STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155621	A. BUILDING 00 B. WING	09/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVER BEND NURSING AND REHABILITATION	3400 STOCKER DR EVANSVILLE, IN 47720

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00413510. Complaint IN00413510 - No deficiencies related to the allegations are cited. Survey dates: September 5, 6, 7, 8 & 11, 2023 Facility number: 000442 Provider number: 155621 AIM number: 100266510 Census Bed Type: SNF/NF: 54 SNF: 4 Total: 58 Census Payor Type: Medicare: 3 Medicaid: 52 Other: 3 Total: 58 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 20, 2023.	F 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective October 11, 2023, to the annual licensure survey completed on September 11, 2023. The facility respectfully asks for a desk review.	
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tina Garrett		10/05/2023

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	§483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this			

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	chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on record review and interview, the facility failed to ensure the completion of resident assessment on 1 of 2 closed records reviewed for comprehensive assessment. (Resident 9) Findings include: On 9/11/23 at 10:00 A.M., Resident 9's clinical record review was done. Diagnoses included but were not limited to atrial fibrillation and hypertension. The most recent admission MDS (Minimum Data Set) Assessment dated 4/17/23 indicated Resident 9 was cognitively intact. On 4/27/23, Resident 9 had a resident initiated discharge. There was no MDS Assessment discharge done or discharge summary completed. During an interview on 9/11/23 at 1:45 P.M., the regional clinical support nurse indicated the MDS assessment should have been done for this resident and was apparently overlooked.	F 0636	**F636** **It is the practice of this facility to assure that resident discharge MDS assessments are completed timely.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #9 no longer resides in facility. ***Other residents that have the potential to be affected have been identified by:*** All residents that have been discharged in the last 30 days have had MDS reviewed to assure that there is a discharge assessment present. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** An in-service has been conducted	10/11/2023

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	During and interview on 9/11/23 at 10:00 A.M., the regional clinical support nurse indicated the facility lacked a current policy but followed the RAI (Resident Assessment Instrument). The RAI indicated " ... the OBRA-Required Tracking Records and Assessments are Federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. Those assessments are coded on the MDS 3.0 in items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting). They include tracking records....discharge return not anticipated or return anticipated)..." 3.1-31(b)		for the MDS Coordinator related to assuring that if a resident discharges, that a discharge MDS assessment is completed. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool that randomly reviews 5 resident discharges (if applicable) to assure that the MDS discharge assessment has been completed. The DON, or designee, will complete the PI tool weekly x3, monthly x3, then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. ***The date the systemic changes will be completed:*** October 11, 2023	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the			

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	resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on interview and record review, the facility failed to ensure care plans were revised after a change in status for 3 of 7 residents reviewed for comprehensive care plans (Resident 36, Resident 37, Resident 23). Findings include: 1. On 9/8/23 at 8:51 A.M., Resident 36's clinical record was reviewed. Resident 36's diagnoses included, but were not limited to, Parkinson's Disease and dementia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 7/20/23, indicated Resident 36 was severely cognitively impaired, had 2 or more falls without injury, and required extensive assistance of 2 staff for transfers and extensive assistance of 1 staff for toileting. A current falls care plan, revised 4/4/23, indicated a toileting program had been implemented starting	F 0657	**F657** **It is the practice of this facility to assure that resident needs are met and the care plan is updated to reflect resident's current needs.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #37 no longer resides at the facility. Resident #23 care plan has been reviewed to assure that it accurately addresses the resident catheter. Resident #36 has been reviewed to assure care plan accurately reflects post fall interventions. ***Other residents that have the potential to be affected have been identified by:*** All resident plans of care have	10/11/2023

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	11/15/21. The toileting program was to toilet upon rising, toilet before and after each meal, toilet HS (at bedtime), and toilet with rounding at night. The clinical record indicated Resident 36 fell 16 times between 9/21/22 and 8/12/23. On 6/26/23 at 4:52 P.M., Resident 36 sustained an unwitnessed fall while attempting to self-transfer to use the toilet. The care plan was not updated with a new intervention. The IDT (Interdisciplinary Team) note, dated 6/27/23, indicated the new intervention for the fall was to educate staff to toilet resident per toileting schedule. On 9/8/23 at 10:08 A.M., LPN (Licensed Practical Nurse) 6 indicated staff was educated to monitor Resident 36 at all times to prevent falls. On 8/2/23 at 5:05 P.M., Resident 36 sustained an unwitnessed fall while attempting to use the toilet by himself. The care plan was not updated with a new intervention. The IDT note, dated 8/3/23, indicated the new intervention for the fall was to toilet the resident after meals. On 9/11/23 at 9:25 A.M., the Regional Clinician indicated that care plans should be updated with new and relevant interventions following each fall. 2. On 9/6/23 at 1:13 P.M., Resident 37's clinical record was reviewed. Resident 37's diagnoses included, but were not limited to, bipolar disorder, anxiety disorder, and major depressive disorder. The most recent Annual MDS Assessment, dated 6/29/23, indicated Resident 37 was cognitively intact and did not receive any antibiotics for the 7 day look back period.		been reviewed to assure that they accurately reflect the residents' current status related to post fall interventions, catheter usage, and antibiotic usage. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The DON, or designee, is responsible for assuring the updates are in place on the care plan including proper catheter identification, antibiotic use, and post fall interventions. The Interdisciplinary team (IDT) has been in-serviced to assure that care plan updates and changes are made as they occur during clinical morning meeting. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 residents related to care plans and revisions related to post fall interventions, catheters, and antibiotic use. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations	

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	Current physician orders lacked any antibiotic medications or orders related to antibiotic medications. A current care plan, revised 5/17/23, indicated Resident 37 was on antibiotic therapy. On 9/11/23 at 9:25 A.M., the Regional Clinician indicated that care plans were reviewed quarterly or with any change. She indicated starting or stopping antibiotic medication was considered a change and the care plan should be updated with the change at the time it occurs.3. On 9/8/23 at 9:11 A.M., Resident 23's clinical record was reviewed. Diagnosis included but not limited to urinary tract infection and presence of orogenital implants. The current quarterly MDS (Minimum Data Set) Assessment dated 8/24/23 indicated that Resident 23 was cognitively intact and has an indwelling catheter. Resident 23 needs extensive assist dressing, transfer, toileting, and mobility. Current physicians order included but were not limited to resident has 20 French Foley with 10 cc (cubic centimeters) balloon with drainage bag to gravity dated 8/12/23. Current progress notes dated 8/8/23 at 4:58 P.M., indicated the resident was experiencing bloody urine from Foley catheter. Was having labored breathing and confused. The vital signs were: blood pressure 114/68, heart rate 115, temperature 99.7, pulse oximetry of 98%, respiration rate 20. He currently had a 16 french Foley with a 30 cc balloon that was anchored on 8/1/23. Triage was called and the resident was sent out to the hospital with bed hold and appropriate people		for additional interventions as needed based on review of the outcomes of the PI tools. ***The date the systemic** changes will be completed:* October 11, 2023	

