STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155581	A. BUILDING 00 B. WING	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF SYRACUSE SKILLED NURSING FACILITY, THE	500 E PICKWICK DR SYRACUSE, IN 46567

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 5, 6, 7, 8, & 9, 2024 Facility number: 000566 Provider number: 155581 AIM number: 100267450 Census Bed Type: SNF/NF: 35 Total: 35 Census Payor Type: Medicare: 5 Medicaid: 18 Other: 12 Total: 35 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/21/24.	F 0000		
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may			

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

Rebecca Dunnuck | Director of Nursing | 03/01/2024

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	be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or			

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	on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on record review and interview, the facility failed to ensure a change in Notice of Medicare Non-Coverage form (NOMNC) was provided timely, for 1 of 3 residents reviewed for beneficiary notices. (Resident 90) Finding includes: The record for Resident 90 was reviewed on 2/8/2024 at 8:55 A.M. Diagnoses included, but were not limited to: acute congestive heart failure, atrial fibrillation and weakness. The resident was admitted under Medicare part A for rehabilitation. A Social Service Progress Note, dated 11/27/2023, indicated the resident's daughter planned for the resident to discharge back to her previous, unlicensed assisted living facility once she was discharged from therapy services. A Social Service Progress Note, dated 12/6/2023, verified the details for the resident's discharge to her previous residence. Social Services indicated they had sent a referral to a home health agency. A Notice of Medicare Non-Coverage form for Resident 90 indicated the resident's last covered date of therapy services was 12/10/2023. The form was not signed and "she went home w [with] HH [home healthcare] choose to go home" (sic) was handwritten under the Additional Information. The form was not signed by the patient or her representative and there was no other date on the form. The facility provided documentation indicating the reason the Medicare Part A	F 0582	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is 3/5/24. The facility is respectfully requesting paper compliance for all deficiencies in this POC. F 582 It is the intent of this facility to issue a Notices of Medicare Non-Coverage. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident 90 was unable to receive NOMNC (Notice of Medicare Non-Coverage form CMS (Center for Medicare and Medicaid Services) as they no longer reside in facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to be affected by the cited practice,	03/05/2024

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	Services/Termination/Discharge date was determined was because therapy had discharged the resident due to feeling she had reached her maximum ability. During an interview with the Business Office Manager, on 2/8/2024 at 8:56 A.M., she indicated there was a newer employee responsible for presenting the NOMNC and ABN forms to get them signed, and then the BOM would file them. She confirmed the NOMNC was not presented timely and was not signed, because the resident went "home." The form was not signed on 12/10/2023 because the resident had already been discharged from the facility. The BOM indicated she had called the family, and they did not want to come sign the form because the resident had already transferred to her previous facility, and it would not make any difference to the resident. The current facility policy, last dated as reviewed on 11/2018, and provided by the Business Office Manager on 2/8/2024 at 10: 30 A.M., included the following procedure regarding NOMNC notices: "1. The NOMNC will be issued to Traditional Medicare Part A, Tradition Medicare Part B and Medicare Advantage Plan Beneficiaries or the authorized Representative, 2 days prior to the Medicare coverage ending when the Beneficiary has benefit days remaining. 2. Must be issues 2 days prior to the effective date...11. The facility may use a Telephone notification and will document the following using the Electronic Health Record Structured Progress note or Narrative Note: a. Statement that all information was provided and the Beneficiary or authorized representative understood the notice. b. Name of the staff person making the telephone notification. c. Name of the authorized Representative. d. Date and Time of the telephone contact...."		therefore, this plan of correction applies to all residents of the facility. What measure will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Social Services has been educated by Social Service Consultant/Administrator to ensure that NOMNCs are issued timely to appropriate residents on or before 3/5/24. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: Administrator/Social Services/designee will ensure completion of NOMNCs three times per week x 4 weeks, twice a week x4, then weekly x 4 months.If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any	

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	There was no documentation regarding the notice of the NOMNC being issued post discharge for Resident 90. 3.1-4(f)(3)		written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficiency will be completed: 3/5/24	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.			

