STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF ROCHESTER	827 W 13TH ST ROCHESTER, IN 46975

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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 IN00400676. Complaint IN00400676 - No deficiencies related to the allegations are cited. Survey dates: June 15, 16, 17, 18, 19, 20 and 21, 2023 Facility number: 000325 Provider number: 155379 AIM number: 100274300 Census Bed Type: SNF/NF: 55 Total: 55 Census Payor Type: Medicare: 6 Medicaid: 43 Other: 6 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 6/29/2023.	F 0000	This plan of correction is prepared and executed because the provisions of state and federal law require it and not because Life Care Center of Rochester agrees with the allegations and citations listed. Life Care Center of Rochester maintains that the alleged deficiencies do not jeopardize the health and safety of the residents nor is it of such character to limit our capabilities to render adequate care. Please accept this plan of correction as our credible allegation of compliance that the alleged deficiencies have or will be correct by the date indicated to remain in compliance with state and federal regulations, the facility has taken or will take the actions set forth in this plan of correction. We respectfully request paper compliance.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Suzanne Wagner	Executive Director	07/14/2023

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

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	freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview, record review and observation, the facility failed to prevent a resident's right to be free from mental and physical abuse for 2 of 3 residents reviewed for abuse. (Resident 53 and 12) Findings include: 1. During an interview, on 6/15/2023 at 12:27 P.M., employee 4 indicated she had been assigned to 1:1 care for a combative resident, Resident 53, and staff had been threatening the resident. Employee 4 indicated "the aides and nurses were threatening." Employee 4 indicated, "when the resident would try to go behind the nurses' station to get food, the staff would say do you want me to get the lotion?" Employee 4 indicated "this is a known trigger for him, and he would do anything to not have lotion applied to him, I believe he had sensory issues. When getting report, I was told if he doesn't listen threaten him with lotion. There was a chair with lotion outside his door in case someone needed to grab the lotion and show him to get him to cooperate." During an interview, on 6/15/2023 at 3:00 P.M., employee 5 indicated that "Resident 53 was Autistic, and she had a family member like him, and she indicated she felt like he was being abused." She indicated" he had a sensitivity to	F 0600	1. Residents 12 and 53 had no significant adverse outcomes. 2. Facility will review documentation last 30 days from date of exit on in house residents to ensure no other concerns with possible abuse and any concerns noted will be reported to MD, family, ISDH, interventions put in place and care plans updated to reflect these concerns as well by date of compliance. 3. Education to ED on abuse, types of abuse, reporting abuse, and following state and federal guidelines on abuse by the RVP. Education on abuse, types of abuse, reporting abuse, and following facility abuse protocol will be completed by ED to current staff by date of compliance. Any staff member who has not completed this education will not work until completed past date of Compliance. 4. ED will perform staff interviews 3 times weekly rotating shifts on the abuse policy and protocol x 2 months then 2 times weekly x 2 months, then one time	07/14/2023

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	lotion, and if he was doing something that they (the nurse and the aides) didn't want him to do, they (the nurse and or the aides) would threaten him with the lotion." She indicated, she "had seen this happen multiple times. It was not that long before he left, (could not remember the exact time/date) they (nurse or the aides) had said to him I'm going to get the lotion, and when they (the nurse and or aides) would tell him that, he would go the other way saying no, no, no, and they would laugh." "Multiple times a day they would do this to him." Employee 5 indicated she "reported to her supervisor. They (the nurse and or aides) would come to him with the lotion, and we would hear no-no-no. Employee 5 indicated "the resident did not want to get a haircut, he kept telling them no, no, no. The nurse brought the hairdresser down to his room when he had already told her no. The resident received the haircut and after the hairdresser and nurse had left his room she stated his pants were wet as if had peed himself." During an interview, on 6/15/2023 at 3:15 P.M., employee 6 indicated she "had overheard the resident saying no, no, no, when she heard some C.N.A's stating, I'm going to get the lotion you better behave-you need to stop; you need to sit down". She stated: she head this multiple times. Employee 6 indicated the Administrator was informed 2- 3 weeks ago of multiple times of taunting the resident with the lotion. During an interview, on 6/16/2023 at 2:09 P.M., the family of Resident 53 indicated that the lotion was a way to deter him to not be so persistent in the things he was doing. During an interview, on 6/19/2023 at 9:23 A.M., CNA 7 indicated she could redirect him. She		weekly x 2 months and then ongoing at that rate of 1 times weekly to assure compliance. Audits will be presented to QAPI ongoing. 5. Date of Compliance: July 14th 2023	

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	indicated some staff did say they would use the lotion, and that he didn't like the lotion. She had "heard staff laughing when he would go back to his room and the staff would laugh at him; everybody did it." CNA 7 indicated that could be abuse. During an interview, on 6/20/2023 at 4:10 A.M., CNA 8 indicated that yes they had used the lotion to get the resident to stop pushing the staff. She indicated she had not heard any of the staff laugh when he would walk away from them. She indicated this could be a form of abuse-- it was humiliating to him. A closed record review was completed on 6/21/2023 at 10:20 A.M., Resident 53 was admitted on 3/31/2023 and discharged on 6/6/2023. Diagnoses included, but were not limited to cancer, Autism, and Asperger's' disease, Adult failure to thrive, mood disorder, and Malignant Neoplasm of parotid gland. An Admission MDS (Minimum Data Set) Assessment, dated 4/7/2023, indicated Resident 53 had severe cognitive impairment. Displayed no behaviors during the assessment period. Required limited assist for bed mobility, transfers, eating, dressing and toilet use. A care plan, dated 5/10/2023, indicated the resident was resistive to care related to adjustment to nursing home and Aspergers syndrome. Resident was having episodes of refusing medication and treatments, refusing lotion for itching. Interventions included but were not limited to: Encourage as much participation/interaction by the resident as possible during care activities. Give clear explanation of all care activities prior to an as they			

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	occur during each contact. Praise the resident when behavior was appropriate. Provide resident with opportunities for choice during care provision. A Progress Note dated, 4/12/2023 at 5:03 A.M., indicated Resident 53 continued to impulsively requested Ensure or Fruit Loops as he continues to learn boundaries. Weight room doors locked, and nurse's station blocked with cart. A Progress Note dated, 4/13/2023 at 12:22 P.M., indicated the resident became agitated when told no to ensure, had 2 ensures this shift, and continues to ask. Other snacks offered, encouraged to drink water, and when told no he would attempt to grab female staff members breast, and laugh and say give me ensure. Message left with brother regarding behaviors, and staff continues to attempt to set boundaries. The clinical record lacked the documentation to show the physician had been notified of the behavior increase. A Progress Note, dated 4/13/2023 at 3:00 P.M., indicated the resident intrusive going behind Nurse's station looking for Ensure and insisting on calling 911 to bring Ensure. The resident educated resident on 911 being for emergency situations only. Resident observed chasing and grabbing on staff, not easily redirected. Resident already offered and accepted Ensure and snacks 20 minutes prior to behaviors. Resident assisted to room x 2 staff assist. Call light within reach. Staff will continue to observe. A Progress Note dated, 4/14/2023 at 5:49 P.M., indicated Resident 53 was observed on the phone at the Nurse's station. The writer asked resident			

