents reviewed for skin conditions (Residents G, 82, and 326). Findings include: 1. The clinical record for Resident G was reviewed 5/16/22 at 3:05 p.m. The Resident's diagnosis included, but were not limited to, tracheostomy and acute respiratory failure. A physician's order, dated 5/23/22, indicated she was on Contact Isolation Precautions related to C-Diff (bowel infection). On 5/26/22 at 9:15 a.m., Respiratory Therapist 15	F 0880	**F 880** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident G is confidential as part of the complaint survey. Resident 82 is no longer in isolation precautions. Resident 326 was unable to be identified. There is no number 326 on the provided resident identifier list. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice. The DON or designee will complete the following:	06/27/2022

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	was observed entering Resident G's room to perform tracheostomy care. There was a sign present on the door indicating she was in Contact Isolation Precautions and that an isolation gown and gloves should be donned prior to entering the room. She indicated her gown was on the bedside table and entered the room to don her isolation gown. She then put on disposable gloves at bedside. She provided tracheostomy care and then removed her isolation gown and gloves. She exited the room without washing her hands with soap and water. She retrieved a container of cleansing wipes, removed the wipes from the container and re-entered the room. She donned an isolation gown when entering the room and cleansed the bedside table. She then removed the isolation gown and glove and used alcohol-based hand sanitizer to clean her hands when leaving the room. During an interview on 5/26/22 at 9:40 a.m., she indicated she normally washed her hands with soap and water when leaving the room but did not because she knew there were no paper towels available in the room. During an interview on 5/26/22 at 9:50 a.m., the Sister Facility Director of Nursing indicated that when caring for a resident with C. Diff, the staff member should use soap and water to wash hands after care not alcohol-based hand sanitizer. 2. The clinical record for Resident 82 was reviewed on 5/17/22 at 10:37 a.m. The Resident's diagnosis included, but were not limited to, Parkinson's disease and anxiety. A Quarterly MDS Assessment, completed 3/23/22, indicated she was cognitively intact.		Staff involved will be educated on how and when to don and doff PPE with return demonstration, including, but not limited to, mask, respirator devices, gloves, gown, and eye protection. Policy: USE OF PPE WHILE IN THE FACIITY CDC: PPE sequence Competency: PPE Competency Validation Donning and Doffing Staff involved will be educated, with return demonstration, for hand hygiene (hand washing and ABHS) and understand when to perform hand hygiene. Follow CDC guidance and facility policy. Ensure Hand Hygiene items, including soap and water or ABHS are available at all times. Policy: General Hand Hygiene Competency: AAPACN Hand Hygiene Competency Licensed Nurses will be education on correct procedure for tracheostomy care Policy: Tracheostomy Care Licensed Nurses and QMAs will be educated on infection control practices during medication administration to prevent possible contamination of medications Policy: Medication Administration	

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	On 5/23/22 at 10:57 a.m., Registered Nurse 8 was observed providing her dressing change. She donned nonsterile gloves and removed the old dressing. She then used a 4 x 4 gauze to cleanse the edges of the wound. She placed the soiled dressing into a trash bag and removed her gloves. She then donned a new pair of disposable gloves and continued cleansed the wound with wound cleanser and applied the new dressing. She did not perform hand hygiene prior to donning the new disposable gloves. During an interview on 5/23/22 at 11:26 a.m., Registered Nurse 8 indicated she cleansed her hands prior to starting the dressing change. She usually cleansed her hand when she changed her gloves. On 5/25/22 at 10:34 a.m., the Director of Nursing provided the Standard Precautions Policy, last reviewed on 3/20/17, which read "...Hand Hygiene...When to perform Hand Hygiene...C. After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressing...G. After glove removal..." On 5/26/22 at 10:39 a.m., the Sister Facility Director of Nursing provided the Enteric Contact Precautions Policy, last reviewed on 10/31/18, which read "...The purpose of this policy is to guide employees to care for residents that require additional or 'high level' contact precautions for enteric infections of clostridium difficile (C. Diff)...Infections are highly transmittable by their nature, disrupting the normal flora of the colon...Staff will use proper PPE [Personal Protective Equipment] including gloves, and gown..." 3. The clinical record for Resident 326 was reviewed on 5/23/22 at 12:16 p.m. Resident 326's		**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** A Root Cause Analysis (RCA) was conducted with the Infection Preventionist (IP) and input from the IDT and the facility Medical Director/IP/DON. The root cause was identified resulting in the facility's failure. Solutions were developed and systemic changes were identified that need to be taken to address the root cause. The Infection Preventionist and IDT reviewed the LTC infection control self-assessment and identified changes to make accurate **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** After the IDT and Infection Preventionist completed the RCA and LTC infection control assessment, training identified above was implemented to facility staff. The training will be conducted by the DON, IP or Medical Director with documentation of completion.	