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	(iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to implement and revise a care plan for 2 out of 15 resident care plans reviewed. (Residents 11 & 17) Findings include: 1. During an observation on 2/7/2024 at 9:45 A.M., Resident 17's continuous positive airway pressure (CPAP) mask and tubing was on the floor next to the nightstand. The resident indicated that he used the machine at night when he sleeps. A record review was completed for Resident 17 on 2/5/2024 at 1:45 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, obstructive sleep apnea and cerebrovascular disease. There was no Physician's Order for the CPAP	F 0656	F656 Develop/Implement Comprehensive Care Plan It is the policy of this facility implement and revise care plans. What corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident 17's care plan was completed for CPAP on 2/8/24 and resident 11's care plan was updated for splint on 2/20/24 by the MDS Nurse. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken: An audit was completed for	03/05/2024

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	machine. There was no Care Plan initiated for the use of the CPAP machine. During an interview on 2/8/2024 at 9:53 A.M. the Director of Nursing indicated Resident 17 should have had a care plan for the CPAP.2. The record for Resident 11 was reviewed on 2/6/2024 at 1:30 P.M. Diagnoses included, but were not limited to: fracture of the fourth metacarpal bone in the left hand and contracture of the left hand. Resident 11 was observed, on 2/5/2024 at 10:37 A.M., seated in her wheelchair. The resident was noted to have contracted hands, especially the left hand. During an interview with Resident 11 at that time, she indicated she had broken a finger on her left hand in the past. The most recent Minimum Data Set (MDS) assessment, completed on 11/16/2023 indicated Resident 11 had no impaired range of motion issues to her upper extremities. The current care plans for Resident 11 included a plan to address the resident's contracture of her left hand, but only included interventions to notify the physician if the contracture worsened and therapy as needed. The use of a hand splint was not on the care plan. During an interview with Employee 7, an occupational therapist, on 2/7/2024 at 1:12 P.M., she indicated she had worked with Resident 11 in the past regarding the left hand contracture, and had posted pictures with application instructions and a splint schedule on the inside of resident's closet door.		residents with splints and CPAP and care plans were updated as indicated on 2/28/24 by the MDS Nurse. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The MDS Consultant educated the MDS Coordinator on 2/28/2024 on the care plan process and updating care plans as needed. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place: The “F656 – Develop and Implement Comprehensive Care Plan Audit” for splints and CPAP/Bipap will be 5 random residents weekly for 4 weeks, 3 random residents weekly for 4 weeks, 3 random resident monthly x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be	

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	During an observation of the resident's closet, on 2/7/2024 at 1:16 P.M., there were no instructions regarding the splint inside the closet door. A hand splint, stored in a plastic basket underneath a few random items, was noted on the floor of the closet. During an interview with Employee 7, on 2/7/2024 at 2:20 P.M., she provided documentation regarding the hand splint with a schedule to wear the splint for 8 hours during the night. Employee 7 indicated she had educated the staff regarding the use of the hand splint and schedule, but did not think the staff were utilizing the splint for Resident 11. The documentation indicated the resident was discharged from skilled therapy services on 2/1/2023. During an interview with the MDS coordinator, on 2/9/2024 at 9:47 A.M., he confirmed the use of the left hand splint was not in the care plan. During an interview with CNA 6, on 2/9/2023 at 10:06 A.M., she indicated Resident 11 was assisted with morning care on the day shift. She had never observed any splint usage on the resident's left arm when she arrived in the mornings to get Resident 11 up out of bed and ready for the day. The facility policy and procedure, titled, "Baseline Care Plan Assessment/Comprehensive Care Plan Assessment" provided by the Administrator on 2/9/2024 at 11:00 A.M. included the following: "...The Comprehensive Care Plan will be finalized within 7 days of the completion of the full Comprehensive MDS assessment and corresponding CAAS. The Comprehensive Care Plan will include participation from IDT (interdisciplinary team) members, as well as a		stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolve. By what date the systemic changes for each deficient will be completed. 3/5/24	

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	CNA, some member of the food/nutritional service staff, restorative nursing team, as applicable, as well as Social Service worker. Further, the Comprehensive Care Plan will include any Specialized Service or Specialized Rehab Services recommended to be provided as a result of any Pre-admission screening and Resident Review....9. The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psychosocial issues...." 3.1-35(a) 3.1-35(d)(2)(B)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review and interview, the facility failed to ensure an individualized activity program was provided, for 2 of 3 residents reviewed for activities. (Residents 21 and 33) Findings include: 1. The record for Resident 21 was reviewed on	F 0679	F679 It is the policy of this facility to ensure an individualized activity program is provided. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	03/05/2024