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	for the phone, Police dispatcher on the other end stating that resident called Police asking for ensure and donuts and hung up. Dispatcher called facility back and resident answered the phone. The writer assured dispatcher that resident is in no immediate danger. Call ended, and educated resident on the severity of calling 911 for non-emergencies. Resident voiced understanding and went to room. Call light within reach. Staff will continue to observe. A Progress Note dated, 4/22/2023 at 5:41 P.M., indicated the resident woke up requesting donuts. Was pushing staff, grabbing their arm, and yelling for donuts, and attempted to enter another resident's room requesting donuts from staff. Grabbed at the telephones at the nurse's station. Swatted at writer as he blocked my path. Will continue to monitor. The clinical record lacked the documentation to show the physician had been notified of the behaviors. A Progress Note dated, 4/23/2023 at 3:29 A.M., indicated Resident 53 required constant redirection and reminders from staff as he tried to come behind the nurses' station multiply times-stop sign was in place but does not stop him. Requested snacks several times even as he was eating, and would ask for more. PRN (as needed) Benadryl given as resident seemed to be constantly itching all over. Refuses any type of lotion. A Progress Note dated, 4/24/2023 at 4:48 P.M., indicated the resident nails were trimmed to aid in itching skin. Resident refuses lotion. Resident's brother states smells triggers behaviors.			

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	A Progress Note dated, 4/25/2023 at 10:16A.M., indicated Resident 53 had dry leather like skin. Resident's brother stated his skin had always been that way. However, had gotten worse after Cancer treatments. Had Asperger/Autism with behaviors. Brother stated lotions and soaps trigger resident behaviors unknown as too why. Resident has given self-inflicted area to left mandible area. Measured 1.5 cm (centimeter) x 0.5 cm. All parties notified and new orders for hydrocortisone 2.5% apply three times a day RN (as needed) for 14 days. A Progress Note dated, 4/26/2023 at 5:05 A.M., indicated it was reported to nurse by the resident across the hall from this resident that he tried to come in her room and opened her door 3 x during the night. States she told him to go back to his room and he did. Resident also stated that he tried taking her coke from her bedside table a couple of times and that she feels she has to hide her stuff now. Will report behavior to supervisor. The clinical record lacked the documentation to show the physician had been notified of the behaviors from 4/13/2023 to 4/28/2023. A Progress Note, dated 4/26/2023, indicated Resident 53 allowed hydrocortisone to be applied to left mandible area of face. Behaviors have been minimal with redirection and consistency. A Progress Note dated, 4/28/2023 at 2:16 P.M., indicated the resident had been seen today for initial psychiatric visit. Progress notes to follow. New order to start Buspar (antianxiety) 5 mg (milligram) three times a day for anxiety. A Psychiatry Initial Consult note, dated 4/28/2023, indicated Resident 53 was evaluated for initial			

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	visit. The resident had presenting symptoms of: anxiety, cognitive decline, confusion, memory loss and poor decision making. Cognition: oriented to person, poor short-term memory, poor long-term memory, short attention, suspected below normal intelligence. Judgement: moderated impairment. Assessment and plan: major depressive disorder: patient appears depressed, continue Lexapro. Insomnia: no problems with sleep reported. Generalized anxiety disorder: patient has increased anxiety with food and impulsivity Buspar 5 mg three times a day and follow up in 2 weeks or as needed. A Physician's Note dated, 5/4/2023 at 1:38 P.M., indicated routine visit, no new issues. VSS (vital signs stable), chest-clear, abdomen soft non tender, extremities and no edema. Asperger's' syndrome, stable. Plan no changes in POC (plan of care). A Progress Note, dated 5/5/2023 at 3:19 P.M., indicated the resident had been seen today for acute psychiatric visit. Progress notes to follow. New orders: Obtain Valproic acid level and ammonia level on next lab day, D/C (discontinue) Buspar. A Psychiatry Progress Note, dated 5/5/2023, indicated Resident 53 was seen by the psychiatric NP for increased behaviors and aggression and anxiety. A Progress Note, dated 5/26/2023 at 2:09 A.M., indicated the resident had no behaviors observed thus far into shift, however the residents in the room next to his report that he's come into their room several times from the shared bathroom and will just stare at them or say peekaboo. Resident 53 reminded not to go into their room as it was			

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	upsetting them, and he stated ok. Will continue to monitor. A Progress Note, dated 5/31/2023 at 1:10 A.M., indicated Resident 53 had gone into the room next to his via the shared bathroom multiple times and was upsetting the residents in the other room. One of the residents reports that he touched his stuff and touched his face/head and tried to take his glasses. Staff has tried multiple times to redirect him, but he just laughs and seems to think it's funny. Will notify nurse manager of behaviors. The resident presents intrusive behavior- reaching over Nurses station for phone and items on counter, coming behind nurses' station and nutrition room, intrusive of personal space, resident has episodes of entering other residents' room during evening/ sleeping hours. Asked the resident not to reach over counter for phone or other items on counter, block entrance to nurses' station as needed to detour residents from being behind the nurse station and kept nutrition room locked as needed. A Progress Note, dated 5/31/2023 at 9:40 A.M. IDT (interdisciplinary Team) met to review resident wandering. SS (Social Services) is working with family to review alternative living. A Progress Note, dated 5/31/2023 at 3:53 P.M., indicated the resident in room 217 reported that this resident came into his room throughout night and hit him on the forehead. This resident placed on close supervision while asleep and one on one supervision when awake. Responsible party, physician, Director of Nursing, Administrator and ISDH notified. A Progress Note, dated 5/31/2023 at 4:03 P.M., indicated Resident 53 wandered into another			

