STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155249	A. BUILDING 00 B. WING	08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHATEAU REHABILITATION AND HEALTHCARE CENTER	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00412354. Complaint IN00412354 - No Federal/State deficiencies related to the allegations are cited. Survey dates: August 2, 3, 4, 7 and 8, 2023 Facility number: 000153 Provider number: 155249 AIM number: 100266910 Census Bed Type: SNF/NF: 87 Total: 87 Census Payor Type: Medicare: 6 Medicaid: 65 Other: 16 Total: 87 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 10, 2023	F 0000	8/22/23 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis Indiana 46204 RE : Survey event ID 495J11 Chateau Rehabilitation and Healthcare 6006 Brandy Chase Cove Fort Wayne IN 46815 Dear Ms Buroker: A Recertification and State Licensure with Complaint survey (IN00412354) was conducted by the Indiana State Department of Health on August 2-8th 2023. Enclosed please find the Statement of Deficiencies with facilities Plan of Correction for the alleged deficiencies. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of 9-8-23 Please feel free to call me with	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tricia Myers	Director of Nursing	08/23/2023

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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			any further questions at 1-260-486-3001. Respectfully submitted, Cathy Vasil HFA Executive Director	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other			

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	applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.			
	Based on observation, interview and record review the facility failed to ensure privacy related to medical treatments for 1 of 24 residents reviewed. (Resident 144). Findings include: During an observation on 8/2/23 at 9:25 AM the following was observed: Resident 144 was sitting in a reclining chair in their room. Taped to the chair was an 8" x 11" sign titled "Dialysis". The sign indicated the resident's first initial, last name and 9:45 AM. Resident 144's record was reviewed on 8/2/23 at 2:14 PM. Diagnoses included diabetes and chronic kidney disease. A review of Resident 144's current Comprehensive Minimum Data Set (MDS) indicated their Basic Interview for Mental Status (BIMS) score was 7 (severe cognitive impairment). The MDS indicated the resident received dialysis. In an interview on 8/823 at 1:13 PM, QMA 8 indicated it was the facility's normal practice to label dialysis transport chairs with the resident's name and time of dialysis. A current policy (no date) provided by the Administrator indicated confidential resident information was to be disclosed only to those authorized to receive it.	F 0583	**F-583 Personal Privacy/Confidentiality of Records** **The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** Resident number 144 no longer resides at this facility. Signage was immediately removed from chair upon discovery. **2. How the facility identified other residents:** All other residents receiving dialysis in this facility have the potential to be	09/08/2023

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	3.1-3(o)		affected by this practice. Audit conducted for all other residents receiving dialysis services in this facility for HIPPA violation signage. All signage removed from dialysis chairs. **3. Measures put into place/ System changes:** Facility staff and dialysis staff were educated on HIPPA/privacy practices. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the executive director/designee who will audit dialysis chairs for HIPPA breech for 3 times a week x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. **Date of Compliance:** 9/8/2023	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a			

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	nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.			
	Based on interview and record review the facility failed to provide the resident with a written explanation of the Notice of Transfer or Discharge within 24 hours of a hospital transfer for 2 of 18 residents reviewed (Resident 34 and Resident 20). Findings include: 1.Resident 34's record was reviewed on 8/3/23 at 2:48 PM. Diagnoses included end stage renal disease, acquired absence of left fingers, 3rd 4th, and 5th digits, and type 2 diabetes mellitus with diabetic neuropathy, unspecified.	F 0625	**F-625 Notice of Bed Hold Policy Before/Upon Trnsfr** **The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to**	09/08/2023