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	2/5/2024 at 2:30 P.M. Diagnoses included, but were not limited to: major depressive disorder, single episode, dementia with mood disturbance, difficulty walking, glaucoma, and bilateral sensorineural hearing loss. The most recent Annual Minimum Data Set assessment, completed on 8/15/2023, indicated it was somewhat important to do things with groups of people, do her favorite activities, have pet visits, go outside when the weather permitted and listen to music she liked. The care plans regarding activities provided a conflicting description of Resident 21's activity needs. The first activity care plan indicated the resident was independent and able to pursue her own leisure , such as watching television, visiting with her son, and reading. The second activity care plan indicated the resident was cognitively impaired and required a low functioning program. The interventions for the second plan included for the resident to participate in a sensory exercise program, and to be asked direct questions to promote participation. A third activity care plan indicated the resident was capable of making decisions regarding activity participation, but needed encouragement. The interventions included ensuring Resident 21 had the newspaper available to read, providing reading materials on her unit, respecting her right not to participate in group activities, providing her with an activity calendar, and assisting her to sit outside when the weather permitted. Resident 21 was observed on 2/5/2024, 2/6/2024 and 2/7/2024 sleeping in her bed, except during the lunch time, when she was assisted to her wheelchair and taken to the dining room. Resident 21 had no music, television or reading		Resident 21, Resident 33, have been identified and interviewed for activities they would like to participate in and care plans were updated with individualized programs on 3/1/24 by the Activities Director. How will other residents having the potential to be affected by same deficient practice be identified and what corrective action will be taken? All residents have the potential to be affected by the cited, therefore, this plan of correction applies to all residents of the facility. A Resident Council Meeting was held on 2/27/24 to ensure activities support residents' choices. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Administrator/Designee educated the Activity Director on individualized activity programming and group activity programming on 2/29/24. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated.	

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	material in her room. On 2/6/2024 after lunch, she was also assisted to the therapy room for approximately 30 minutes. A Quarterly Activity Note, dated 6/6/2023, indicated the resident attended Bingo and birthday parties, and needed encouragement to come, but enjoyed herself once she was at the activities and interacted with others at the activities. The Activity Participation Log for Resident 21 indicated she participated routinely in a group activity at the 5 PM evening mealtime. It was not clear if the activity was the evening meal. She also was marked a few times in the past month as having participated in self-directed activities The only two activities marked for Resident 21 from 2/5/2023 - 2/9/2023 was a Memory Stimulation activity during evening meal time and an Art/Crafts activity during the evening mealtime. During an interview with Activity Assistant (AA) 11, on 2/9/2023 at 11:20 A.M., she indicated Resident 21 spend a large position of her day sleeping in her bed. She did not complete 1:1 activity logs for Resident 21 because she was not receiving Hospice services. She indicated she did try to stop in and talk to her, and sometimes brought a sensory cart for Resident 21 to experience. She worked on Tuesday and Thursday evenings, and tried to get Resident 21 to participate in activities during those hours. AA 11 indicated she was not responsible for documenting the activity participation for Resident 21. 2. The clinical record for Resident 33 was reviewed on 2/6/2024 at 2:47 P.M. Diagnoses		How¿the¿corrective¿actions¿will¿be¿monitored to ensure the deficient practice will not recure, i.e., what quality assurance program will be put into place? Activity Director/administrator and/or designee will interview 10 random residents a week x 4 weeks to ensure activities meet their individualized needs and care plans are updated, then 5 random residents a week x 4 weeks, then 3 random residents monthly x 6 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date will the systemic changes for each deficiency be completed? 3/5/24	

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included, but were not limited to: degenerative disease of the basal ganglia, mild cognitive impairment, generalized anxiety disorder, dementia, and major depressive disorder.

The Admission Minimum Data Set (MDS) assessment, completed on 9/5/2023, indicated it was somewhat important for Resident 33 to do her favorite activities, listen to music she liked, have pet visits and go outside for fresh air.

The first care plan for Resident 33 regarding activity participation, indicated the resident was independent in her "leisure/recreation pursuits." The plan indicated the resident enjoyed television, movies, and music, and preferred to be alone in her activities. The interventions included introducing Resident 33 to the activity staff, offering materials, providing a monthly activity calendar, and introducing Resident 33 to her peers.

The second activity care plan indicated, although the resident was cognitively impaired, she was able to make decisions regarding activity participation and preferred not to attend some group activities. The plan indicated the resident was to be included in pet visits, taken outside when weather permitted, and be invited to music programs, as well as have music in her room.