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	resident room #217 and stood in front of his TV, telling male resident he wanted to watch his TV. He hit the pillow the resident was laying on and hit him in the forehead. Resident was told to leave the room, and eventually left the room. Social Service called the Psych NP to review medications with the Nurse. Resident 53 was on 1 on 1 staff observations until he sleeps- then on 15-minute checks. Social Service staff phoned the residents brother and left a voice mail to return call and ask brother to come in ASAP to discuss resident. A Progress Note, dated, 6/1/2023 at 2:10 P.M., indicated the physician had visited. Reviewed medications, behaviors, one on one status, refusals of labs. Resident had a fear of needles. To check Depakote level. New order to discontinue Risperdal (antipsychotic) and to start Lamictal (anticonvulsant) 25 mg every other day for 2 weeks then daily. If resident responds positive to Lamictal then will discontinue Depakote and lab draw. Add diagnosis of Mood Disorder. Physician states can discontinue one on one supervision at this time, however, can place back on one on one if necessary. Nursing will continue to monitor mood and behaviors. A Progress Note, dated 6/1/2023 at 3:44 P.M., indicated the resident continued one on ones with staff, and will end at 6:00 P.M. Resident 53 had teased staff throughout the day. Would tease about pulling alarm and walk away laughing. The resident noted to be "touchy, feely" with staff, and had no further incidents with residents. A Progress Note, dated, 6/2/2023 at 3:25 A.M., indicated Resident 53 had been placed back on 1:1 monitoring at the start of shift per direction from the Administrator. The resident was witnessed by family member and aide going into			

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	room next door and poking one of the residents on his shoulder and refusing to leave room. Once resident was back in his room, he was banging on the bathroom door trying to get back in room. The resident tried going into room a couple more times but 1:1 aide was able to redirect. Resident 53 had slept off and on and has had 2 cans of beefaroni and 2 cans of Pepsi so far this shift. The resident was in bed awake at this time with the aide at bedside. A Progress Note dated, 6/2/2023 at 12:31 P.M., indicated the one on ones continue. A Referral to (name of hospital) Social Service Staff called Resident 53'sbrother and left a message to return call regarding referral to hospital. A Progress Note, dated, 6/4/2023 at 1:46 AM., indicated the resident was yelling in the halls. Observed throwing pop can at TV and not easily redirected. Denies pain/discomfort. Continues 1:1 supervision. Staff will continue to observe. A Progress Note, dated 6/6/2023 at 2:16 P.M., indicated the Social Service staff spoke with (name of resident's sister) this morning and explained resident would be transferring to (facility name) this afternoon. Sister reported, she understood and stated she wanted resident to get a Neurology appointment. Social Service staff referred her to the Social worker at new facility. During an interview, on 6/21/2023 at 8:30 A.M., the Administrator indicated she did not know the staff were using lotion as an intervention to get the resident to stop doing things he was not to do. She indicated she was never made aware from any staff members that the staff were doing this. When asked if that could be considered a form of abuse she replied yes.			

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	During an interview, on 6/21/20223 at 9:02 A.M., CNA 21 indicated she had cared for this resident and stated she could get him to go out of the nurse's station with food and walking with him. She indicated other staff had used the lotion. During an interview, on 6/21/2023 at 9:07 A.M., Social Service Staff indicated she had told the staff in general to not use the lotion, due to it was a trigger. She had talked with the brother, and he indicated his behaviors started after the cancer treatments. He was a very high functioning resident and was not like this before the treatments. The Social Service staff indicated he liked sports and that would work for him. Stated in general the brother said that tactile things -- lotion would trigger his behaviors. She indicated the resident had been seen by psych services. She stated he did go into the other resident room that shares the bathroom and stands in front of the TV. The resident will say get away and he had pulled the pillow from under his head and touched the resident's forehead. She indicated they had reported this to state, and he had did this to a couple of other residents, as if he was teasing them. His behaviors had escalated and was very impulsive. She stated she had talked with the family on Monday and indicated she would be calling the facility he had come from because they had stated he could come back there if needed. She sent info to the facility, and he was transferred out to the facility on 6/6/2023. 2. During an interview, on 6/15/2023 at 10:47 A.M., Resident 12 indicated her roommate had hit her three times and it took 2 staff members to move her off. Indicated staff had moved her roommate to another room and indicated she has had an anxiety attack because of that.			

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	A record review was completed, on 6/19/2023 at 2:48 P.M. Resident 12's diagnoses included, but were not limited to Bipolar, vascular dementia, depression, anxiety, and Schizoaffective disorder. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/18/2023, indicated Resident 12 was able to make her needs known and had intact cognition. She presented with no behaviors and required extensive staff assist of 2 for bed mobility, transfers, toilet use and dressing. A Nurses' Progress Note, dated 6/14/2023 at 11:23 P.M., indicated a CNA and the resident reported the roommate had grabbed her arm aggressively. Resident 12's roommate was moved to a different room. No injury observed from altercation. Resident 12 tearful and wished for room mate to remain out of room indefinitely. Staff member assigned to sit outside of residents' room to ensure safety. Physician, Administrator and emergency contact notified of event. A Nurse's Progress Note, dated 6/15/2023 at 4:45 P.M., indicated Social Service staff met with Resident 12 to discuss incident with roommate last evening. The resident reported roommate came up to her an hit her on the arm while she was sitting in her recliner. Resident 12 told her to get out and told the staff. She tried to hit me three times yesterday. A Nurse's Progress Note dated 6/15/2023 at 5:22 P.M., Resident 12 indicated her former roommate made her anxious today. A current care plan, dated 6/15/2023, indicated Resident 12 was at risk for change in mood due to recent incident with roommate. Document any			

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	155379	A. BUILDING 00 B. WING	06/21/2023

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	changes in mood and behavior. Notify MD of any changes in mood. Social services will offer support. The Administrator provided a State Reportable Incident, dated 6/14/2023, indicating Resident 23 had grabbed Resident 12's arm. Type of injury: no physical injury, but Resident 12 is tearful and stated she is afraid of Resident 23. A Follow up Reportable, dated 6/20/2023, indicated neither resident have had on-going aggressive behaviors since initial room move. Resident 23 had been started on an antibiotic for UTI (urinary tract infection). Both residents will be seen by psych services. On 6/16/2023 at 1:30 P.M., the Administrator provided the policy titled," Abuse Prevention", dated 10/4/2022, and indicated the policy was the one currently used by the facility. The policy indicated"...It is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation... 2. Identify, correct, and intervene in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur to include trained and qualified, registered, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and sure that the staff assigned have knowledge of the individual resident's care needs and behavioral symptoms, if any... 4. Identify, assess, care plan for appropriate interventions, and monitor residents with needs and behaviors which might lead to conflict or neglect, such as; a. Verbally aggressive behavior; B. Physically aggressive behavior; c. Sexually aggressive behavior; d. Taking, touching, or rummaging through other; s property; e.			