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	A review of Resident 34's current quarterly Minimum Data Set (MDS) indicated their BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact). The MDS indicated Resident 34 received dialysis. A review of a Notice of Transfer or Discharge form dated 6/14/23 did not contain a resident signature or indication the resident was unable to sign at transfer or indication of a copy being given to or mailed to a resident representative. During an interview on 8/8/23 at 10:26 AM the Social Services Director indicated upon discharge from the facility nursing staff should call the resident or their representative and provide transfer information if they are unable to personally had deliver the policy at the time of discharge. During and interview on 8/8/23 at 10:23 AM, Licensed Practical Nurse (LPN) 3 indicated the management team is notified when a transfer policy is not able to be delivered to a resident when nurses are not able to hand deliver the notice at the time of discharge.2.Resident 20's record was reviewed on 8/3/23 at 2:17 PM. Diagnoses included unspecified dementia, unspecified psychosis not due to a substance or known physiological condition, anxiety disorder, recurrent major depressive disorder, and type 2 diabetes mellitus. A review of Resident 20's current quarterly Minimum Data Set (MDS) assessment indicated his BIMS (Basic Interview for Mental Status) score was 11 (mild cognitively impaired). A review of a Notice of Transfer or Discharge form dated 4/29/23 did not contain a		**continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** Resident 34 no longer resides in facility. Was sent notice of bed hold/transfer/discharge paperwork. Resident 20 was provided with notice of transfer/discharge paperwork. **2. How the facility identified other residents:** Any resident discharging from the facility has the potential to be affected. **3. Measures put into place/ System changes:** staff educated on components of F625 notice of bed hold policy, including requirements for notice to be provided to resident/ responsible party upon discharge, including the statement of appeal rights. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the social services/designee who will audit discharged resident records to for	

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	resident/representative signature, indicate the resident was unable to sign at the time of transfer or indicate a copy was mailed/given to the resident/representative. A review of progress notes dated 4/29/23 did not contain an indication the resident/representative was notified of the Notice of Transfer or Discharge Notice. During an interview on 8/7/23 at 10:22 AM the Director of Social Services indicated Resident 20's Notice of Transfer or Discharge Notice was not given to the resident/representative at the time of transfer or mailed out and it should have been. During an interview on 8/8/23 at 10:26 AM the Social Services Director indicated upon discharge from the facility nursing staff should call the resident or their representative and provide information if they are unable to personally deliver the transfer policy at the time of discharge. During an interview on 8/8/23 at 10:23 AM, Licensed Practical Nurse (LPN) 3 indicated the management team is notified when a transfer policy is not able to be delivered to a resident when nurses are not able to hand deliver the notice at the time of discharge. During an Interview on 8/7/23 at 2:15 PM the Administrator indicated the Transfer Policy the facility used was the same as the Discharge Policy Notice provided to the resident on transfer. A current policy titled "Bed Hold Policy Notice", undated, provided by the Administrator on 8/7/23 at 2:15 AM provided no pertinent to the citation. No further information was provided by survey exit.		notice of discharge and provision of appeal statement for compliance with regulation weekly x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance** 9/8/2023	

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	3.1-12(a)(25)(26)			
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on observation, interview, and record review the facility failed to ensure a nurse's permission was obtained prior to the administration of a pro re nata (prn or as needed) medication by a Qualified Medication Aide for 1 of 16 residents observed during medication pass (Resident 143). Findings include: During a continuous medication pass observation on 8/7/23 at 11:20 AM a family member approached Qualified Medication Aide (QMA) 4 and indicated Resident 143 needed pain medicine. After finishing the task she was completing, QMA 4 interviewed resident 143 for his pain level and administered Hydrocodone/Acetaminophen 5/325 mg, 2 tablets (a controlled substance for pain). Resident 143 answered questions correctly indicating alertness and orientation to person, place, and time. QMA 4 did not consult a nurse prior to the administration of the medication. Resident 143's record was reviewed on 8/7/23 at 2:21 PM. Diagnoses included partial traumatic amputation of the left foot, level unspecified, subsequent encounter, type 2 diabetes with diabetic neuropathic arthropathy, and peripheral vascular disease.	F 0658	**F-658 Services Provided Meet Professional Standards** **The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** Resident 143 was assessed for pain and side effects of medication administration. **2. How the facility identified**	09/08/2023