On 2/5/2024, from approximately 9:45 A.M. - 3:00 P.M., Resident 33 was observed to remain in her bed. She was not observed to participate in any group and/or individual activity. A male visitor was noted to spend time with her from approximately 12:15 P.M. - 2:30 P.M. Resident 33 was awake during the mealtime but otherwise appeared to be sleeping most of the time. She did briefly awaken for a short in room dog visit in the

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WATERS OF SYRACUSE SKILLED NURSING FACILITY, THE	500 E PICKWICK DR SYRACUSE, IN 46567

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	afternoon. On 2/6/2024, Resident 33 was noted to be in bed from 8:30 A.M. until right before lunch time, around 12:00 P.M. The resident remained in her wheelchair after lunch, and was noted to be visited by three family members and their dog and attended a care plan meeting. After the care plan meeting, Resident 33 was assisted back into her bed. On 2/7/2024, Resident 33 was observed to be in her bed until lunch time. At 9:48 A.M., an activity staff member was observed going from room to room inviting residents to an exercise activity, but Resident 33 was receiving personal care and the activity staff did not invite her to the group activity. Resident 33 was assisted to a wheelchair for lunch and was observed at 1:17 P.M. with her eyes closed, seated in her wheelchair beside her bed in her room. At 1:30 P.M., Resident 33 was assisted back into her bed. She did not have the television on or any in-room activity materials. On 2/8/2024 at 9:30 A.M. Resident 33 was observed in her bed, sleeping. The television in her room was not on and there was no music playing. On 2/9/2024 at 9:05 A.M., Resident 33 was observed in her bed, sleeping. The television in her room was not on and there was no music playing in her room. On 2/9/2024 from 12:55 P.M. - 1:59 P.M. Resident 33 was observed seated in her room, in her wheelchair awake without any music or television playing. She also did not have any visitors at the time. A nursing student entered her room once and provided her with fresh water and assisted			

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	her to get a drink. The Activity Director was observed walking about the unit a few times, carrying a compact disc player. Resident 33 was not invited to activities or provided with any in room materials. The only documentation of activity participation for Resident 33 from 2/5/2024 - 2/9/2024 was a family visit and pet visit on 2/5/2024 and a conversation and beverage/snack on 2/6/2024. During an interview with Activity Assistant, Employee 11, on 2/9/2023 at 11:30 A.M. she indicated Resident 33 really did not desire to be around many people when she first admitted to the facility. The resident was now coming out of her room for meals and Employee 11 indicated she attempted to engage her when she saw her in the dining room. She indicated Resident 33 also has a male visitor that came routinely to visit her. When queried about in room materials for residents who do not desire group activities, she indicated sometimes she provided word searches for residents in their rooms. She indicated she also tried to make sure Resident 33 was assisted to get a drink when she has the beverage cart and took it around. The current policy and procedure, titled, "Activities" and provided by the Administrator on 2/9/2024 at 11:46 A.M., included the following: "...It is the policy of the facility to ensure that each resident's interests an needs are identified and that an ongoing program of activities that is designed to appeal to his/her interest and to enhance the resident's highest practicable level of physical, mental and psychosocial well-being. Note For residents who will not or cannot participate in planning their activities, or for residents needing specialized or extended			

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	programs to enhance their overall daily routine and activities, a One -to-One activity program may be implemented..." 3.1-33(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interviews, the facility failed to ensure a splint to prevent contracture progression was applied, for 1 of 1 resident reviewed for limited range of motion. (Resident 11) Finding includes: The record for Resident 11 was reviewed on 2/6/2024 at 1:30 P.M. Diagnoses included, but were not limited to: fracture of the fourth metacarpal bone in the left hand and contracture	F 0688	F688 It is the policy of this facility to ensure a splint to prevent contracture progression in applied. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 11 was assessed, and order received by nurse practitioner to discontinue the left	03/05/2024

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	of the left hand. Resident 11 was observed on 2/5/2024 at 10:37 A.M., seated in her wheelchair. The resident was noted to have contracted hands, especially the left hand. During an interview with Resident 11, on 2/5/2024 at 10:38 A.M., she indicated she had broken a finger in her left hand in the past. The most recent Minimum Data Set (MDS) assessment, completed on 11/16/2023, indicated Resident 11 was cognitively intact. The current care plans for Resident 11 included a plan to address the resident's contracture of her left hand, with interventions to notify the physician if the contracture worsened, and therapy as needed. There was also a care plan for the resident to complete range of motion exercises by herself and/or with the assistance of her family. During an interview with Occupational Therapist (OT) 7, on 2/7/2024 at 1:12 P.M., she indicated she had worked with Resident 11 in the past regarding the left hand contracture, and had left pictures with splint application instructions and a splint schedule on the inside of resident's closet door. During an observation of the resident's closet, on 2/7/2024 at 1:16 P.M., there were no instructions regarding splint application or schedule observed inside the closet door. A hand splint, stored in a plastic basket underneath a few random items, was noted on the floor of the closet. During an interview with OT 7, on 2/7/2024 at 2:20 P.M., she provided documentation, completed on 2/1/2023, regarding the hand splint, with a schedule to wear the splint for 8 hours during the night. OT 7 indicated she had educated the staff		hand splint and begin using a rolled washcloth in the left palm during the night by the DON/Designee on 2/12/24. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? Any resident who has contractures or limited range of motion has the potential to be impacted by this allegedly deficient practice. A facility wide audit was completed on 2/26/24 by the DON/Designee to ensure residents with devices to prevent further contractures have appropriate orders and care plans. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses and Qualified Medication Aides were educated by the Director of Nursing on the policy entitled “Splint and Brace Care” on or before 2/27/24. Certified Nursing Assistances were educated by the Director of nursing on the policy entitled “Splint and Brace Care" on or before 3/5/24. Anyone who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated.	