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	diagnoses included, but not limited to, brain injury, diabetes type II, and schizophrenia. Resident 326 was admitted to the facility on 5/16/22. Resident 326's immunization record indicated, she had been vaccinated against COVID-19 on 5/16/21 and 7/7/21. She was eligible for the COVID-19 booster at the time of her admission but refused the booster. An interview with AC (Admissions Coordinator) 50 conducted on 5/24/22 at 10:15 a.m. indicated, Resident 326 had not been tested for COVID on day one of her admission, so she was required to be in contact isolation for 10 days. An interview with AC 50 conducted on 5/24/22 at 4:31 p.m. indicated, Resident 326 was placed in contact isolation for 10 days related to not being up to date on COVID vaccination at the time of her admittance. An observation of Resident 326's room door was made on 5/23/22 at 12:23 p.m. Resident 326's room had a sign on the door which indicated, the room was a contact precaution room and stipulated the necessary PPE (Personal Protective Equipment) was required prior to entering the room. An observation was made on 5/23/22 at 12:24 p.m. of LPN (Licensed Practical Nurse) 5. LPN 5 donned a gown, gloves, N 95 mask, and face shield then entered Resident 326's room to check her blood sugar. LPN 5 preformed the blood glucose check and when completed placed the glucometer on the resident's bedside table. LPN 5 picked up the glucometer then placed it into her pocket, doffed her PPE and exited the room. LPN 5 did not clean and or sanitize the glucometer prior		To ensure Infection Control Practices are maintained, the following monitoring will be implemented. 1. The IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA and as noted above, daily or more often as necessary for 6 weeks and until compliance is maintained. Ensure staff performed hand hygiene at appropriate times, such as before donning/after doffing PPE, after touching facemask, before entering/after leaving a resident room, between glove change. Ensure staff don / doff the correct PPE appropriately before entering / when exiting an isolation room Ensure RTs and Licensed Nurses correctly execute tracheostomy care procedure Ensure Licensed Nurses and QMAs demonstrate proper infection control practices during medication administration 2. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate	

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	to leaving resident 326's room. An observation was made of CNA (Certified Nursing Assistant) 51 on 5/23/22 at 12:25 p.m. CNA 51 entered into Resident 326's room to answer the call light. CNA 51 was not wearing a N 95 mask nor gloves when she entered the room and stood within 6 feet of Resident 326 and touched her bedside table. An interview with DON (Director of Nursing) conducted on 5/23/22 at 12:35 p.m. indicated, staff are to wear the appropriate PPE required based on the type of isolation that was in place. She further indicated, the glucometer should have been cleaned/disinfected after its use and prior to leaving the resident's room. An Infection Prevention Program policy was received on 5/16/22 at 11:03 a.m. from ED (Executive Director). The policy indicated, "The facility will utilize current CDC guidelines for infection control monitoring and guidance....The goals of the facility infection prevention program are to: a. Reduce the spread of infectious disease within the facility through implementation of the Standard and Transmission-based Precautions... d. Monitor occurrences of infection and implement appropriate control measures... f. Identify and correct problem relation to infection prevention practices... Procedure...c. Education i. Staff and resident education focuses on risk of infection and practices to decrease risk including but not limited to hand hygiene compliance and cough/sneeze etiquette to break the chain of infection. Education to staff on donning and doffing of personal protective equipment is a focus of the infection prevention program. d. Policy and		Infection Control Practices and complying with the solutions identified in B1 as above. This will occur for 6 weeks and until compliance is maintained. Infection Control Practices Ensure staff performed hand hygiene at appropriate times, such as before donning/after doffing PPE, after touching facemask, before entering/after leaving a resident room, between glove change. Ensure staff don / doff the correct PPE appropriately before entering / when exiting an isolation room Ensure RTs and Licensed Nurses correctly execute tracheostomy care procedure Ensure Licensed Nurses and QMAs demonstrate proper infection control practices during medication administration **Quality Assurance and Performance Improvement (QAPI):** The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	