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	A review of an Admission Observation form dated 8/1/23 at 5:21 PM, Resident 143 was identified as alert and oriented to person, place, and time. Resident 143's admission MDS was not due for completion at the time of review. A review of physician orders dated 8/3/23 at 1:45 PM indicated Hydrocodone/Acetaminophen 5/325 mg 2 tablets was ordered to be given every 6 hours as needed for pain. In an interview on 8/7/23 at 11:40 AM Licensed Practical Nurse (LPN)3 indicated QMA 4 had not discussed administering a prn medication with her that day. LPN 3 indicated QMA staff should discuss any requested prn medication with her prior to administration. In an interview on 8/7/23 at 11:43 AM QMA 4 indicated she did not believe she needed to obtain a nurse's permission to administer a prn medication. A current policy, undated, titled Qualified Medication Aide Scope of Practice provided on 8/7/23 at 12:10 AM by the Regional Nurse Consultant indicated a QMA should only administer a prn medication if given permission by a Licensed Nurse. A current document titled QMA Scope of Practice from the Indiana Department of Health website indicated under (11) Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility ' s licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (C) Obtain permission to administer the medication each time the symptoms occur in the resident.		**other residents:** Any resident prescribed prn medications administered by QMA's have the potential to have be affected. **3. Measures put into place/ System changes:** Nursing administrative staff educated floor nurses and QMA's on QMA scope of practice and need to have approval from licensed nurse before administering PRN med. Floor nurse to complete corresponding assessment. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing/designee who will audit Medication administration record (MAR)/Progress Note for compliance with regulation days a weekly x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance 9/8/2023**	

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	3.1-25(b)(8)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on interview and record review the facility failed to ensure assessment and implementation of care according to individualized resident needs for 2 of 19 residents reviewed. (Residents 48 and 144) Findings include: 1. Resident 144's record was reviewed on 8/2/23 at 2:14 PM. Diagnoses included diabetes and chronic kidney disease. A review of Resident 144's current Comprehensive Minimum Data Set (MDS) indicated their Basic Interview for Mental Status (BIMS) score was 7 (severe cognitive impairment). The MDS indicated the resident received dialysis. A review of physician orders dated 7/27/23 indicated Resident 144's dialysis access site was to be monitored for pain, redness, warmth, swelling or abnormal drainage every shift. The physician order did not include an order for a dressing to the site.	F 0684	**F-684 Quality of Care** **The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken**	09/08/2023

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	A review of Resident 144's dialysis communication book indicated the resident's dialysis catheter site was to have a clean dressing applied if the dressing became soiled or dislodged between treatments. A review of Resident 144's dialysis communication book indicated on 7/27/23 and 7/28/23 the resident arrived at the dialysis unit without a dressing on the dialysis catheter site. In an interview on 8/7/23 at 3:06 PM, the Administrator indicated the facility should have obtained a physician order for a dressing to the dialysis catheter site. A current policy dated 11/2020 provided by the Administrator indicated the nurse would assess the dialysis catheter site for any signs of drainage and condition of the dressing every shift. 2. Resident 48's record was reviewed on 8/3/23 at 2:56 PM. Diagnoses included rectal cancer, diabetes, amputation of right foot, and chronic congestive heart failure. A review of Resident 48's current Comprehensive Minimum Data Set (MDS) indicated their Basic Interview for Mental Status (BIMS) score was 5 (severe cognitive deficit). The MDS indicated the resident was able to usually make needs known and usually understood return communication. The MDS indicated the resident occasionally had moderate pain. The MDS indicated the resident had received routine doses of pain medicine. The MDS indicated the resident had not received pain medicine as needed (PRN) and had not received non-medication interventions for pain relief. A review of Resident 48's most recent Care Plan		**for those residents identified:** Resident 144 and 48 no longer reside at this facility. **2. How the facility identified other residents:** All residents on hospice or with dialysis catheters have the potential to be affected by this practice. **3. Measures put into place/ System changes:** Nursing staff educated on Change in condition and family/hospice notification and collaboration of care with hospice provider. Licensed Nurse to ensure that dressing present over Inner Jugular dialysis cath and that orders are in place to check that dressing present and intact and no signs and symptoms of infection present. 4. **How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing /designee who will audit for presence of change of condition and family/hospice notification and collaboration and Licensed Nurse to ensure that dressing present over Inner Jugular dialysis cath and that orders are in place to check that dressing present and intact and no signs	