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	regarding the use of the hand splint and schedule, but did not think the staff were utilizing the splint for Resident 11. During observations, on 2/8/2024 at 9:45 A.M. and 2/9/2024 at 8:51 A.M., the splint remained in the resident's closet, in a basket on the closet floor, unmoved from the previous observation. During an interview with Resident 11, on 2/8/2024 at 9:45 A.M., she indicated no one had assisted her with wearing the splint on her hand. She could not remember the last time anyone had placed the splint on her wrist. During an interview with the resident and her friend, who visits almost every morning, on 2/9/2024 at 8:55 A.M., it was indicated the splint had not been utilized for "a very long time." The friend had provided other types of devices for her hand contractures, like a squishy ball and a soft plastic squeezable device, but the resident did not remember or initiate utilizing the items on her own. During an interview with the MDS coordinator, on 2/9/2024 at 9:47 A.M., he confirmed the use of the left hand splint was not in the care plan regarding the contracture, nor was it in the plan of care for the aides and nursing staff to know and document splint usage. He indicated since he arrived in October 2023, he was now getting written documentation from therapy regarding recommendations at discharge from therapy. He reviewed the Plan of Care (POC- electronic information regarding personal care needs the certified nursing assistants viewed and documented care for residents) and order history, and could not find any specific documentation of a splint schedule/use after Resident 11 was discharged from therapy.		How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nursing or designee will review the order listing report and complete the "Splinting – ongoing audit of physician orders" five times weekly for four weeks, then three times weekly for four weeks, then weekly x four months. The Director of Nursing or designee will monitor five residents five times weekly for four weeks, then five residents three times weekly for four weeks then five residents weekly for four months and complete the "Splinting – ongoing audit for use" to ensure splints are worn as ordered if applicable. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolve. By what date will the systemic changes for each deficiency be completed?	

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	During an interview with CNA 6, on 2/9/2023 at 10:06 A.M., she indicated Resident 11 was assisted with morning care on the day shift. She had never observed any splint usage on the resident's left arm when she arrived in the mornings to get Resident 11 up out of bed and ready for the day. The facility policy and procedure, titled, "Section 4 Splint and Brace Care" provided by the Administrator on 2/9/2024 at 11:45 A.M. included educational instructions on applying splints and braces and restorative nursing forms, but no specific instructions on ensuring the therapy recommendations were placed in the plan of care. 3.1-42(a)(2)		3/5/24	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure residents had respiratory orders, tubing changes and equipment properly stored when not in use, for 2 of 7 reviewed for respiratory care. (Residents 17 & 20) Findings include:	F 0695	F695 It is the policy and practice of this facility to ensure residents who need respiratory care have respiratory orders, tubing changes and equipment properly stored when not in use.	03/05/2024

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	1. During an observation on 2/7/2024 at 9:45 A.M., Resident 17's continuous positive airway pressure (CPAP) mask and tubing was on the floor next to the nightstand. The resident indicated that he used the machine at night when he sleeps. During an observation on 2/7/2024 at 1:37 P.M., the CPAP mask and tubing was lying on floor next to the nightstand. During an observation on 2/8/2023 at 9:33 A.M., the CPAP mask and tubing was lying on top of the machine on the nightstand, uncovered. A record review was completed for Resident 17 on 2/5/2024 at 1:45 P.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, obstructive sleep apnea and cerebrovascular disease. A review of Physician Order's indicated that Resident 17 did not have an order for CPAP use or cleaning/changing of the equipment. A Care Plan was not located for CPAP or respiratory concerns. During an interview on 2/8/2024 at 9:39 A.M., LPN 4 indicated when respiratory equipment was not in use, it should be stored in a bag. During an interview, on 2/8/2024 at 9:53 A.M., the Director of Nursing (DON) indicated Resident 17 did not have an order for the CPAP or cleaning of the tubing, but one should have been obtained. On 2/9/2024 at 9:26 A.M., the DON provided a policy titled, "Continuous Positive Airway Pressure", undated, and indicated the policy was		What corrective action will be accomplished for those residents found to have been affected by the deficient practice? On 2/8/24, a physician's order was received for resident 17 to wear a CPAP and equipment cleaning. Resident 17's equipment was cleaned and placed in plastic bag on 2/8/2024 by the DON/Designee. Care plan for resident 17's CPAP was completed on 2/8/24 by DON/Designee. A physician's order was obtained 2/8/24 for resident 20's oxygen by the DON/Designee. Care plan for resident 20's oxygen was completed on 2/8/24 by the DON/Designee. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? Any resident requiring the use of oxygen or CPAP have the potential to be impacted by this allegedly deficient practice. Facility wide audits were completed 2/22/24 by the DON/Designee to ensure residents with CPAPs or oxygen have appropriate orders and care plans. What measures will be put into place and what systemic changes will be made to ensure that the	