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	Procedure i. Policies, procedures and aseptic practices are followed by employees in performing procedures and in disinfection of equipment." 3.1-18(b) 3.1-18(l)			
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy by prescribing antibiotics for not a true infections, for excessive duration and without adequate indication for use based on the McGeer's Criteria for 1 of 5 residents reviewed for unnecessary medications (Resident 60). Findings include: The clinical record for Resident 60 was reviewed on 5/18/22 at 10:45 a.m. The Resident's diagnosis included, but were not limited to, open wound of the left ankle and paraplegia. A physician's order, dated 4/14/22, indicated he was to receive Macrodantin capsule 50 mg (Milligram) one capsule at bedtime for UTI (Urinary Tract Infection) prevention.	F 0881	F881 1) Resident 60 was not harmed by the deficient practice. The physician has added documentation for the rational for continued use of Macrodantin. 2) All residents on antibiotics have the potential to be affected. An audit was performed to ensure McGeer's criteria is being followed and any antibiotic not meeting criteria has physician documentation to explain rationale. 3) IDT team including nurse managers were educated on facility's policy "Minimum criteria for antibiotic use" with an emphasis on ensuring residents receiving antibiotics meet Mcgeer's criteria and if they do not	06/27/2022

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	A care plan, initiated 4/14/22, indicated He had a UTI and was on antibiotic for prophylaxis. The goal, initiated 4/14/22, was for him to be free of signs and symptoms of complications related to the infection. The goals included, but were not limited to, administer medications per medical providers order and observe for signs and symptoms of urinary infection. During an interview on 5/23/22 at 10:00 a.m., the Corporate Infection Preventionist indicated that the facility used the McGreer's Criteria for antibiotic use. If a physician wanted to use an antibiotic prophylactically, she would expect to see a progress note giving the rational for the extended use. There was no physician's progress note which provided rational for the continued use of the Macrodantin. On 5/23/22 at 10:17 a.m., Nurse Consultant 3 provided the Minimum Criteria for Antibiotic Use Policy, last reviewed on 2/24/2022, which read "...The purpose of this policy is to meet requirements for Long-Term facilities to establish minimum guidelines for antibiotic use in the facility. The facility will use McGeer's Criteria for Long-Term Care as a foundation for reporting infections...I. General Ordering Overview...ii. Reducing the use of broad-spectrum antibiotics is considered optimizing antibiotic use...d. Prophylactic use of antibiotics is used for the subset of the population that has the diagnosis to support use in surgical or dental procedures e. Documentation in the progress notes helps both the provider and nurse communicate current symptoms for surveillance and optimizing antibiotic use..."		ensure physician documentation on rationale. 4) Director of Nursing or designee will review new orders for antibiotics in morning clinical meeting to ensure mcgeers criteria has been met and if treatment does not meet criteria that physician documents rationale. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	
F 0886 SS=F	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	§483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and			

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	155272	A. BUILDING 00 B. WING	05/26/2022

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	(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. Based on interview and record review, the facility failed to document that testing for COVID-19 was completed for staff and the results of each staff test for COVID-19. This had the potential to effect 123 residents residing in the facility. Findings include: A list of unvaccinated staff was received on 5/18/22 at 10:30 a.m. from DON (Director of Nursing). The facility was asked to provide COVID-19 testing results for a sample of 3 unvaccinated staff members, Employee 52,	F 0886	**F 886** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** All residents have the potential to be affected by this alleged deficient practice. **Identification of other residents having the potential to be affected by the same alleged**	06/27/2022

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	Employee 53, and Employee 54. An interview with ED (Executive Director) conducted on 5/26/22 at 2:04 p.m. indicated, the facility's Infection Preventionist (IP) had injured themselves and was out of the building. ED stated, the IP was the person responsible for ensuring the unvaccinated staff was tested weekly for COVID-19. At that time, the unvaccinated staff testing results could not be located. ED was unable to provide any employee COVID-19 testing results for the last three months prior to exit on 5/26/22 at 4:30 p.m.		**deficient practice and corrective actions taken**: DON or designee will ensure all current unvaccinated employees are tested at the frequency prescribed in the routine testing table based on the level of community transmission. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Director of Nursing Services or designee will re-educate the facility staff on the following policy: Facility Testing Requirement **How the corrective measures will be monitored to ensure the alleged deficient practice will not recur:** The following audit for 10 unvaccinated employees will be conducted by the Director of Nursing Services or designee 2x per week x 3 months to ensure all current unvaccinated employees are tested at the frequency prescribed in the routine testing table based on the level of community transmission. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further	