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	notified via AMR ambulance at 5:30 P.M. Resident was admitted to Gateway Hospital. A current progress note dated 8/13/23 at 3:11 P.M., indicated that the resident returned from hospital with a new 20 French indwelling Foley with a 10 cc balloon with drainage bag to gravity anchored. A current care plan indicated that the resident has a 16 french 5-10 cc balloon that intervention was dated on 1/23/23. There was no revision indicated from the return of the hospital dated 8/13/23. During an interview on 9/11/23 at 11:10 A.M., the regional clinical support nurse indicated if the resident returns from the hospital with a new order for something such as a new catheter. The care plan must be revised upon return. On 9/8/23 at 2:55 P.M., a current non date policy "Care Plan Revisions Upon Status Change" was received by the Administrator. The policy indicated the purpose is to provide consistent process for reviewing and revising when the resident experienced a status change. The policy explanation indicated when a resident experienced a status change the care plan will be updated with the new of modified interventions. 3.1-35(d)(2)(B) 3.1-35(e)			
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			

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	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 proper tracheal suctioning and oxygen services were provided according to physician orders for 2 of 2 residents reviewed for respiratory care. (Resident 56, Resident 115) Finding includes: 1. On 9/6/23 at 10:05 A.M., Resident 56's oxygen concentrator tubing and humidified water bottle was observed to not be dated. On 9/7/23 at 9:52 A.M., the suction canister and tubing were observed to be undated. On 9/08/23 at 2:40 P.M., RN (Registered Nurse) 10 was observed suctioning a tracheotomy using clean gloves with an alleged sterile suction catheter. She replaced the catheter in the same package. Removed the clean gloves. The resident needed to be suctioned again and donning clean gloves and removed the used suction catheter and reused it to suction the resident. She used tap water to clear the suction catheter when full of mucus. On 9/7/23 at 3:32 P.M., Resident 56's clinical record was reviewed. Diagnoses included, but were not limited to, anoxic brain damage and pneumonia. The most recent significant change MDS (minimum data set) Assessment, dated 7/28/23,	F 0695	**F695** **It is the practice of this facility to assure that residents with tracheostomies receive services in accordance with physicians' orders and acceptable standards of practice.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident # 115 no longer resides at facility. Resident #56 is receiving tracheostomy services in accordance with the acceptable standard including sterile technique. This resident also has oxygen tubing, O2 humidifier, suction canister and tubing dated appropriately. ***Other residents that have the potential to be affected have been identified by:*** All residents that require respiratory services have been reviewed to assure that they are receiving those services in accordance with acceptable standards. The facility has also assured that resident utilizing oxygen or suction have proper dating of equipment. ***The measures or systematic***	10/11/2023

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	indicated Resident 56 was severely cognitively impaired, required extensive assistance of 2 staff for transfers and bed mobility, and was on oxygen. Current physicians included but were not limited to: Shiley Flex Disposable Inner Annular 6.5 Uncuffed to be changed two times a day for trach care dated 8/16/23. Change O2 mask/nasal cannula/tubing every night shift every Sunday for infection control dated 5/26/23. Suction PRN as needed for suction dated 6/3/23. Current care plans included, but were not limited to: Resident has tracheostomy related to anoxic brain damaged that included the interventions, but was not limited to, give humidified oxygen as prescribed to suction as necessary dated 5/25/23. During an interview on 9/7/23 at 10:00 A.M., RN 10 indicated the tubing should be changed weekly. The tubing and water bottle should be dated also. 2. On 9/5/23 at 11:41 A.M., Resident 115's oxygen concentrator tubing,humidified water bottle, and suction tubing were observed to be undated. On 9/5/23 at 11:00 A.M., RN 15 was observed doing trach care and changed the inner cannula using clean gloves. He also suctioned the resident with clean gloves and suction catheter with tap water to clear the tube. He indicated that procedure was done as a clean technique.		***changes that have been put into place to ensure that the deficient practice does not recur include:*** The nurses have been in-serviced related to assuring that respiratory services, including tracheostomy services, are being performed in accordance with acceptable standards including sterile technique. The nurses have also been in-serviced related to assuring that respiratory equipment id dated appropriately in accordance with professional standards. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 (if applicable) nurses related to care of tracheostomy in accordance with professional standards. In addition, the tool will cover oxygen/suction equipment and proper dating. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tools. ***The date the systemic*** *changes*	

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	On 9/7/23 at 3:32 P.M., Resident 115 clinical record was reviewed. Diagnoses included, but were not limited to, anoxic brain damage and tracheostomy. The most recent admission MDS (minimum data set) Assessment, dated 8/29/23 , indicated Resident 115 was severely cognitively impaired, required extensive assistance of 2 staff for transfers and bed mobility, and was on oxygen. Current physician orders included but were not limited: Change oxygen tubing, and humidification bottle, clean oxygen filter, inspect easy foam wraps (replace if soiled or missing) every night shift every Sun AND as needed dated 8/22/23. Suction PRN no directions specified for order dated 8/22/23. Trach care daily and PRN, Shirley 6 one time a day dated 8/22/23. Current care plans included, but were not limited to: Resident has tracheostomy related to anoxic brain damaged that included the interventions, but was not limited to, give humidified oxygen as prescribed and suction as necessary dated 8/23/23. On 9/5/23 at 11:00 A.M., RN 15 indicated trach care and suctioning were done as a clean techniques. On 9/7/23 at 9:46 A.M., RN 7 indicated trach care is done with sterile technique. She uses sterile gloves to change the inner cannula. She will also use sterile gloves, water and suction catheter to clean the inner cannula.		*will be completed:* October 11, 2023	

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	On 9/8/23 at 2:55 P.M., a current non date policy "Trach Care with Inner Non-Disposable Cannula" was received by the Administrator..." The policy of the facility that trach care with a disposable innercannula will be done by licensed personnel... using sterile technique every shift and prn...Procedure is to put on sterile gloves...to replace inner cannula..." On 9/8/23 at 3:00 P.M., a current policy "Suctioning" revised August 2014 was received by the Regional Clinical Support Nurse. "...purpose is to help prevent nosocomial infections associated with suctioning and to prevent transmission of ... infections to residents and staff. Guidelines...3. Wear exam gloves on each hand when performing oral suctioning....4. Wear sterile gloves on both hands when performing care of tracheostomy...suctioning. 8. always date and initial sterile water used to flush suction catheter... pour the solution... into a sterile container for use. 9. Only use single container... found in suctioning kits once and then discard." 3.1-47(a)(4) 3.1-47(a)(5) 3.1-47(a)(6)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident			

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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
	assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on interviews and record review, the facility failed to maintain 8 hours of Registered Nurse (RN) coverage in a 24-hour period a total of 10 days from 1/1/23 to 3/31/23 for 1 of 1 quarters reviewed for sufficient staffing. Findings include: On 9/5/23 at 9:00 A.M., the Certification And Survey Provider Enhanced Reports (CASPER) for second quarter 2023-2024 was reviewed. The CASPER indicated that one-star staffing rating was triggered for further investigation during the survey. On 9/13/23 R 12:00 P.M., the records of RN coverage hours were reviewed: 1/11/23 - 0 1/16/23 - 0 1/17/23 - 0	F 0725	**F725** **It is the practice of this facility to assure RN coverage is in place appropriately.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** No residents were specifically identified. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected by the alleged deficient practice. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur***	10/11/2023

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	1/24/23. - 4.25 2/4/23 - 0 2/7/23 - 0 2/8/23 - 4.5 2/22/23 - 4.5 3/14/23 - 5.75 A facility nurse staffing policy was requested but not received. 3.1-17(b)(3)		***include:*** The facility is in the process of hiring RNs to assure that we have RN coverage 8 hours daily. The scheduler has been in-serviced related to assuring that an RN is scheduled 8 hours per day, or she must notify DON/ADMIN. See below for monitoring. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews required nursing schedule information to assure proper RN coverage. The Director of nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. ***The date the systemic changes will be completed:*** October 11, 2023	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.			