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	Wandering into other's room/space... 8. Identify who is responsible for the supervision of staff on all shifts and how supervision will occur in order to identify inappropriate staff behaviors; 9. Provide staff information on how and to whom they report concerns, such as insufficient staffing or shortage of supplies, without the fear of retribution; and provide feedback regarding the concern they have expressed...." 3.1-27(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the			

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	interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to ensure resident care plan meetings were held timely for 1 of 20 residents reviewed for care plan meetings. (Resident 33) Finding includes: During an initial interview with Resident 33 on 6/15/2023 at 12:09 P.M., she indicated that she was unsure if care plan meetings had occurred. She indicated her granddaughter worked at the facility. On 6/19/2023 a clinical record review was completed. Diagnoses included, but were not limited to: Diabetes Mellitus type 2, chronic kidney disease, and hearing loss. An Annual Minimum Data Set (MDS) Assessment on 5/31/2023, indicated Resident 33 was cognitively intact. A review of the Progress Notes indicated no entries for care plan meetings were documented. There were no documents in the electronic medical record that indicated a care plan meeting had occurred in the past year. During an interview on 6/20/2023 at 10:27 A.M., the Social Service Director indicated that a progress note would be placed when the care plan meeting occurred, and she had a binder that the care plan meeting notes were stored. She indicated the last meeting notes were in March of 2022. She indicated that care plan meetings should occur quarterly, with a significant change, and annually.	F 0657	1. Resident 33 has had care plan scheduled and revised on 06-21-23. 2. An In House audit will be Completed on all residents to validate care plans and conferences were completed going back 90 days to ensure compliance by MDS/SSD by date of compliance. 3. Education will be completed by the CRS to the IDT team on the Regulation on timing and revisions of care plan conferences by date of compliance. 4. DON/Designee will audit 3 charts weekly x 2 months, then 2 charts weekly x 2 months, then 2 charts monthly x 2 months to assure compliance. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits 5. Date of Compliance: July 14th, 2023	07/14/2023

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	A policy was provided on 6/21/2023 at 9:01 A.M., by the Director of Nursing. The current policy titled, "Comprehensive Care Plans and Conferences" indicated, " ...The facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the plan and making decisions about his or her care ...1. Facility staff develops the comprehensive care plan within seven days of the completion of the comprehensive assessment (Admission, Annual or Significant Change in Status) and review and revise the care plan after each assessment ...iii reviewed and revised by the interdisciplinary team after each assessment, including both comprehensive and quarterly review assessments ...3. The facility has a responsibility to assist residents to engage in the care planning process. E.g., helping residents and resident representatives, if applicable, understand the assessment and care planning process, holding care plan meetings at the time of day when the resident is functioning best; planning enough time for information exchange and decision making; encouraging a resident's representative to participate in care planning and attend care planning conferences ...." 3.1-35(d)(2)(B) 3.1-35(e)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that			

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	applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview, record review and observation, the facility failed to ensure a physician's order had been followed for a resident who used a pacemaker monitoring device for 1 of 1 residents reviewed for a heart device. (Resident 11) Finding includes: During an interview, on 6/19/2023 at 10:08 A.M., Resident 11's daughter indicated the staff didn't plug in the pacemaker monitoring device that resident 11's Cardiologist supplied to transmit data from the pacemaker. A record review, was completed on 6/19/2023 at 2:30 P.M. Diagnoses included, but not limited to: heart failure, unspecified atrial fibrillation, and hypertension. A physician's order, dated 3/31/2023, indicated to make sure pacemaker monitoring device is plugged in and functioning every shift. A care plan, dated 9/20/2022 and current through 6/21/2023, indicated Resident 11 had a pacemaker related to heart failure and atrial fibrillation and is at risk for mechanical failure. Interventions included, but were not limited to: nursing staff should check pacemaker monitoring device to ensure it is working properly, dated 3/31/2023.	F 0684	1. Resident # 11 had no adverse reactions. MD notified and new orders received for Pacer checks. Family notified. 2. In house audit completed for residents with pacemakers to assure MD orders in place and being followed for pacer checks and equipment in working order including battery status No other issues were noted. 3. Education will be provided to licensed staff by nursing management to include following order, pacemaker policy, orders accurate and equipment status by date of compliance as well as competencies will be completed on licensed nurses. No nurse will work after date of compliance until education completed. 4. Nursing managers will validate pacer checks being completed as ordered per each resident’s specific order, md notifications, and equipment is in working order ongoing. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits 5. Date of Compliance: July 14th, 2023	07/14/2023

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	A June 2023 Treatment Administration Record (TAR) indicated that both Registered Nurse 9 and Licensed Practical Nurse 11 had signed off as performing the pacemaker monitoring device check for every shift they had been assigned to Resident 11. On 6/19/2023 at 2:40 P.M., RN 9 was observed checking the pacemaker's monitoring device. The monitoring device was plugged in, but not turned on. When the monitoring device was turned on, it showed a dead battery. During an interview, on 6/19/2023 at 2:42 P M., RN 9 indicated he typically takes care of Resident 11 when he works and had last checked the monitoring device a week prior. RN 9 indicated he didn't know how to work the monitoring device and didn't know if there was a manufacturer's manual. During an interview, on 6/20/2023 at 11:30 A.M., the Office Manager of the resident's Cardiology office, indicated the Cardiologist's office had tried to contact the facility by phone unsuccessfully in April to obtain a transfer of information from the pacemaker equipment. The Office Manager indicated a letter had been sent to the facility in April, asking for an upload and included directions to plug in the monitoring device and make sure it is always functioning. When no transmission was received in April, another letter had been sent to the facility in May indicating if a transmission was not received from the pacemaker monitoring device by the end of May 2023, the pacemaker would be turned off. A transmission of data from the pacemaker monitoring device was received at Resident 11's Cardiologist office on May 26, 2023.			