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	the one currently used by the facility. The policy indicated "...Guideline: 1. CPAP therapy must have a written physician's order. The order must include the level of CPAP, FI02 if needed, and humidifier if needed. Procedure: 15. When that CPAP machine is not in use the face mask is stored in a plastic bag at the bedside. 16. Facemask can we (sic) cleaned with a mild soap and water or vinegar water weekly...." 2. On 2/5/2024 at 9:41 A.M., Resident 20 was observed to have oxygen in place via nasal cannula at two liters. A record review for Resident 20 was completed on 2/7/2024 at 11:18 A.M. Diagnoses included, but were not limited to: congestive heart failure, anemia in chronic kidney disease, pleural effusion, and history of Covid-19. Current Physician Orders lacked an order for oxygen use. A Care Plan was not located for oxygen use or respiratory issues. A Nurse's Note, dated 11/10/2023 at 9:51 P.M., indicated Resident 20 was complaining of shortness of breath with an oxygen saturation of 88 percent on room air. Oxygen was applied as a nursing measure. During an interview on 2/8/2024 at 2:19 P.M., LPN 4 indicated a Physician's Order was required for oxygen use. A policy was provided on 2/9/2024 at 9:17 A.M. by the Director of Nursing (DON). The policy, titled, "Oxygen Administration", indicated, " ...1. Check physician's order for liter flow and method		deficient practice does not recur? Licensed nurses and Qualified Medication Aides were educated by the Director of Nursing on the policies “Continuous positive airway pressure (CPAP) and “Oxygen administration” on or before 2/27/24. Anyone who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The DON/Designee will review 24 hour report for change in condition requiring oxygen and verify order 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. The DON/Designee will complete room rounds checking for Oxygen and CPAP/Bipap and ensure orders are in place 5 x a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written	

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	of administration ...." 3.1-47(a)(6)		by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolve. By what date will the systemic changes for each deficiency be completed? 3/5/24	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure residents were free from significant medication errors related to not following a Physician's Order for Coumadin (warfarin, a blood thinner) therapy, for 1 of 5 residents reviewed for unnecessary medications. (Resident 22) Finding includes: A record review for Resident 22 was completed on 2/6/2024 at 12:10 P.M. Diagnoses included, but were not limited to: pulmonary embolism and Alzheimer's disease. A Quarterly Minimum Data Set (MDS) assessment, dated 1/27/2024, indicated Resident 22 received an anticoagulant. A Nurse's Note, dated 1/23/2024 at 3:46 A.M., indicated a lab draw was completed. A PT/INR (prothrombin time/international	F 0760	F760 Residents are free of significant med errors. It is the policy and practice of this facility to ensure residents are free of any significant medication errors related to not following physician orders for Coumadin. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The DON/Designee assessed Resident 22 had no adverse effects related to Coumadin dosing on 2/7/2024. The DON/Designee notified the physician of the medication error on 2/7/2024, new order to discontinue Coumadin and begin Eliquis. How will other residents having the potential to be affected by the	03/05/2024