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	(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, interview and record review, the facility failed to ensure the complete and accurate staffing records were posted for 5 of 6 days of the survey. Findings include: During an interview with the DON on 9/7/23 at	F 0732	**F732** **It is the practice of this facility to assure required posted nursing staffing is in place appropriately.** ***The correction action taken for those residents found to be affected by the deficient practice***	10/11/2023

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	10:51 A.M., she pointed to a plastic bracket under the receptionist sign where the posted nurse staffing was supposed to be, but the bracket was empty. Copies of posted nurse staffing were requested for the week. On 9/7/23 at 11:40 A.M. The Admin and DON provided copies of posted nurse staffing records for 9/4/23, 9/5/23, 9/6/23, and 9/7/23. On 9/8/23 at 8:23 A.M., the empty bracket was observed to have no staffing posted. On 9/8/23 at 9:45 A.M. the nurse staffing was posted, a copy was provided by the receptionist. During an interview with the regional nurse on 9/8/23 at 11:40 A.M. she indicated the facility had both 8 and 12-hour shifts. On 9/4/23, the daily staffing sheet failed to identify the length of shift and actual number of hours worked for each discipline On 9/5/23, the daily staffing sheet failed to identify the length of shift and actual number of hours worked for each discipline. On 9/6/23, the daily staffing sheet failed to identify the length of shift and actual number of hours worked for each discipline. On 9/7/23, the daily staffing sheet failed to identify the length of shift and actual number of hours worked for each discipline. On 9/8/23, the daily staffing sheet failed to identify the length of shift and actual number of hours worked for each discipline.		***include:*** No residents directly affected by the alleged deficient practice. Staffing is posted appropriately. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected by the alleged deficient practice. Staff are assigned for the appropriate posting of staffing. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The receptionist has been in-serviced related to assuring that proper staffing is posted. The managers have been in-serviced related to assuring posted on the weekends when they are the manager on duty. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews required nursing staffing information to assure posted appropriately. The Director of nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with	

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	On 9/8/2023 at 2:30 P.M., the facility nurse staffing posting information policy, undated, indicated the daily staffing sheet will be posted on a daily basis and will contain the following information: a. facility name b. the current date c. the facility's current resident census d. the total number and the actual hours worked by the following categories of licensed and unlicensed staff directly responsible for resident care per shift: i. Registered Nurses ii. Licensed Practical Nurses/Licensed Vocational Nurses iii. Certified Nurse Aides The facility will post the daily staffing sheet at the beginning of each shift.		recommendations as needed based on the outcomes of the tools. ***The date the systemic changes will be completed:*** October 11, 2023	
F 0756 SS=E Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a			

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	separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.			
	Based on interview and record review, the facility failed to ensure medication regimen recommendations were reviewed or addressed by a Physician for 6 of 6 residents reviewed for unnecessary medications. (Resident 22, Resident 53, Resident 12, Resident 37, Resident 6, Resident 56) Findings Include: 1. On 9/6/23 at 2:02 P.M, Resident 53's clinical record was reviewed. The resident's profile included a diagnosis, but was not limited to, Type 2 Diabetes Mellitus. A quarterly quarterly Minimum Data Set (MDS) assessment, dated 7/12/23, indicated Resident 53's	F 0756	**F756** **It is the practice of this facility to assure Drug Regimens are completed appropriately with necessary follow-up.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #37 no longer resides in facility. Medication reviews completed for residents #22, #53, #12, #6, and #56 with follow through as needed. ***Other residents that have the potential to be affected have been identified by:***	10/11/2023

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	cognition level was unable to be assessed and received insulin injections for seven days during the seven day assessment. A Physician's order, dated 8/28/23, indicated Lantus (an insulin medication) 20 units two times a day. Physician orders, dated 8/29/23, indicated Novolin R (an insulin medication) 6 units before meals, and Novolin R sliding scale, when blood sugar readings were above 150, before meals. A pharmacy recommendation received on 9/11/23 at 11:11 A.M., dated 8/23/23, indicated Resident 53 was receiving Lantus 20 units, Humulin (Novolin) 6 units and Novolin sliding scale. The pharmacy recommendation indicated Resident 53 had multiple hypoglycemic episodes and suggested decreasing her Lantus and discontinuing her Novolin sliding scale. A request for a pharmacy recommendation, or clinical rationale for continuing the medication, signed or addressed by the Physician was requested and not provided. 2. On 9/7/23 at 10:58 A.M., Resident 22's clinical record was reviewed. The resident's profile included a diagnosis, but was not limited to, dementia with anxiety. A quarterly Minimum Data Set (MDS) assessment, dated 5/23/23, indicated Resident 22 was cognitively intact and received anti-anxiety medications for one day during the seven day assessment. A physician's order, dated, 5/17/23, indicated lorazepam (an anti-anxiety medication) 0.5 milligrams (mg) by mouth every 8 hours as needed (PRN) for anxiety.		All residents have been reviewed for drug regimen with follow through on recommendation as needed. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All nurses have been in-serviced on assuring that pharmacy consultant recommendations on drug regimens are followed through appropriately. The DON is responsible to assure that when the report is received that there is documentation of physician review and changes as ordered. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews the pharmacy consultant report to assure that recommendations are followed up appropriately. The Director of Nursing, or designee, will complete this tool monthly x6. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcome of tools. ***The date the systemic changes will be completed:*** October 11, 2023	

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	A pharmacy recommendation received by the Director of Nursing (DON) on 9/7/23 at 1:58 P.M., dated 7/28/23, indicated Resident 22 received lorazepam 0.5 mg every 8 hours PRN, and required a documented clinical rationale as well as a specific treatment length. A request for a pharmacy recommendation, or clinical rationale for continuing the medication, signed by the Physician was requested and not provided. 3. On 9/7/23 at 9:53 A.M., Resident 12's clinical record was reviewed. Resident 12 was admitted on 12/1/17. Resident 12's diagnoses included, but were not limited to, generalized anxiety disorder, major depressive disorder, and insomnia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 8/14/23, indicated Resident 12 was cognitively intact and received antianxiety medication, antidepressant medication, insulin, opioids, and a diuretic during the 7 day look back period. Current physician orders included, but was not limited to: Duloxetine HCl (hydrochloride) (Cymbalta) Capsule Delayed Release Particles 30 MG (milligrams) - Give 1 capsule by mouth one time a day for depression, dated 1/11/23 Duloxetine HCl Capsule Delayed Release Particles 60 MG - Give 1 capsule by mouth one time a day for depression, dated 1/11/23 Trazodone HCl Oral Tablet 50 MG - Give 1 tablet by mouth at bedtime for insomnia, dated 3/15/23			