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	During an interview, on 6/21/2023 at 8:48 A.M., LPN 11 indicated she normally took care of Resident 11, and didn't know she had a pacemaker monitoring device, or where the device was located. LPN 11 indicated she had never received an in-service for the use of pacemakers. On 6/21/2022 at 1:15 P.M., a policy for following physician's orders was requested. A policy for following physician's orders was not provided prior to the survey exit. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review and interview, the facility failed to prevent a resident from developing 2 new deep tissue injuries in 1 of 1 resident reviewed for pressure ulcers. (Resident 25) Finding includes:	F 0686	1. Resident # 25 was assessed, Wound observation tool completed, Md and family notified, TX orders obtained, and care plan updated immediately to reflect new area and the fact she kicks her boots off intentionally and refuses at times.	07/14/2023

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	During an observation, on 6/17/2023 at 9:53 A.M., Resident 25 was observed lying in bed with pressure relieving boots at the end of the bed. A record review was completed on 6/20/2023 at 5:34 A.M. Resident 25's diagnoses included, but were not limited to heart failure, anxiety, depression, diabetes, dementia, psychotic disorder, and Schizophrenia. An Annual MDS (Minimum Data Set) Assessment, dated 3/31/2023, indicated the resident had hallucinations and delusions. Required extensive assist of 2 staff for bed mobility, transfers, toilet use and dressing and supervision of 1 staff for eating and had no pressure ulcers. Current physician orders for Resident 25 included: apply skin prep to bilateral heels every shift, float heels while in bed every shift for preventative. Weekly skin assessment: complete skin integrity data collection tool every Saturday. During an observation, on 6/20/2023 at 6:45 A.M., Resident 25 was lying in bed with the pressure relieving booties lying at the end of the bed. With RN/Wound Nurse 19, Resident 25's feet were observed with the following observations: -On the outer aspect of the left foot was a blackened area along the side of the foot approximately 1" in length and 1/2" in width. The posterior of the left foot had a dime sized blacked area along the base of the foot. - On the right foot was a quarter size blackened area to the base of the right heel. During an interview, on 6/20/2023 at 6:55 A.M.,		2. An in house skin sweep was completed by facility to ensure no other areas of concern are identified. An audit has been completed of pressure prevention devices to assure orders in place, any residents who have refusals are care planned for this as well. This will be completed by date of Compliance. 3. Education will be completed by nursing managers on how to report refusals of pressure ulcer interventions and any new pressure ulcers found. This education will include licensed nursing and aides will report to wound nurse as well by date of compliance. No licensed nurses, QMAS, or nursing aides will work after date of compliance until education completed. 4. Nursing manager's will observe 5 residents weekly x 3 months, then 3 residents weekly for 3 months to ensure anti pressure interventions are in place. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits. 5. Date of Compliance: July14th,2023	

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	RN 19 indicated the resident had seen the wound physician for a couple weeks. She indicated the areas to the left foot were not present there yesterday, and they had a hard time trying to see the residents' feet. RN 20 indicated the area to the right heel was a combination of diabetic and DTI (deep tissue injury) per the wound physician and the treatment to the area was painting the area with betadine (topical antiseptic). A current care plan, dated 9/20/2022, indicated Resident 25 had an ADL (activity of daily living) self-care performance deficit related to confusion, dementia, and limited mobility. Interventions included but were not limited to: resident requires limited to extensive weight bearing assist to perform bed mobility, toileting, and transfers. Bathing. Showering: provide sponge bath when full bath or shower cannot be tolerated. A current care plan, dated 6/8/2023 and updated on 6/20/2023, indicated the resident had the potential for pressure ulcer and diabetic ulcer development related to history of ulcers, visual deficits, impaired cognition, diabetes, incontinence and need for assist in ADL (activities of daily living) activities. DTI's (deep tissue injury) to right heel and left lateral foot. Resident often becomes combative when staff attempts to apply pressure reducing devices such as heel boots. Interventions included but were not limited to: Educate the resident/family/caregivers as to causes of skin breakdown; including transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition, and frequent repositioning. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Heel boots to bilateral feet as resident allows (if resident refuses attempt to offload with pillows)			

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	initiated 6/19/2023. Serve diet as ordered, monitor intake and record. The resident needs moisturizer applied daily to skin. Do not massage over bony prominence's and use mild cleansers for peri-care/washing. The resident requires supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing. The resident requires pressure reducing mattress and wheelchair cushion. During an interview, on 6/20/2023 at 1:26 P.M., QMA 2 indicated the resident indicated the resident dose wear the booties, but we are constantly having to put them back on. She indicated if an area was found, the nurse would be called to look at the area. QMA 2 indicated the resident received showers two times a week. During an interview, on 6/21/23 at 11:42 A.M., the Wound nurse indicated the wound were preventable. Shower sheets for Resident 25 were provided for May and June 2023. Resident 25 had received a shower on the following dates: 5/1, 5/4, 5/9, 5/11, 5/15, 5/18/2023. Resident 25 had not received a shower on the following dates due to refusals: 5/22, 5/25, 5/29, 6/1, 6/5, 6/8, 6/12, and 6/15/2023. Weekly nursing skin integrity data sheets dated 5/27, 6/3, and 6/17 indicated no skin issues and skin intact. A Nursing Wound Observation Tool, dated 6/12/2023, indicated Resident 25 had an acquired pressure area to the right anterior heel. The stage was unstageable. Specify: DTI (deep tissue injury). Describe other: calloused area. The area measured 1.7 cm length x 2.0 cm width and 0 cm depth. Current treatment included betadine and			

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	weekly wound rounds. A Wound Evaluation & Management Summary, dated 6/12/2023, indicated the resident was ambulatory with walker, for transfer. Unstageable DTI of the Right Heel- Partial thickness. Measured: 1.7 cm Length X 2.0 cm Width with the dept not measured. Dressing Treatment Plan: Betadine apply once daily for 30 days. Plan of Care Reviewed and Addressed: Off- load Wound: Pressure Off-loading Boot. A Weekly Skin Integrity Data Collection form, dated 6/17/2023, indicated Resident 25's skin was intact and no new findings. A Wound Evaluation & Management Summary, dated 6/19/2023, indicated the resident had wounds on the right heel. Was ambulatory with walker, for transfer of left lower extremities: No edema, Foot warm, wound present. Examination of the right lower extremities: No edema, Foot warm, wound present. Unstageable DTI of the Right Heel- Partial thickness. Measured: 1.5 cm Length X 1.8 cm Width with the dept not measured. Dressing Treatment Plan: Betadine apply once daily for 23 days. Plan of Care Reviewed and Addressed: Off- load Wound: Pressure Off-loading Boot. A Nursing Wound Observation Tool, dated 6/20/2023, indicated Resident 25 had an acquired pressure ulcer to the left lateral foot. Stage was unstageable. Specify: DTI (deep tissue injury). First observed. The area measured 2.0 cm length x 0.8 cm width and 0.1 cm depth. Current treatment included betadine and weekly wound rounds. A Braden Scale (For Predicting Pressure Sore Risk) form, dated 6/20/2023, indicated Resident 25			

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	was slightly limited to sensory perception; occasionally moist; chairfast; could not bear own weight; had no limitations in mobility-made major and frequent changes in position; adequate nutrition; and potential problem with friction/shear- moves feebly in bed or requires minimum assistance. Mild risk was between 15-18 points. Resident 25 score was 17 points, indicating at low risk. Risk factors checked as apply included: decreased or Impaired Bed/Chair Mobility, existing pressure ulcers, incontinence, pain that effects movement or mood and diabetes. During an interview, on 6/21/2023 at 11:42 A.M., RN 19 indicated the wounds were preventable. On 6/21/2023 at 11:49 A.M., the Director of Nursing provided the policy titled," Skin Integrity & Pressure Ulcer/Injury Prevention and Management", undated, and indicated the policy was the one currently used by the facility. The policy indicated..." A skin assessment/inspection occurs on admission/readmission. Skin observation also occur throughout points of care provided by CNA's during ADL care (bathing, dressing, incontinent care, ect). 3. A skin assessment/inspection should be performed weekly by a licensed nurse. 4. Measures to maintain and improve the residents tissue tolerance to pressure are implemented in the plan of care...4. a) skin inspections with particular attention to bony prominence's... 5. b). utilize positioning devices to keep bony prominences from direct contact; c). ensure proper body alignment when side- lying; d). heel protection/suspension if indicated... 7. When skin breakdown occurs, it requires attention and a change in the plan of care may be indicated to treat the resident...."			