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			recommendation.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to maintain a clean and sanitary kitchen environment which had a potential to affect 109 of 123 residents residing at the facility. Findings include: On 5/16/22 at 10:44 a.m., the facility kitchen was observed with the Dietary Manager. The dry storage room had food crumbs and debris present under the wire storage racks. The ceiling tiles over the food service area were soiled, with rust visible on the drop ceiling grates. The air filtration grates above the food service area had grey dust build up on them and on the ceiling tiles adjacent to them. The sugar bin had a soiled appearance, with a brown substance dried on the rim of the container. On 5/19/22 at 11:50 a.m., the facility kitchen was observed. It continues to have food crumbs and debris under the wire storage racks in the dry storage room. There were creamer packets and a salad dressing packet on the floor under the wire shelving. The sugar and flour containers were splattered with dry food and sticky to touch. The rims of the containers had a brown substance dried onto the rims. The ceiling in the food service area continued to be soiled and the air filtration grates above the food area continued to have a	F 0921	**F921-Safe/Functional/Sanitary/ Comfortable Environ** **1. The facility kitchen was cleaned to meet the requirements of a clean and sanitary kitchen environment.** **2. 109 residents had the potential to be affected by this alleged deficient practice. The kitchen has been cleaned to meet the requirements of a clean and sanitary kitchen environment with emphasis on the dry storage room, ceiling tiles, air filtration grates, flour and sugar bins.** **3. The Dietary Manager or designee will in-service the Dietary Staff on the implementation of the updated daily cleaning schedules to meet the requirements of a clean and sanitary kitchen environment with emphasis on the dry storage room, ceiling tiles, air filtration grates, flour and sugar bins.**	06/27/2022

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	grey dust build up in the vents and the ceiling tiles adjacent to them. During an interview on 5/19/22 2:52 p.m., Dietary Manager 1 indicated that the flour and sugar bins should be cleaned and the lid should be closed. The ceiling tiles were soiled and there was rust on the drop ceiling grates. The maintenance department was aware of the ceiling grates being soiled. The air vents should be cleaned weekly and that there was dust on the ceiling tiles over the food service area. 410 IAC 7-24-310 Cleaning ventilation systems Sec. 310. (a) Intake and exhaust air ducts shall be cleaned, and filters changed so they are not a source of contamination by the following: (1) Dust. (2) Dirt. (3) Other materials. 410 IAC 7-24-295 Equipment food-contact surfaces, nonfood-contact surfaces, and utensils Sec. 295. (a) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of: (1) dust; (2) dirt; (3) food residue; and (4) other debris; and shall be cleaned at a frequency necessary to preclude accumulation of soil residue.		**4. The following audits via observation will be conducted by the Dietary Manager or designee to ensure compliance with a clean and sanitary kitchen environment : audit the daily cleaning check offs and observe the dry storage room, ceiling tiles, air filtration grates, flour and sugar bins 5 days a week for 4 weeks, 3 days a week for 2 months, and 1 time a week for 3 months.** **5. The Dietary Manager/Designee will bring the results of the audits to the monthly QAPI meeting. The results of the audit will be reported, reviewed, and trended for a minimum of 6 months, Then randomly thereafter for further recommendations.**	
F 0943 SS=E	483.95(c)(1)-(3) Abuse, Neglect, and Exploitation Training			

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Bldg. 00	§483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. Based on interview and record review, the facility failed to ensure staff was provided abuse, neglect, exploitation and misappropriation of resident property, and the procedures for reporting incidents of abuse neglect, exploitation, or the misappropriation of resident property. This had the potential to effect 123 residents residing within the facility. Findings include: The staff personal files were provided by ED on 5/24/22 at 9:00 a.m. They indicated, the following staff was not up to date in regards to annual abuse training along with hire date: CNA 52; 12/15/21 & CNA 56; 6/27/17. An interview with ED (Executive Director) conducted on 5/26/22 at 10:34 a.m., indicated he was unable to provide/locate evidence of CNA	F 0943	**F943** **Staff member 52 and 56 were provided education on abuse training and had their employee personnel files updated with the provided education as it results to abuse, neglect, exploitation and misappropriation of resident property, and the procedures for reporting incidents of abuse neglect, exploitation, or the misappropriation of resident property.** **All residents have the**	06/27/2022

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	52's nor 56's abuse training within the last year. An Abuse & Neglect & Misappropriation policy was received on 5/16/22 at 11:03 a.m. The policy indicated, "Employees will receive abuse prevention training as required as part of their orientation, as needed/indicated and annually thereafter...Training Provide education and training upon hire, annually and as needed for re-training to include but not limited to: a. Definition of abuse/neglect/misappropriate of personal property b. Prohibition of such acts in facility (including corporal punishment and involuntary seclusion) c. Methods of protecting residents from verbal, mental, sexual and physical abuse, misappropriation d. No employment of those convicted of abuse/neglect or mistreatment of individuals e. Observations that may identify abuse or neglect f. Reporting allegations of abuse/neglect. misappropriation without fear of reprisal g. Interventions to deal with aggressive behaviors h. Recognition of burn out, frustration/stress in self and others i. Timely and appropriate reporting of reasonable suspicion of crime in facility 2. Education and training in-services documentation of attendance will be maintained". 3.1-28(a) 3.1-27(a) 3.1-27(b)		**potential to be affected.** **The Human Resource Director or designee will conduct an audit of all employee personnel files for verification of completion of education as it relates to abuse, neglect, exploitation and misappropriation of resident property, and the procedures for reporting incidents of abuse neglect, exploitation, or the misappropriation of resident property. Any current staff found to have incomplete employee personnel files had their file(s) updated with the required information/education/documents. All new hires will complete during orientation and Human Resource Director will validate completion.** **The Human Resource Director, ED, and DON have been educated on the state and federal requirements for accurate and complete employee personnel files and staff education with emphasis on staff education as it relates to abuse, neglect, exploitation and misappropriation of**	