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	Melatonin Tablet 5 MG - Give 1 tablet by mouth at bedtime for insomnia, dated 2/24/21 Medication Regimen Reviews (MRR) that had been signed by the physician were requested for the past year. Unsigned MRRs were provided dated 2/24/23, 3/24/23, 4/25/23, and 8/23/23. An unsigned MRR, dated 2/24/23, indicated "her Cymbalta was previously indicated for Neuropathy and Depression, however the Neuropathy diagnosis fell off...please evaluate to ensure no reduction is appropriate, and may we update both the 60 mg and 30 mg diagnosis on the MAR (medication administration record) to be "Depression AND neuropathy" so that we do not have to attempt GDRs (gradual dose reductions) in the future". The MRR also indicated Resident 12 "has taken the Melatonin 5mg QHS (at bedtime) for two years...please evaluate if a reduction to Melatonin 3mg QHS may be appropriate". An unsigned MRR, dated 3/24/23, indicated Resident 12 "was started on Trazodone 50mg QHS...on 3/15. Can nursing please follow up with her to ensure that this was started on the correct resident...I am wondering if this was not supposed to be for her". An unsigned MRR, dated 8/24/23, indicated Resident 12 "received Cymbalta 30mg+60mg QD (every day). The current listed diagnosis...is for Depression ... Can we please update the Cymbalta 30 mg and Cymbalta 60mg diagnoses to Depression and Diabetic Neuropathy ... updating the diagnosis on the MAR will exempt having to attempt GDRs in the future". 4. On 9/6/23 at 1:13 P.M., Resident 37's clinical			

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	record was reviewed. Resident 37 was admitted on 5/28/20. Resident 37's diagnoses included, but were not limited to, bipolar disorder, anxiety disorder, major depressive disorder, and insomnia. The most recent Annual MDS Assessment, dated 6/29/23, indicated Resident 27 was cognitively intact and received antipsychotic medications, antianxiety medications, antidepressants, and hypnotics during the 7 day look back period. Current physician orders included, but was not limited to: Seroquel Tablet 100 MG (milligrams) - Give 1 tablet by mouth one time a day for Bipolar disorder, dated 10/1/22 Seroquel Tablet 200 MG - Give 200 mg by mouth at bedtime for Bipolar disorder, dated 9/30/22 Fluvoxamine Maleate ER (extended release) Capsule (Luvox) 100 MG - Give 1 capsule by mouth at bedtime related to bipolar disorder, dated 10/7/21 Lunesta Tablet 1 MG (Eszopiclone) - Give 2 mg by mouth at bedtime for insomnia, dated 5/16/23 Ativan Tablet 1 MG (Lorazepam) - Give 1 tablet by mouth two times a day for anxiety, dated 7/27/21 Topiramate Tablet 25 MG (Topamax) - Give 1 tablet by mouth at bedtime related to other frontotemporal neurocognitive disorder, dated 10/8/22 Topiramate Tablet 50 MG (Topamax) - Give 1 tablet by mouth two times a day for bipolar disorder, dated 8/29/22			

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	Medication Regimen Reviews (MRR) that had been signed by the physician were requested for the past year. Unsigned MRRs were provided dated 9/26/22, 11/23/22, 12/30/22, 2/24/23, 3/24/23, and 5/31/23. The unsigned MRR, dated 12/30/22, requested the physician to evaluate if Resident 37 was a candidate for reductions for Ativan from 1 mg BID (twice a day) to 0.5 mg QAM (every morning) and 1 mg QHS (at bedtime), Topamax from 50 mg BID and 25 mg QHS to 50 mg QAM and 25 mg BID, Lunesta from 1 mg QHS to DC (discontinued), Seroquel from 100 mg QAM and 200 mg QHS to 75 mg QAM and 200mg QHS, and Luvox from 100 mg QHS to 50 mg QHS. The MRR indicated "if no changes are made, please document a clinical contraindication statement". The unsigned MRR, dated 3/24/23, requested the physician to evaluate if Resident 37 was a candidate for reductions for Ativan from 1 mg BID (twice a day) to 0.5 mg QAM (every morning) and 1 mg QHS (at bedtime), Topamax from 50 mg BID and 25 mg QHS to 50 mg QAM and 25 mg BID, Lunesta from 1 mg QHS to DC (discontinued), Seroquel from 100 mg QAM and 200 mg QHS to 75 mg QAM and 200mg QHS, and Luvox from 100 mg QHS to 50 mg QHS. The MRR indicated "if no changes are made, please document a clinical contraindication statement". The clinical record lacked any clinical contraindication statement documentation.5. On 9/7/23 at 2:15 P.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited, to major depressive order and anxiety disorder.			

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	The most recent annual MDS (Minimum Data Set) Assessment dated 6/9/23, indicated Resident 6 was cognitively intact and received antidepressant medication and antipsychotic medication during the 7 day look back period. Current physician's orders included but were not limited to: Sertraline HCl oral tablet 100 mg(milligrams). Give 2 tablets by mouth at bedtime related to major depressive disorder dated 4/8/23. Trazodone HCL 100 mg. Give 1 tablet at bedtime for insomnia dated 12/16/22. Abilify Oral Tablet 2 mg (Aripiprazole). Give 2 mg by mouth in the morning related to major depressive disorder. Medication Regimen Reviews (MRR) that had been signed by the physician were requested for the past year. Unsigned MRRs were provided dated 2/24/23 and 8/23/23 An unsigned MRR, dated 2/24/23, indicated Resident 6 " was on Trazodone 100 mg Q HS. Zoloft 150 mg QD... was due for a reduction evaluation at this time per federal guidelines. She receives Abilify increased in December... Trazodone was increased 2/22... Zoloft was decreased 3/22 and increased 7/22. Please evaluated if she is a candidate for any reductions... If no changes.... please document a clinical contraindication statement." An unsigned MMR, dated 8/23/23, indicated Resident 6 "receives Zoloft 200 mg QD, Trazodone 100 mg QHS...was due for a reduction evaluation at this time per federal guidelines. She			

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	has been tapered down on her Abilify to 2 mg QHS this month... any further reductions may be inappropriate at this time. Please evaluated if she is a candidate for any reductions... If no changes.... please document a clinical contraindication statement." A request for a pharmacy recommendation, or clinical rationale for continuing the medication, signed by the Physician was requested and not provided. 6. On 9/7/23 at 10:51 A.M., Resident 56's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder and specified anxiety disorders. The most recent quarterly MDS Assessment dated 7/14/23 indicated Resident 56 was cognitively intact received antidepressant medication and antipsychotic medication during the 7 day look back period. Current physician orders included but not limited to: TraZODone HCl Tablet 50 mg. Give 1 tablet by mouth at bedtime for insomnia dated 8/29/23. Escitalopram Oxalate Tablet 20 mg. Give 1 tablet by mouth one time a day for depression dated 8/29/23. A request for MMRs was requested for Resident 56 and none were provided. During an interview on 9/08/23 at 8:25 A.m., the regional clinical support nurse indicated the physician is to sign the GDR (Gradual Dose Reduction) once it is done.			