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	155379	A. BUILDING 00 B. WING	06/21/2023

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	3.1-40			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on interview, record review, and observation, the facility failed to ensure nursing staff were competent in using a pacemaker	F 0726	1. 1. Resident # 11 had no adverse reactions. Md notified and new orders received for Pacer	07/14/2023

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	monitoring device for 1 of 1 residents reviewed who required mechanical device monitoring. (Resident 11) Finding includes: During an interview, on 6/19/2023 at 10:08 A.M., Resident 11's daughter indicated the staff didn't plug in the pacemaker monitoring device the Cardiologist supplied to transmit data from the pacemaker. A record review, completed on 6/19/2023 at 2:30 P.M. Resident 11's diagnoses included, but not limited to, heart failure, unspecified atrial fibrillation, and hypertension. A physician's order, dated 3/31/2023, indicated to make sure pacemaker monitoring device is plugged in and functioning every shift. A care plan, dated 9/20/2022 and current through 6/21/23, indicated Resident 11 had a pacemaker related to heart failure and atrial fibrillation and is at risk for mechanical failure. Interventions included but were not limited to nursing staff should check pacemaker monitoring device to ensure it is working properly, dated 3/31/2023. On 6/19/2023 at 2:40 P.M., RN 9 was observed checking the pacemaker's monitoring device. The monitoring device was plugged in, but not turned on. When the monitoring device was turned on, it showed a dead battery. During an interview, on 6/19/2023 at 2:42 P.M., RN 9 indicated he typically takes care of Resident 11 when he works and had last checked the monitoring device a week prior. RN 9 indicated he didn't know how to work the monitoring device		checks. Family notified. 2. 2. In house audit completed for residents with pacemakers to assure MD orders in place and being followed for pacer checks and equipment in working order including battery status No other issues were noted. 3. Education will be provided to licensed staff by nursing management to include following order, pacemaker policy, orders accurate and equipment status by date of compliance as well as competencies will be completed on licensed nurses on pacer checks by nursing management by date of compliance. No nurse will work after date of compliance until education/competency has been completed. 4. Nursing managers will perform pacer check competencies on licensed nurses as follows. 2 competency checks weekly x 2 months, then 1 competency check weekly x 2 months, then 1 competency check every other week x 2 months, then 1 competency check monthly ongoing. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits 5. Date of Compliance: July 14th, 2023	

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	and didn't know if there was a manufacturer's manual. During an interview, on 6/19/2023 at 2:50 P.M., the Director of Nursing indicated that she didn't know how to operate the pacemaker monitoring device and didn't know where the manufacturer's manual was, but she would locate the manual. A manual was never provided. During an interview, on 6/20/2023 at 10:22 AM, Registered Nurse 9 indicated that he has never received training on pacemakers or pacemaker monitoring devices while employed at the facility. During an interview, on 6/20/23 at 10:45 A.M., RN 19 indicated she was responsible for education of the staff, and if a resident was admitted with special medical equipment, she provided an in-service to provide education to staff on the medical equipment. RN 19 indicated she couldn't remember if she had an in-service for pacemakers but indicated she should have provided an in-service to staff. A request for any in-service training on pacemakers was requested but no in-service records for pacemaker education was provided. During an interview, on 6/20/2023 at 11:30 A.M., the Office Manager of the resident's Cardiology office indicated the Cardiologist's office had tried to contact the facility by phone unsuccessfully in April to obtain a transfer of information from the pacemaker equipment. The Office Manager indicated a letter had been sent to the facility in April, asking for an upload and included directions to plug in the monitoring device and make sure it is always functioning. When no transmission was received in April, another letter had been sent to the facility in May indicating if a			

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	transmission was not received from the pacemaker monitoring device by the end of May 2023, the pacemaker would be turned off. A transmission of data from the pacemaker monitoring device was received at Resident 11's Cardiologist office on May 26, 2023. During an interview, on 6/21/2023 at 8:48 A.M., LPN 11 indicated she normally took care of Resident 11, and didn't know she had a pacemaker monitoring device, or where the device was located. LPN 11 indicated she had never received an in-service for the use of pacemakers. On 6/20/2023 at 11:30 A.M, RN 19 provided the policy titled," Permanent Pacemaker", revised on 7/20/2016 and indicated the policy was the one currently used by the facility. The policy indicated " ...the facility will assist in facilitating the check of the pacemaker in accordance with the schedule set by the resident's cardiologist			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			

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	§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, record review and interview, the facility failed to ensure medication carts were free from loose pills, failed to date medication when opened and failed to ensure the freezer section of a medication refrigerator was free from ice buildup in 3 of 3 medication storage areas observed. (Central Hall medication cart, Skilled Hall medication cart and South Hall Medication room) Findings include: 1. During a medication storage audit, on 6/17/2023 at 10:45 A.M., with LPN 20 on the Central East medication cart, the following was observed: 5 loose pills and 3 pieces of a white pill were observed in two of the med cart drawers. During an interview, on 6/17/2023 at 10:46 A.M., LPN 20 indicated the loose pills should not be in the cart. 2. During a medication storage audit, on 6/17/2023 at 10:50 A.M., with LPN 20 on the Central Hall medication cart, the following was observed: - A packaged Loperamide (anit-diarrhea) pill in the drawer and an opened and undated bottle of Lactulose (laxative and ammonia reducer).	F 0761	1. Med carts cleaned immediately, date open stickers placed where needed on medications and medication refrigerator/ freezer defrosted. 2. Medication and Treatment carts have been cleaned, date open stickers placed on appropriate medications and any medication refrigerators/freezers have been checked for ice buildup by date of compliance. Any concerns noted have been addressed. 3. Education will be provided to nurses and QMAS on the policy for med storage and appropriate labeling using date open stickers as well as policy for ice buildup on medication refrigerators and freezers by nursing management by date of compliance. No nurses or QMAS will work past date of compliance without this education completed. 4. Nursing managers will check 3 med/ carts and the medication refrigerators weekly x 2 months and then 2 times weekly x 2	07/14/2023