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			resident property, and the procedures for reporting incidents of abuse neglect, exploitation, or the misappropriation of resident property. **The following audits will be conducted by the Human Resource Director or designee to ensure compliance with new employee personnel files and education with emphasis on abuse training: An audit of up to all new hires will be completed for 4 weeks, then 20 staff per month for 8 weeks and then 10 staff per month for 3 months to ensure employee personnel files are up to date.** **The ED/Designee is responsible for compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any**	

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			trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 9999 Bldg. 00		F 9999	**9999-final observations**	06/27/2022
	3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (l) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. The nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired		**Staff members identified as 1, 52, 54, 55, 56, 57, 58, 59, 61, and 62 had their employee files reviewed and updated to ensure the state requirement for complete and accurate employee personnel files were met in regards to references, tuberculin skin testing, resident rights and/or dementia training.** **All residents have the potential to be affected.** **The Human Resource Director or designee will conduct an audit of all employee personnel files for verification of completion of dementia, references, tuberculin skin testing, and resident rights training. Any current staff found to have incomplete employee personnel files had**	

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	residents and to gain understanding of the current standards of care for residents with dementia. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method, (5 TU PPD), administered by person having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or		**their file(s) updated with the required information/education/documents. All new hires will complete during orientation and Human Resource Director will validate completion.** **The Human Resource Director has been educated on the state requirements for accurate and complete employee personnel files with emphasis on completion of dementia, references, tuberculin skin testing, and resident rights training.** **The following audits will be conducted by the Human Resource Director or designee to ensure compliance with new employee personnel files with emphasis on references, tuberculin skin testing, dementia and resident rights: An audit of up to all new hires will be completed for 4 weeks, then 20 staff per month for 8 weeks and then 10 staff per month for 3 months to ensure employee personnel files are up to date.**	

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	preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to provide staff members with references, tuberculin skin testing, resident rights and/or dementia training for 10 of 10 employee personal files reviewed. (Certified Nursing Assistant (CNA) 55, CNA 56, CNA 57, Certified Medication Assistant (CMA) 58, CNA 59, Dietary Manager (DM) 1, CNA 52, Activities Assistant (AA) 54, Respiratory Therapist (RT) 61 and Laundry Assistant (LA) 62. Findings include: The staff personal files were provided by the Executive Director (ED) on 5/24/22 at 9:00 a.m. The following Personnel files were reviewed on 5/24/22 and the following was found to be missing and date of hire: 1. CNA 55's file did not contain dementia training within the last year. Date of hire: 4/8/22, 2. CNA 56's file did not contain Resident Rights nor Dementia training within the last year. Date of hire: 6/27/17, 3. CNA 57's file did not contain Dementia training within the last year. Date of hire: 4/9/20, 4. CMA 58's file did not contain Dementia training within the last year. Date of hire: 9/9/21, 5. CNA 59's file did not contain Dementia training within the last year. Date of hire: 9/29/21, 6. CNA 52's file did not contain a job description; general or specific orientation; or Dementia training within the last year. Date of hire: 12/15/21,		**The ED/Designee is responsible for compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.**	

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	7. DM 1's file did not contain Dementia training within the last year. Date of hire: 7/1/19, 8. AA 54's file did not contain any reference checks, a second step TB (tuberculosis) test, nor Dementia training within the last year. Date of hire: 3/17/22, 9. RT 61's file did not contain a first or second step TB test prior to working in the facility; and Dementia training within the last year. Date of hire: 4/4/22, & 10. LA 62's file did not contain a criminal background check, reference checks, a second step TB test, nor did they have any Dementia training hours within the last year. Date of hire: 12/13/21. An interview with ED conducted on 5/26/22 at 10:34 a.m. indicated, he was unable to locate/provide evidence for the missing contents from each of the listed employee files.			