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	During an interview on 9/8/23 at 10:40 A.M., the regional clinical support nurse indicated that she could not find any more MMRs and was unable to find any except for the ones done for January and March 2023. During an interview on 9/11/23 at 12:00 P.M., the Administer indicated that is was the facility policy for the Physician to sign the GDR once it was done. but no policy was provided. 3.1-25(h) 3.1-25(i)			
F 0758 SS=E Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose			

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	reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview, and record review, the facility failed to ensure GDRs (gradual dose reductions) were completed for psychotropic medications and PRN (as needed) antianxiety medications were evaluated every 14 days for 4 of 7 residents reviewed for unnecessary medications (Resident 12, Resident 37, Resident 25, Resident 22). Findings include: 1. On 9/7/23 at 9:53 A.M., Resident 12's clinical record was reviewed. Resident 12's diagnoses included, but were not limited to, spinal stenosis, chronic kidney disease, diabetes mellitus,	F 0758	**F758** **It is the practice of this facility to assure that medications are reviewed for appropriateness and to assure all medications are necessary, care planned, and supported by diagnosis.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #37 no longer resides at facility. Residents #12, #22, and #25 have been reviewed for gradual dose reductions and their PRN	10/11/2023

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	generalized anxiety disorder, and major depressive disorder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 8/14/23, indicated Resident 12 was cognitively intact and received an antianxiety medication, antidepressants, insulin, opioids, and a diuretic during the 7 day look back period. Current physician orders included, but was not limited to: Hydroxyzine HCl (an antianxiety medication and an antihistamine) 25 MG (milligrams) - Give 1 tablet by mouth every 8 hours as needed for itching, dated 2/28/23 The August 2023 MAR (medication administration record) indicated Resident 12 received hydroxyzine on 8/4, 8/5, 8/6, 8/12, 8/19, and 8/26. The September 2023 MAR indicated Resident 12 received hydroxyzine on 9/9. A (MRR) medication regimen review by the pharmacist, dated 1/30/23, indicated hydroxyzine was an anxiolytic therapy and required a stop date or a documented clinical rationale if given over 14 days. The clinical record lacked documentation of clinical rational by a physician for the hydroxyzine given greater than 14 days. On 9/11/23 at 9:45 A.M., the Regional Clinician indicated Resident 12 received hydroxyzine as needed for anxiety. She indicated that hydroxyzine was coded as an antianxiety medication as per the RAI (Resident Assessment Instrument) manual		psychotropic medication review. ***Other residents that have the potential to be affected have been identified by:*** All residents on psychotropic medications have been reviewed to assure medication is appropriate, has been reviewed for Gradual Dose Reduction. Any resident on PRN psychotropic has been reviewed for 14-day continuance. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The nurses have been in-serviced related to the use of psychotropic medications and the need for gradual dose reductions. In addition, they have been in-serviced on assuring that new orders for PRN psychotropic medication includes a 14-day review. A behavior meeting will occur monthly which includes the use and evaluation for reduction of psychoactive medications. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 residents (if applicable) on psychotropic medication related to medication reduction and PRN review to assure that each has been appropriately evaluated. The Director of	

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	and, as a PRN antianxiety medication, should not be continued past 14 days without documentation from a physician. 2. On 9/6/23 at 1:13 P.M., Resident 37's clinical record was reviewed. Resident 37's diagnoses included, but were not limited to, bipolar disorder, anxiety disorder, major depressive disorder, and insomnia. The most recent Annual MDS Assessment, dated 6/29/23, indicated Resident 37 was cognitively intact and received antipsychotic medications, antianxiety medications, antidepressants, and hypnotics during the 7 day look back. Current physician orders included, but was not limited to: Seroquel (an antipsychotic medication) 100 MG (Quetiapine Fumarate) - Give 1 tablet by mouth one time a day for bipolar disorder, dated 10/1/22 Seroquel 200 MG (Quetiapine Fumarate) - Give 200 mg by mouth at bedtime for bipolar disorder, dated 9/30/22 Lunesta Tablet 1 MG (Eszopiclone) - Give 2 mg by mouth at bedtime for insomnia, dated 5/16/23 GDR (gradual dose reduction) documentation for the past year was requested and not provided. On 9/11/23 at 11:11 A.M., the Regional Clinician indicated they were unable to find documentation of any GDR attempts in the past year for Resident 37. 3. On 9/7/23 at 9:27 A.M., Resident 25's clinical record was reviewed. The resident's profile		Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcome of tools. ***The date the systemic changes will be completed:*** October 11, 2023	

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	included diagnoses, not limited to, respiratory failure, chronic kidney disease, and hypertensive heart disease with heart failure. A quarterly Minimum Data Set (MDS) assessment, dated 5/26/23, indicated Resident 25 was cognitively intact and received anti-anxiety medications for seven days during the seven day assessment period. A physician's order, dated 11/20/2021, indicated lorazepam (an anti-anxiety medication) 0.5 milligrams (mg) by mouth every 4 hours as needed. Resident 25's clinical record lacked any physician reassessment for lorazepam after the initial 14 days after it was ordered. During an interview on 9/11/23 at 11:40 A.M., the Administrator indicated Resident 25 was receiving PRN lorazepam longer than 14 days due to being on hospice, but was unable to provide a documented clinical rationale with that information. 4. On 9/7/23 at 10:58 A.M., Resident 22's clinical record was reviewed. The resident's profile included a diagnosis, but was not limited to, dementia with anxiety. A Quarterly Minimum Data Set (MDS) Assessment, dated 5/23/23, indicated Resident 22 was cognitively intact and received anti-anxiety medications for one day during the seven day assessment period. A physician's order, dated, 5/17/2023, indicated lorazepam (an anti-anxiety medication) 0.5 milligrams (mg) by mouth every 8 hours as needed			

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	(PRN) for anxiety. Resident 22's clinical record lacked any physician reassessment for lorazepam after the initial 14 days after it was ordered. During an interview on on 9/11/23 at 9:15 A.M., the Regional Clinician indicated as needed (PRN) antianxiety medications should be reviewed by the Physician every 14 days but was unable to provide reviews completed by the Physician. On 9/11/23 at 10:34 A.M. the Regional Clinician provided a policy titled "Antipsychotic Medication Use", revised December 2016. The policy indicated "14. The need to continue PRN orders for psychotropic medications beyond 14 days requires that the practitioner document the rationale for the extended order. The duration of the PRN order will be indicated in the order. 15. PRN orders for antipsychotic medications will not be renewed beyond 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication." On 9/18/23 at 2:53 P.M., a current Gradual Dose Reduction of Psychotropic Drugs policy, undated, indicated "Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility will attempt a GDR in two separate quarters, unless clinically contraindicated. The GDR may be considered clinically contraindicated for reasons that include, but that are not limited to the physician has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior". 3.1-48(b)(2)			

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	3.1-48(a)(2) 3.1-48(a)(4)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure that all drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable, for 2 of 2 medication carts reviewed for medication labeling and storage.	F 0761	**F761** **It is the practice of this facility to assure that residents' medications are stored, dated, and destroyed properly in accordance with the regulations.** ***The correction action taken for***	10/11/2023