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	normalized ratio) blood test, dated 1/23/2024, indicated an INR of 1.8 (therapeutic range 2.0-3.0). The lab report had a handwritten note that indicated to begin warfarin 6 milligrams, and recheck the PT/INR lab on 1/30/2024. A Nurse's Note, dated 1/24/2024 at 4:13 P.M., indicated the Nurse Practitioner was notified of the INR result of 1.8, and an order was received to increase the warfarin to 6 milligrams, and recheck the PT/INR in one week. The Enoxaparin Sodium (an anticoagulant injection) was to continue until the warfarin level was at therapeutic level. The Medication Administration Record (MAR) for January 2024, indicated warfarin 4 milligrams was administered on 1/23/2024 and 1/24/2024. On 1/25/2024, the MAR indicated, " ...Warfarin 6 milligrams, give 4 milligrams by mouth one time a day ...." On 1/26/2024-1/31/2024, the MAR indicated warfarin 6 milligrams was administered. A PT/INR blood test on 1/30/2024, indicated an INR of 1.3. A Nurse's Note on 1/30/2024 at 11:48 P.M., indicated the Nurse Practitioner was notified of the INR result, and the lab result was placed in the Nurse Practitioner book for review. On 1/31/2024 at 10:47 P.M., a Nurse's Note indicated the Nurse Practitioner was notified of the INR result from 1/30/2024, and an order was received to increase the warfarin to 8 milligrams daily, repeat the INR lab draw on 2/6/2023, and once the INR was in therapeutic level the warfarin would be discontinued, and Eliquis started.		same deficient practice be identified and what corrective action will be taken? Any resident receiving Coumadin has the potential to be impacted by this allegedly deficient practice. Facility wide audits were completed 2/14/24 by the DON/Designee to ensure residents receiving Coumadin had complete and correct orders. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses and Qualified Medication Aides were educated by the Director of Nursing on the policies “Coumadin guidelines” and “Physician orders” on or before 2/27/24. Anyone who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nursing or designee will review the order listing report and ordered labs and complete the “Coumadin (Warfarin) ongoing audit” to ensure compliance with lab monitoring and obtaining/following physician orders five times weekly for four	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF SYRACUSE SKILLED NURSING FACILITY, THE	500 E PICKWICK DR SYRACUSE, IN 46567

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	During an interview on 2/8/2024 at 2:17 P.M., LPN 4 indicated the INR labs were drawn on Tuesdays. The nursing staff call the Nurse Practitioner the same day as the results come back before dinner time, and the warfarin would not be given until the lab results were received and reported to the Nurse Practitioner. A policy was provided on 2/9/2024 at 9:17 A.M. by the Director of Nursing (DON). The policy, titled, "Coumadin Guidelines", indicated, " ...It is the intent of the facility to monitor the effects of the use of Warfarin or Coumadin an anticoagulating medication that is used to prevent blood clotting ...The International Normalization ration [INR] lab is routinely performed to monitor warfarin levels. For most individuals, a stable, safe INR level will be between 2 and 3.5 depending on the reason for the medication ...." An additional policy, titled, "Physician Orders", was provided on 2/9/2024 at 9:17 A.M., by the DON. The policy indicated, " ...It is the policy of the facility to follow the orders of the physician ...." 3.1-48(a)(2)		weeks, then three times weekly for four weeks, then weekly x four months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolve. By what date will the systemic changes for each deficiency be completed? 3/5/24	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals			

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	§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, and interview, the facility failed to document the open date of Tubersol (tuberculin skin test serum), and keep lorazepam liquid stored/locked properly in the Pyxis system, for 1 of 1 medication rooms reviewed for storage and labeling. Findings include: 1. On 2/9/2024 at 10:19 A.M., a locked miniature refrigerator was observed, with RN 3, to have a bag of two Tubersol 5 units per 0.1 milliliters vials with one opened and the other vial opened. The open vial did not have an open date written. Another bag of one opened vial of Tubersol received from the pharmacy on 12/6/2023, was not dated with an open date. During an interview on 2/9/2024 at 10:23 A.M., RN 3 indicated Tubersol needed to be used within 28 days of opening, and dated with the date opened. 2. On 2/9/2024 at 10:21 A.M., the unlocked Pyxis	F 0761	F761 Label/store drugs and biologicals It is the policy of this facility to document the open date on Tubersol and keep Lorazepam Liquid stored and locked properly in the Pyxis system. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No Residents were identified for the cited deficiency. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? The DON/Designee completed an audit of the medication rooms and medication carts on or before	03/05/2024