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	During an interview, on 6/17/2023 at 11:00 A.M., LPN 20 indicated the pill should not be in the cart and the liquid should have been dated when opened. 3. During a medication storage audit, on 6/17/2023 at 11:00 A.M.,with LPN 20 on the South Hall medication room, the following was observed: - The medication/iv refrigerator had a large build up of ice in the freezer section of the fridge where the door to the area could not be moved. During an interview, on 6/17/2023 at 11:02 A.M., LPN 20 indicated the refrigerator/freezer should have been defrosted. On 6/17/2023 at 11:13 A.M., RN 19 provided the policy titled,"Storage and expiration dating of Medications and Biological's", dated 7/1/2022, and indicated the policy was the one currently used by the facility. The policy indicated"... 3.4 Facility should ensure that infusion therapy products and supplies are stored separately from other medications and biological's, under appropriate temperature... 5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened... 17. Facility should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis...." 3.1-25(j) 3.1-25(q)		months then weekly x 2 months to ensure compliance. Audits will be presented to QAPI x 6 months and Qapi will determine the need for further audits. 5. Date of Compliance: July 14th, 2023	

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to provide a cleanly kitchen environment with proper sanitation for 1 of 1 kitchens. This deficient practice had the potential to affect 55 of 55 residents who ate their meals in the kitchen. Findings include: On 6/15/2023 at 7:52 A.M., during the initial tour of the kitchen, the following was observed: - A bottle of 409 spray cleaner with Lawry's seasoning salt and a bucket of puree bread mix was observed on the bottom shelf of a three-tiered cart by the steam table.	F 0812	1. The bottle of 409 spray was immediately removed from the bottom shelf of the three-tier cart. 2. The stove top was cleaned on the top and all six wells were cleaned. The outside oven, convection oven, and knife holder were cleaned to remove food debris. 3. The stainless-steel storage drawers were cleaned and liners placed in each drawer. 4. The stainless six-drawer counter drawers were cleaned to remove food debris.	07/14/2023

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	- The stovetop had food debris on top and three of the six wells had significant debris. The outside oven, convection oven, and knife holder had food debris visible. - The stainless-steel storage drawers with ladles, spoons, and spatulas in the first drawer, scoops in the second drawer, and whisks, large utensils and miscellaneous in the third drawer, had visible rust in the drawers. There were no coverings in the drawers. - A stainless steel six-drawer counter containing paper products of lids, souffle cups, bowl lids, condiment cups, cupcake liners, hand mixer with beaters, and plastic storage container lids had food debris in the drawers. During an interview on 6/15/2023 at 8:18 P.M., Dietary Aide 19 indicated the red bucket was the sanitation bucket for surfaces. She tested the bucket with a Hydrion test strip that indicated a test of 150. She felt the test was a proper sanitation concentration. She indicated that the test strip should be greater than 400 and 200 was the best testing indicator. The test strips used had an expiration date of 11/15/2021. She read the test strips and indicated the date on the cartridge. Dietary Aide 19 indicated she did not know the test strips had an expiration date. During handing of a bag of 10 test strips, she indicated, "I see this has an expiration of March 1." During an observation on 6/20/2023 at 9:38 A.M., the oven continued to have food debris. There were no sanitation buckets prepared for table sanitation. The expired test strips were still available for use. The stainless steel six-drawer still had food debris observed.		5. The oven was cleaned of food debris. The expired test strips were discarded and replaced with new ones. Sanitation buckets were prepared at the appropriate levels. 6. The stainless steel six-drawer was cleaned to remove food debris. 1. The dietary staff will be in-serviced by the Dietary Manager on the Sanitation and Maintenance Policy, Safe Chemical Storage and cleaning schedules on or before 7-14-23. No kitchen employee will work until education completed. 2. Executive Director and/or designee to perform random audits of the kitchen a minimum of 3 times weekly on various shifts for the next 60 days and then twice weekly for 60 days and then weekly for 60 days. Any concerns identified will be addressed immediately. Audits will be presented to QAPI x 6 months then QAPI will determine the need for further audits. Compliance date: 7/14/23. The Administrator at Life Care Center of Rochester is responsible in ensuring compliance in the Plan of Correction.	

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	During an interview on 6/20/2023 at 9:43 A.M., the Dietary Manager indicated chemicals should not be mixed with food products. She indicated the sanitation test strips should not be used if outdated. During an interview on 6/21/2023 at 11:59 P.M., the Dietary Manager indicated the sanitation solution utilized was Quat 40. A policy was provided on 6/21/2023 at 9:01 A.M. The policy titled "Safe Use of Chemicals", indicated, " ...Serve, prepare, describe and serve food in accordance with professional standards for food device safely ...3. When chemicals are not in use, they are stored in a designed area away from any food products ...." A policy was provided on 6/21/2023 at 9:01 A.M., titled "Cleaning Schedule". The current policy indicated, " ...1. The Director of Food and Nutrition Services develops a cleaning schedule to include all equipment and areas to be cleaned ...4. The Director of Food and Nutrition Services monitors the cleaning schedule to ensure the tasks are completed timely and appropriately ...." On 6/21/2023 at 9:01 A.M., the Director of Nursing provided the policy titled, "Sanitation and Maintenance". The current policy indicated, " ...3. The Director of Food and Nutrition Services develops a cleaning schedule and posts the schedule each month ...." 3.1-21(i)(2)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions			