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	Findings include: During an interview with LPN 6 on 9/6/23 at 8:38 A.M., the second floor medication cart was found to contain loose pills in the bottom of the medication drawers. There were 2 large round red pills, 1 small white pill, 1 square orange pill, and 2 large round white pills. LPN 6 disposed of the loose pills in the sharps container. During an interview with LPN 18 on 9/6/23 at 8:55 A.M., the first floor medication cart was found to contain loose pills in the bottom of the medication drawers. There were 1 large red pill, 1 red gel cap, 3 round brown pills, 2 oblong gold pills, 1 large round pink pill, 4 small white pills, 1 large oblong pill, 2 large round white pills, 3 small oval white pills, 1 small round yellow pill. LPN 18 disposed of the loose pills in the Drug Buster. The facility medication storage policy, undated, indicated unused medications... are destroyed in accordance with our Destruction of Unused Drugs Policy. 3.1-48(c)(2)		***those residents found to be affected by the deficient practice include:*** No specific residents were identified. The medication carts identified in the 2567 have been addressed. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected. Please see below for system changes and monitoring. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Nurses and QMAs have been in-serviced related to assuring that the medication carts are kept clean with no loose pills in the bottom of the carts. In addition to the audit below, Nursing Administration will be monitoring medication carts as part of their daily rounds. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement tool has been established that reviews the 2 medication carts on a random basis to assure they are clean without loose pills in the bottom. The Director of Nursing, or designee, will review randomly the medication carts. The tool will be completed weekly x3, then	

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			monthly x3, then quarterly x3. Any issues identified will be immediately addressed. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed based on the outcome of the tools. ***The date the systemic changes will be completed:*** October 11, 2023	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on interview and observation, the facility failed to provide each resident with food and drink that was served at a safe and appetizing temperature. Food that was supposed to be served hot was served at below the recommended temperature; food that was supposed to be cold was served above the recommended temperature for 1 of 1 trays reviewed for temperature. Findings include: During an observation on 9/5/23 at 11:55 A.M., in the second floor dining room, food was observed	F 0804	**F804** **It is the practice of this facility to assure that food is served at appropriate temperatures.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified. Residents are receiving their food at appropriate temperatures. ***Other residents that have the***	10/11/2023

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	being served in Styrofoam containers with plastic tableware. During an interview with the Dietary Manager on 9/5/23 at 12:06 P.M., Styrofoam containers were being used because the elevator had been broken for more than 2 weeks and there was no good way to get the heavy dishes up to the second floor dining room. The staff formed a line going up the stairs and passed the trays up the stairs. Parts to repair the elevator are not expected to arrive before October. Additional interviews were obtained from residents. On 9/5/23 at 10:10 A.M., Resident 22 indicated the food is cold by the time it gets to the room, sometimes undercooked, out of items like condiments a lot; On 9/6/23 at 8:37 A.M., Resident 25 indicated...there is no variation with the substitute it is always hot dog, hamburger, never really hot; On 9/6/23 at 11:08 A.M., Resident 35 indicated the food doesn't taste real good; on 9/6/23 at 9:03 A.M. Resident 6 indicated the food tastes like dog food. On 9/8//23 at 11:57 A.M., a tray was received from the second floor dining room. Temperatures were: fish 105 degrees F(Fahrenheit), tasted cool and chewy tater tots 114 degrees F, not crisp, chewy, tasted cool Cole slaw 62 degrees F, tasted cool On 9/8/23 at 2:45 P.M., the facility policy for food temperatures for meal service, undated, was reviewed. The policy failed to include the recommended food temperatures for meal service. 3.1-21(a)(1) 3.1-21(a)(2)		***potential to be affected have been identified by:*** All residents are receiving their food at appropriate temperatures. Please see systematic changes below to prevent reoccurrence. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All staff involved with the serving of food to the residents has been in-serviced related to assuring that food served to the residents is at appropriate temperatures. The in-service included assuring that hot/cold food is served at appropriate temperatures. The Dietary Manager is responsible for assuring that temperatures are appropriate when served to the residents. Please see below for means of monitoring. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** The Dietary Manager is responsible for assuring that temperatures of food are appropriate for the residents. This position, or designee, is responsible for reviewing the documented temperatures and assuring that they fall within the acceptable ranges in accordance with the regulation. The Dietary Manager via a Performance Improvement tool will review 5	

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			meals weekly x3 weeks, then monthly x3, then quarterly x3 to assure that food being served is the correct temperatures. Randomly 5 residents will also be interviewed on the same tool and schedule related to their satisfaction with food temperatures. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tracking of temperatures at the scheduled meetings with recommendations as needed for additional interventions as necessary based on the outcome of the logs. ***The date the systemic changes will be completed:*** October 11, 2023	
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			

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	from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview. the facility failed to store, distribute, and serve food in accordance with professional standards for food services safety for 3 of 3 observations of the kitchen. Findings Include: During a tour of the kitchen beginning on 9/5/23 at 8:46 A.M., the Dietary Manager (DM) indicated the kitchen had been very short staffed and they had recently hired new staff in the past 2 weeks but they needed to be trained. During an interview with the DM on 9/5/23 at 9:00 A.M., she indicated the dishwasher uses hot water to sanitize the dishes. On 9/5/23 at 9:35 A.M., the dishwasher was observed during the wash/rinse cycle. The wash was 150 degrees F(Fahrenheit), rinse was 165 degrees F. On 9/7/23 at 9:56 A.M., the dishwasher was observed during the wash/rinse cycle. The wash was 140 degrees F, the rinse was 175 degrees F. On 9/5/23 at 9:36 A.M., the kitchen floor was observed to be dirty and sticky, especially near the dishwasher. During observation of the two reach-in refrigerators in the kitchen on 9/5/23 at 9:09 A.M. The reach-in refrigerator on the right had a temperature of 42 degrees F. The reach-in refrigerator on the right had:	F 0812	**F812** **It is the practice of this facility to assure that sanitary practices are in place related to food storage and food preparation, and food service.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified. The areas identified in the 2567 have all been addressed. This includes dishwater temperatures, kitchen floor, opened unlabeled/dated items in refrigerator, dry storage room, ice maker room, spice rack, first floor nourishment room, and proper use of hair nets. ***Other residents that have the potential to be affected have been identified by:*** All residents could potentially be affected. Please refer below to systematic changes to prevent reoccurrence. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All dietary staff have been in-serviced related to assuring that	10/11/2023