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	system refrigerator was observed with RN 3. Two bottles of lorazepam liquid were observed in an unlocked drawer of the refrigerator. During an interview on 2/9/2024 at 10:27 A.M., RN 3 indicated since the Pyxis system had been installed, the lorazepam had not been locked. A policy was provided on 2/9/2024 at 11:16 A.M. by the Director of Nursing (DON). The policy titled, "Medication Storage in the Facility", indicated, " ...Medications and biologicals are stored safely, securely, and properly following the manufacture or supplier recommendations. The medication supply is accessible only to licensed personnel, pharmacy personnel, or staff members lawfully authorized to administer medications ...9. All drugs classified as Schedule II of the Controlled Substance Act will be stored under double locks. Schedule II-V medications must be maintained in separately locked, permanently affixed compartments and cannot be stored with other nonscheduled medications ...14. Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will be immediately withdrawn from stock by the facility ...." 3.1-25(n) 3.1-25(o)		2/26/24. The open Tubersol that did not have a date opened was destroyed and the Lorazepam was secured in the pyxis on 2/9/24. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses and Qualified Medication Aides were educated by the Director of Nursing on the policies “Controlled substances medications” and “Medication storage in the facility” on or before 2/27/24. Anyone who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nursing or designee will monitor medication rooms and medication carts for medication storage to ensure proper medication storage and dating five times weekly for four weeks, then three times weekly for four weeks, then weekly x four months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly	

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			QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolve. By what date will the systemic changes for each deficiency be completed? 3/5/24	
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, 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;			

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	§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. §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			

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	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 and interview, the facility failed to sanitize a community use blood glucose monitor after use, which had the potential to affect 4 residents who receive blood glucose testing. Finding includes: During an observation of the medication pass on 2/6/2024 at 7:53 A.M., RN 3 was observed to obtain a blood sugar for Resident 6. The blood glucose monitor was taken from the right upper medication cart drawer. No prior sanitation of the monitor was observed. After the blood glucose test was completed, RN 3 was observed placing the blood glucose monitor back into the medication cart without sanitizing the monitor. During an interview on 2/6/2024 at 8:23 A.M., RN 3 indicated she should have sanitized the blood glucose monitor prior to placing the monitor into the medication cart. She indicated, "Sometimes you don't think about it." A policy was provided on 2/9/2024 at 11:16 A.M., by the Director of Nursing (DON). The policy titled, "Cleaning/Disinfecting/Maintaining Glucose Meters", indicated " ...The Glucose meters will be disinfected between each resident use to prevent the spread of microorganisms including blood borne pathogens. Disinfection of the machine will be completed with PDI Super Santi Germicidal wipe or Bleach Wipes as per guidelines of the manufacturer of the glucometer ...."	F 0880	F880 Infection prevention and control It is the policy of this facility to sanitize a community used blood glucose monitor after use. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? RN 3 was re-educated 2/9/24 by the DON/Designee on the Glucometer Cleaning policy with a return demonstration completed. Residents requiring blood glucose monitoring were assessed by the DON/Designee on February 29, 2024, with no negative outcomes related to the alleged deficient practice. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? All residents that require blood glucose monitoring have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents in the facility.	03/05/2024

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	3.1-18(b)		What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses and Qualified Medication Aides were educated by the Director of Nursing on the policy "Cleaning/disinfecting/maintaining glucometer meters with return demonstration on or before 2/27/24. Anyone who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Director of Nursing or designee will monitor 5 random Nurses/Qualified Medication Assistants (QMA) on random shift for glucometer cleaning to ensure proper procedures weekly for four weeks, then 3 random nurse/QMA weekly for four weeks, then 3 random nurses/QMA monthly x four months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However,	

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			any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolve. By what date will the systemic changes for each deficiency be completed? 3/5/24	
F 9999 Bldg. 00	3.1-14 PERSONNEL (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (4) A detailed review of the appropriate job description, including a demonstration of equipment and procedures required of the specific position to which the employee will be assigned. (7) Documentation of orientation to the facility and to the specific job skills. This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure job description documentation and job specific orientation was available for 1 of 5 new employees whose records were reviewed. (RN 10) Finding includes:	F 9999	**F9999** It is the intent of this facility to ensure job description documentation and job specific orientation was available in the employee records. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The employee file for staff member number 10 was updated with a job description and job specific orientation on 2/29/2024 by the Human Resource Specialist. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	03/05/2024

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	The Employee records were reviewed on 2/9/2024 at 9:23 A.M., Registered Nurse 10, hired on 1/16/2024, lacked documentation of a job description and job specific orientation. During an interview, on 2/9/2024 at 10:44 A.M., the Business Office Manager indicated RN 10 did not have a job description or job specific orientation in her personnel file and it should have been completed. A policy was requested, but none was provided.		**action(s) will be taken;** An audit was completed of all current employee files on March 1,2024. All were reviewed and the required documentation is in place by the Human Resource Specialist. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Administrator in-serviced the Human Resource Specialist on the requirements for employee files on 3/1/2024. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The Administrator/Designee will audit new employee files for job description and job specific orientation weekly x 6 months. If the facility is within 95% compliance at the end of the 6	

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			months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **By what date the systemic changes for each deficiency will be completed**. 3/5/24	