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	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review and interview, the facility failed to ensure a functional, sanitary and comfortable environment was maintained in 2 of 4 halls observed for environment.(South Hall and Central Hall) Findings include: During an environmental tour, on 6/22/2023 at 11:35 A.M., with the Maintenance Director the following items were observed on the South Hall: - Room 316 The entry room door had gouged unpainted areas. Dark brown spots were on the floor by bed 1. A headboard was off the bed. the bathroom doors were scratched and had missing paint, the floor was stained and had wet floor tiles under the toilet with a strong urine smell. - Room 317 had gouged doors, walls, floors with black marks in the entrance to the room. - Room 318's entry door had gouges and missing paint. - Room 320 the doors to the room and the bathroom had gouges with missing paint. The floor in the bathroom had black marks along the bathroom entrance. - Room 321's entry door had a large area of gouged and missing paint. The bathroom inside door was gouged, a strong urine smell under the toilet and rust looking tiles were around the toilet. - Room 322's room door was gouged and had areas of missing paint. A wall by the bathroom door had spackled areas that were not painted. - Room 323's floor in the bathroom had black marks, a patched unpainted area to the wall and the door had gouged areas and missing paint.	F 0921	1. The exterior doors in rooms 316, 317, 318, 320, 321, 322, were repaired and painted. The headboard was placed back on the bed, toilet was checked for leaks and repaired. The floors in rooms 317, 320, 323 and 324 were cleaned. Tile has been ordered for rooms 316 and 321 and will be replaced once arrives. Rooms 322 and 323 the walls that were sited have been put on the work schedule to be painted. Room 324 numbers were replaced. 2. The heater/air conditioner cover in the quiet TV lounge was repaired. 3. The wall outside of the kitchen door was repaired. 1. The Maintenance Director/Housekeeping Supervisor will be in-serviced on the Preventative Maintenance Program by the Executive Director by 7-14-23. 2. Maintenance Director and/or designee will include identified areas in the current preventative maintenance program and conduct routine resident room rounds according to facility protocol utilizing the TELS system.	07/14/2023

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	- Room 324 had a missing room number out side of the door. The floor by bed 1 had dark brown stains under and bedside the bed. During an environmental tour on 6/21/2023 of the Central Halls the following was observed: - In the quiet TV lounge across from the nurse's station the cover to the heater/air conditioner was falling off the left side of the unit. - Outside of the kitchen door the wall with carpeting along side of it had a gouged area with exposed dry wall. During an interview, on 6/21/2023 at 11:45 P.M., the Maintenance Director indicated he was looking at a different hall every week and tries to complete the important things as they arise. He indicated the painting, patches and other areas should have been repaired. On 6/21/2023 at 11:49 A.M., the Director of Nursing provided the policy titled," Preventative Maintenance Program", dated 1/11/2023, and indicated the policy was the one currently used by the facility. The policy indicated"...The Plan Operations/Maintenance Department will respond to and correct identified problems within the scope of their operations or arrange for the correction by a qualified individual in a timely manner. Corrective actions will be recorded in TELS...." 3.1-19 (f)		3. The Housekeeping Supervisor will conduct routine resident room rounds according to the facility protocol. 1. The Maintenance Director and/or Designee to conduct resident room observation 3x weekly for the next 3 months, and then weekly ongoing through the facility preventive maintenance process through TELS to ensure the resident's environment is in good repair from gouged/scratched doors, flooring repairs and all general repairs. 2. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for a total of 6 months and then quarterly thereafter. Any issues identified will be immediately addressed and all results will be discussed and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary. QA will determine the need for further audits.	

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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
F 9999 Bldg. 00	State Rules 3.1-14 PERSONNEL (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:	F 9999	1. No negative results noted. 2. Facility will complete an In House audit of all current employees' files to ensure any concerns are addressed by date of compliance. 3. ED will educate department heads involved in employee files on what is required and when by date of compliance. 4. New employee files will be audited by the ED/Designee going forward once completed ongoing. Audits will be presented to QAPI x 6 months and Qapi will determine the need for ongoing audits. 5. Date of Compliance: July 14th, 2023	07/14/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155379	A. BUILDING 00 B. WING	06/21/2023

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	(3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination; and (B) reports of all employment-related health examinations. This state rule was not met as evidenced by: Based on interview and record review the facility failed to provide pre-employment references for 4 of 5 employee records reviewed, pre-employment physicals for 5 of 5 records reviewed, general orientation for 1 of 5 records reviewed, and resident right's education for 1 of 10 records reviewed. Findings include: A review of employee records was completed on 6/20/2023 at 1:54 P.M. 1. A review of the records indicated, CNA 12 had a form titled, "Initial/Annual Associate Physical Examination & Assessment". The form provided vital signs and recommendations based on vital signs to be completed and signed by a licensed medical professional with an LPN signature. No professional or personal references were located in the employee file. 2. A review of the records indicated, QMA 13 had a form titled, "Initial/Annual Associate Physical Examination & Assessment". The form provided vital signs and recommendations based on vital signs to be completed and signed buy a licensed medical professional and had an LPN signature. No professional or personal references were located in the employee file.			

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	3. Housekeeper 14 had a form titled, "Initial/Annual Associate Physical Examination & Assessment". The form provided vital signs and recommendations based on vital signs to be completed and signed buy a licensed medical professional and had an LPN signature. No professional or personal references were located in the employee file. The general and specific job descriptions were not found in the provided file. 4. A review of the records of Cook 15 indicated, a form titled, "Initial/Annual Associate Physical Examination & Assessment". The form provided vital signs and recommendations based on vital signs to be completed and signed buy a licensed medical professional with an LPN signature. No professional or personal references were located in the employee file. Specific job orientation was not found in the file. 5. A review of the records of Physical Therapist 16 had a form titled, "Initial/Annual Associate Physical Examination & Assessment". The form provided vital signs and recommendations based on vital signs to be completed and signed buy a licensed medical professional with an LPN signature. 6. A review of the records of Dietary Aide 17 indicated no education on resident rights. During an interview on 6/21/2023 at 10:26 A.M., the Payroll Personnel indicated a tuberculosis test, blood pressure, pulse, and sometimes oxygen saturation are obtained for a pre-employment physical by a nurse. She indicated a medial doctor or nurse practitioner does not oversee the pre-employment physical. During the review of employee files on 6/21/23			

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	10:26 A.M., the Payroll Personnel indicated CNA 12 did not have references since this was her first job, and no references were returned. She indicated QMA 13 did not have any references on file. She indicated Cook 15 did not have references. She indicated Housekeeper 14 had not completed general orientation. She looked in the file, and found a blank general orientation form without signatures or dates for Housekeeper 14. A review of CNA 15's file could not identify a specific orientation. Dietary Aide 17 did not have resident's rights training. A policy was provided on 6/21/2023 at 12:31 P.M., by the Director of Nursing. The current policy titled, "Personnel Policies and Procedures", indicated, "...Each associate has a complete employment record, which is kept confidential, The record contains:...Current associate health status report...." A Policy was provided on 6/21/2023 at 12:31 P.M. by the Infection Preventionist Nurse. The policy titled, "Reference Check Policy", indicated, "...Satisfactory completion of the reference check process is a prerequisite for any offer of employment or other status with Life Care...." A policy was provided on 6/21/2023 at 12:31 P.M., by the Director of Nursing. The current policy titled, "Education and Training Requirements", indicated, "...9. The following training requirements should be met prior to associates and volunteers independently providing services to residents, annually, and as necessary based on the facility assessment...b. Resident rights and facility responsibilities (F942)...."			