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	1. 1 bag shredded cheese open not labeled or dated 2. 1 5-lb package Swiss cheese open not labeled or dated 3. 1 5-lb package American cheese open not labeled or dated 4. 1 5-lb carton Daisy cottage cheese open not dated 5. 1 4/5 lb lettuce salad mix, half full, open not dated 6. 1 1-lb package slice lunch meat, open not labeled or dated During a tour of the dry storage room on 9/5/23 at 9:30 A.M., the floor under the storage shelves was observed to be black-ish and had debris (papers, crumbs), 2 mouse traps observed, no mice in them. During a tour of the room with the icemaker on 9/5/23 at 9:40 A.M., water was draining from a hose attached to the ice machine motor. The hose was not totally on the drain and water was seeping out onto the floor in front of and to the right side of the icemaker. The wall and floor behind the icemaker had a black mold-like substance on it. There was a drainage pipe to the right of the icemaker that was draining water from an unidentifiable source. The pipe and wall were wet, the pipe was slimy. The wall beneath them was covered with a black mold-like substance. The floor was dirty. During observation of the spice rack on 9/5/23 at 10:00 A.M.: The nutmeg was dated 5/21, the container was sticky. The dill label was unreadable but was completely faded and the container was nearly empty. The ground white pepper was open to air, dated 12/21, the container was very sticky.		the areas identified in the 2567 including as noted above. The in-service also includes the following of the cleaning schedule for the dietary department. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews dietary to assure that the kitchen is clean and includes the areas identified in the 2567. The Dietary Manager, or designee, will complete this tool weekly x3, then monthly x3, then quarterly x3. Any issues identified on the Performance Improvement Tools will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcome of the tools. ***The date the systemic changes will be completed:*** October 11, 2023	

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	The rubbed sage was dated 5/21, the container was sticky. During observation of the nourishment refrigerator on first floor on 9/5/23 at 10:10 A.M., the shelves in the refrigerator door were dirty and sticky. During an interview with the DM on 9/7/23 at 9:49 A.M., she indicated the licensed dietitian comes in once a week and goes through NAR (nutrition at risk) weight loss, wounds, and adds dietary supplements as needed. Daily menus come from corporate in Pennsylvania (regional dietitian). The snack menu comes from corporate. They have Controlled Carbohydrate (CCHO) diet for diabetics: the only thing they do is maybe cut desserts in half. Styrofoam is being used temporarily for service to the second floor dining room as the elevator is broken. The food is served directly from the steam table in the kitchen to the Styrofoam containers, then taken to the second floor. There is a steam table in the second floor dining room, but she does not have enough staff to use it. She only has 1 cook and 1 aide. 09/07/23 09:59 A.M. Received the approved snack list from DM. The list lacked a CCHO diet, but she indicated nursing is supposed to know what to give diabetics. During observation in the kitchen on 9/8/23 at 11:36 A.M., Cook 4 was observed with hair sticking out of the hair covering, Cook 10 was observed with hair sticking out of the back of the hair covering. During an interview with Cook 4 on 9/8/23 at 1:38 P.M., she indicated she was not sure what the dishwasher temp needs to be. She looked at the			

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	log and said that "looks about right". The facility policy for dishwasher temperatures, received 9/8/23 at 2:30 P.M., undated, indicated that for a stationary rack, dual temperature machine, the wash temperature shall be 150 degree F, the final rinse shall be 180 degrees F but not exceed 194 degrees F. The facility policy for food safety requirements, received 9/8/23 at 2:30 P.M., undated, indicated that food that require refrigeration shall be refrigerated immediately upon receipt or placed in the freezer,whichever is applicable. The policy fails to specify temperature requirements for refrigerators and freezers. 3.1-21(i)(2) 3.1-21(i)(3)			
F 0814 SS=C Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation and interview, the facility failed to ensure garbage was disposed of properly for 1 of 1 dumpsters observed on the east side of the building. The dumpster was left open and used gloves were observed around the dumpster. Finding includes: On 9/6/23 at 12:05 P.M., the dumpster outside of the therapy entrance was observed uncovered. There were 4 blue gloves on the ground around the dumpster. The dumpster was filled to the top with white plastic trash bags filled with garbage. On 9/7/23 at 8:20 A.M., the dumpster outside of the therapy entrance was observed uncovered.	F 0814	**F814** **It is the practice of this facility to assure that dumpster area is clean.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified. The dumpster remains closed and the area around the dumpster is clean. ***Other residents that have the potential to be affected have been identified by:*** All residents could potentially be	10/11/2023

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	There were 4 blue gloves on the ground around the dumpster. The dumpster was filled to the top with white plastic trash bags filled with garbage. On 9/11/23 at 12:12 P.M., the Administrator indicated all trash should be in the receptacle and the dumpster lid should be closed. At that time, she indicated there was not a policy related to the dumpster usage, but all staff should be ensuring proper handling of trash by placing trash in the dumpster and closing the lid. 3.1-21(i)(5)		affected. Please see changes and monitoring below. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Maintenance Director has been in-serviced on assuring dumpster remains closed and surrounding area clean. All staff have been in-serviced that take trash to the dumpsters has been in-serviced related to assuring lid of dumpster remains closed and that area surrounding dumpster remains clean. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews the dumpster area for compliance. The Maintenance, or designee, will complete this tool weekly x3, then monthly x3, then quarterly x3. Any issues identified on the Performance Improvement Tools will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcome of the tools. ***The date the systemic changes will be completed:*** October 11, 2023	

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F 0880 SS=E 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; §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;			

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	(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 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 observations, interviews and record reviews, the facility failed to properly prevent and contain COVID-19 for 3 of 7 residents reviewed for infection control and providing safe and sanitary environment for 9 resident rooms and Stocker unit. (Resident 6, Resident 56, Resident 115)	F 0880	**F880** **It is the practice of this facility to assure that all procedures and services are conducted in a manner that is in accordance with infection control guidelines.** ***The correction action taken for***	10/11/2023

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	Findings include: 1. On 9/8/23 at 8:14 A.M., RN (registered nurse) 28 was observed coming out of a Covid resident 6 room and only wearing a regular face mask. She indicated she forgot to but on the PPE. The precautions were marked on the door as a red zone and for donning the proper PPE in order. She then, did not wash hands, but changed to N-95 face mask, placed clean gloves. She did not use eye protection. Proceeded into the resident's room and gave medication. She came out of the room and indicated the PPE was taken off in the room and she had washed her hands in the room. 2. On 9/05/23 at 10:48 A.M., RN 15 was observed suctioning Resident 115's mouth using clean gloves then proceeded to do trach care and changing inner cannula with the non-sterile gloves 3. On 9/5/23 at 11:00 A.M., RN 15 was observed doing trach care and changed the inner cannula using clean gloves. He also suctioned the resident with clean gloves and suction catheter with tap water to clear the tube. 4. On 9/08/23 at 2:40 P.M., RN (Registered Nurse) 10 was observed suctioning a tracheotomy using clean gloves with an alleged sterile suction catheter for Resident 56. She replaced the catheter in the same package. Removed the clean gloves. The resident needed to suctioned again and donning clean gloves and removed the used suctioned catheter and reused it to suction the resident. She did not wash hands between changing gloves. During an interview on 9/5/23 at 11:00 A.M., RN 15 indicated that trach care suctioning was a clean		***those residents found to be affected by the deficient practice include:*** Resident #115 no longer resides in facility. Resident #6 is receiving services in accordance with infection control guidelines. The nurse involved was in-serviced at the time of event. Resident #56 is receiving trach care/suctioning in accordance with infection control guidance. Water has had proper testing for Legionella. Antibiotics are being reviewed as part of QA. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected related to improper infection control protocol. Please see below for measures implemented to prevent reoccurrence below. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All nurses have been in-serviced related to assuring that infection control practices are in place during trach care/suctioning including sterile technique, glove changes, and handwashing. All staff have been in-serviced on the utilization of proper PPE during infection outbreaks. The IDT team have been in-serviced on antibiotic use review as part of the QA. This includes antibiogram from labs.	