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	indicated the resident was admitted to hospice services with a goal of hospice and facility staff would collaborate to provide comfort care through 7/14/23. Interventions included comfort care, hospice was to be notified of increased pain or any change in condition. A review of physician orders dated 6/8/23 indicated the resident was to be administered hydrocodone (a narcotic pain medication) by mouth every 6 hours as needed for pain. A physician order dated 5/28/23 indicated the resident was to be administered morphine sulfate (a narcotic pain medicine) 5 milligrams (mg) by mouth every 2 hours as needed for pain or discomfort. A physician order dated 7/17/23 indicated the resident was to be administered morphine sulfate extended release 15 mg by mouth every 12 hours for increased pain. A physician order dated 6/19/23 indicated non-medication interventions for pain relief were to be recorded every shift. A physician order dated 6/19/23 indicated the resident was to be monitored for narcotic side effects of sedation, dizziness, nausea, vomiting, constipation, physical dependence, tolerance and respiratory depression every shift. A hospice visit note dated 7/14/23 indicated Resident 48 was going home for the weekend and pain medications were increased. A hospice visit note dated 7/17/23 indicated the resident's daughter had been left a message about morphine.		and symptoms of infection present. 5 times weekly for compliance with regulation x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance 9/8/2023**	

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	155249	A. BUILDING 00 B. WING	08/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHATEAU REHABILITATION AND HEALTHCARE CENTER	6006 BRANDY CHASE COVE FORT WAYNE, IN 46815

(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

A progress note dated 7/19/23 at 8:49 PM indicated morphine sulfate extended release tablet was not administered as scheduled due somnolence.There was no description of resident status or an assessment

A progress note date 7/21/23 at 7:28 AM indicated morphine sulfate extended release was not administered as scheduled at the resident's daughter's request. There was no description of resident status or an assessment.

A progress note dated 7/21/23 at 10:22 AM indicated the resident's respiratory rate was 8 breaths per minute, was briefly opening her eyes and not responding. The note indicated hospice had been notified earlier in the shift of the resident's change in condition. The note indicated the resident's condition continued to decline, the resident was a full code and the resident's daughter did not want to change the resident's code status. The resident was transferred to the emergency department by ambulance.

A progress note dated 7/21/23 at 3:04 PM indicated the resident was admitted to the hospital with a urinary tract infection.

A progress note dated 7/24/23 at 2:50 PM indicated the resident was admitted to the hospital due to low respirations.

Resident 48's medication administration record (MAR) dated 7/2023 indicated the resident's vital signs were most recently assessed on 7/5/23. The MAR indicated the resident was monitored for opioid side effects and no side effects were noted. The MAR indicated non-medication pain relief interventions were not offered. The MAR