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	technique and he was taught that way. During an interview at 9/8/23 at 8:28 A.M., the regional clinical support nurse indicated she had just done in servicing about wearing proper PPE the day before. During an interview on 9/8/23 at 2:40 P.M. RN 19 indicated that she suctions using clean gloves and did not use sterile because she was taught that way. She used a suction catheter that was in an already opened package, suctioned the resident, placed the same suction catheter back into the already open package. The resident needed suctioning again and did the same things again. She indicated that she was taught this way. During an interview on 9/8/23 at 3:40 P.M., the regional clinician indicated that at one time the facility had respiratory service who took care of training and taking care of residents. She indicated that she did not know who did the competency or training for the nursing staff. She only did check off for the annual check off. She thought the DON (Director of Nursing) did training. During an interview on 9/8/23 at 4:00 P.M., the Administrator indicated the DON did the training. 5. During an interview with the administrator on 9/5/23 at 1:00 P.M., she indicated she was currently acting as the infection preventionist. During interview with maintenance staff (MS) 20 on 9/5/23 at 10:15 A.M., he was filling in for the maintenance supervisor who was out of the office all week. He found no documentation of water testing in the maintenance file, either from an outside lab or from the city's municipal water source. In the file were paper records listing rooms		***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly observes 5 staff members during provision of care to practices are in accordance with acceptable infection control guidelines. This includes trach care/suctioning, and PPE usage. The Director of Nursing, or designee, will complete these tools weekly x3, monthly x3, then quarterly x3. An additional took has been implemented that assures that antibiotic usage is reviewed as part of QA and that proper legionella water testing was completed. The Administrator will be responsible for this tool to be completed monthly. Any issues identified will be immediately corrected and additional training will immediately occur. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for new interventions as needed based on the outcomes of the tools. ***The date the systemic changes will be completed:*** October 11, 2023	

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	407, 408, 409, 410, 411, 412, 413, 414, 415, the utility room on Stocker 2 unit, and the nurse restroom, all of which are currently closed and not in use. The record indicated the hot and cold water were turned on in the showers and sinks for a 5-minute period to prevent the growth of Legionella bacteria. Also included on the same record were outside faucets on the Harmony unit exit, the Cafe exit, the main lobby, therapy, south ambulance entrance, mechanical room #1, north side of building main entrance. The record indicated that all the faucets were run for 5-minute periods to prevent growth of Legionella bacteria. The records indicated these measure were done daily Monday through Friday. Documentation was obtained for 3/6/23 through 8/25/23. During an interview on 9/6/23 at 1:35 P.M., the administrator indicated there had been no lab testing of the water. The facility lacked a risk assessment of water system components to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water system. During an interview on 9/6/23 at 1:40 P.M., the administrator indicated the QAA committee does not routinely review antibiotic drug regimens. The current medical director does not attend the QAA meetings, but they are getting a new medical director October 1, 2023, who will attend. She indicated they do not currently have a system of feedback reports on antibiotic use, antibiotic resistance patterns based on lab data, and prescribing practices for the prescribing practitioner and for the QAA committee. She was aware there is supposed to be an angiobiogram			

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	from the lab that should come in the mail. On 9/11/23 at 8:23 A.M.,the Administrator provided the water management policy and procedure, dated 11/28/2016, indicated that: 2. A risk assessment of water system components will be conducted to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. 3. The risk assessment will be completed by the facility leadership and the Infection Preventionist with collaboration from other facility team members such as maintenance employees, safety officers, risk and quality management staff, and the Director of Nursing. On 9/11/23 at 8:23 A.M., the administered provided the infection prevention, control, and antibiotic stewardship policy, revised 7/22/22, indicated that by collecting, analyzing, and trending data, actions can be instituted to improve resident outcomes. The Infection Prevention and Control Plan provides staff with a coordinated organizational structure, technical procedures, comprehensive work practices, and guidelines to reduce the risk of transmission of infection ad to exercise antibiotic steward. On 9/11/23 at 9:53 A.M., the Administrator provided a current policy revised 10/2018 "Personal Protective Equipment ... is appropriate to specific requirements is available at all time... 3...the type of PPE required is based on the a. the type of transmission-based precautions." On 9/8/23 at 2:55 P.M., a current non date policy "Trach Care with Inner Non-Disposable Cannula" was received by the Administrator..." The policy of the facility that trach care with a disposable innercannula will be done by licensed personnel...			

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	using sterile technique every shift and prn...Procedure is to put on sterile gloves...to replace inner cannula..." On 9/8/23 at 2:58 P.M., a current non dated policy "General Trach Care..." was received by the Administrator"...it is the policy of the facility that trach care... will be done by licensed personnel...using sterile technique every shift and prn...procedure...4. put on sterile gloves...." On 9/8/23 at 3:00 P.M., a current policy "Suctioning" revised August 2014 was received by the Regional Clinical Support Nurse. "...purpose is to help prevent nosocomial infections associated with suctioning and to prevent transmission of ... infections to residents and staff. Guidelines...3. Wear exam gloves on each hand when performing oral suctioning....4. Wear sterile gloves on both hands when performing care of tracheostomy...suctioning. 8. always date and initial sterile water used to flush suction catheter... pour the solution... into a sterile container for use. 9. Only use single container... found in suctioning kits once and then discard 3.18(l) 3.1-18(b) 3.1-18(b)(1)			
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 and interviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public, for 3 of 3 observations of the second	F 0921	**F921** **It is the practice of this facility to assure that residents have a safe and comfortable**	10/11/2023

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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
	floor dining room and 1 of 1 observations of the first floor hallways. Findings include: 1. During an observation of the second floor dining room on 9/5/23 at 11:43 A.M., dead bugs were observed in 6 of the 7 fluorescent light covers. There were brown water marks on 5 ceiling tiles. Tables and chairs were scattered throughout the room in no particular order. Baseboards were missing on every side of the room. Paint was smeared on the chair rail on every wall of the room. During an observation of the second floor dining room on 9/6/23 at 12:00 P.M., the same was observed. During an observation of the second floor dining room on 9/8/23 at 12:15 P.M., the same was observed. 2. During an observation on 9/7/23 at 9:36 A.M., 10 of 10 ceiling vents on the 400 hall were rusty. An environmental cleaning policy was requested but not received. 3.1-19(f)		**environment.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** The second-floor dining room has been thoroughly cleaned and the areas identified in the 2567 addressed. The first-floor hallways have had vents addressed related to presence of rust. ***Other residents that have the potential to be affected have been identified by:*** Please see systems changes and monitoring below. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Maintenance and Housekeeping have been in-serviced on the importance of following the cleaning schedule to assure residents have a safe and comfortable environment. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 areas of the facility for proper cleanliness. The Administrator, or designee, will complete this tool weekly x3, then monthly x3, then quarterly x3. Any issues identified on the Performance Improvement Tools	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155621	A. BUILDING 00 B. WING	09/11/2023

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			will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcome of the tools. ***The date the systemic changes will be completed:*** October 11, 2023	