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	indicated hydrocodone had not been administered. The MAR indicated the resident was administered morphine sulfate 5 mg PRN on 7/2/23, 7/4/23, 7/5/23, 7/7/23, 7/10/23, 7/15/23 and 7/17/23. In an interview on 8/8/23 at 11:19 AM, Resident 48's daughter (Daughter) indicated the resident was administered Narcan (a medication that reverses the effects of narcotics) by ambulance paramedics. Daughter indicated the resident became alert after the dose of Narcan. Daughter indicated she had voiced concerns to the facility staff related to the resident being over medicated and had asked the facility to refrain from administering morphine so often. Daughter indicated she was not made aware of the reason for the increase in pain medication. Daughter indicated she did recall a voicemail by a hospice nurse that the morphine was increased but recieved no information related to the resident's condition. The daughter indicated she had voiced suspicion to facility staff of the resident having an infection. The daughter indicated she requested 911 to be called due to the resident not responding verbally. The resident was diagnosed with a urinary tract infection while hospitalized. In an interview on 8/8/23 at 12:33 PM, LPN 7 indicated they knew Resident 48 well as the resident was on their assigned unit. LPN 7 indicated facility staff communicated with hospice staff by phone or the hospice communication book. LPN 7 indicated phone calls to hospice would be documented in the progress notes. LPN 7 indicated a decline in condition would be documented in the progress notes related to vital signs, level of consciousness (LOC) and overall condition. LPN 7 indicated Resident 48 was transferred to the hospital due to a decline in			

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	condition and a decreased LOC (level of conciousness). LPN 7 indicated the resident was a hospice client, the daughter refused to change code status and the daughter wanted the resident sent to the hospital. 3.1-37			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			
	Based on record review and interview the facility failed to ensure consistent respiratory care for 1 of 3 residents reviewed with respiratory therapy. (Resident 25). Findings include: Resident 25's record was reviewed on 8/7/23 at 9:32 AM. Diagnoses included diagnoses dementia, senile degeneration of brain, essential hypertension, unspecified edema, oropharyngeal phase of dysphagia, and anxiety. A review of Resident 25's current quarterly Minimum Data Set (MDS) assessment indicated her Basic Interview for Mental Status (BIMS) score was 5 (moderately impaired) and not interviewable. The MDS indicated the resident was on oxygen therapy while at the facility.	F 0695	**F-695** **Respiratory/Tracheostomy Care and Suctioning** **The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory**	09/08/2023

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A review of Resident 25's current Care plan indicated the resident had a problem of chronic conditions with a risk for discomfort, complications, and decline, with a goal to attain or maintain her highest practicable level of well-being and minimize risk of complications. Interventions included for cardiopulmonary issues to provide oxygen per physician orders.

A review of Resident 25's physician order dated 9/9/21 at 11:00 PM indicated to check humidification bottle every shift and change when empty.

A review of Resident 25's physician order dated 5/11/22 at 3:00 PM indicated to keep an ear saver in place on oxygen tubing to prevent tubing from rubbing behind the resident's ears.

A review of Resident 25's physician order dated 12/12/23 at 11:00 PM indicated to change oxygen tubing on Sunday nights.

A review of Resident 25's Medication Administration Record (MAR) dated 7/1/23 to 7/31/23 indicated no documentation was found for orders on the following dates:

Check humidification bottle every shift and change when empty.

No documentation - Day shift on 7/9/23, 7/13/23, 7/14/23, 7/23/23

Night Shift on 7/30/23

Keep ear saver in place on oxygen tubing to prevent tubing from rubbing behind the resident's ears.

No documentation - Day shift on 7/9/23, 7/13/23, 7/14/23, 7/23/23

Night Shift on 7/30/23

Change oxygen tubing on Sunday nights.

requirements.

1. **Immediate actions taken for those residents identified:** Resident 25 oxygen tubing, ear savers, and humidifier were replaced, dated and documented in the TAR.
2. **How the facility identified other residents:** Any resident utilizing oxygen therapy has the potential to have been affected. All other residents that receive oxygen therapy were audited and tubing, humidification and ear savers, replaced, dated, and documented in the Treatment Administration Record (TAR).
3. **Measures put into place/ System changes:** Facility staff educated on components of F 695 respiratory oxygen services, focus on changing, dating, and documenting of oxygen tubing, ear savers, and humidification in the treatment administration record (TAR).
4. **How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing/designee who will audit all residents who require oxygen therapy for compliance with

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	No documentation - 7/30/23 (last documented oxygen tubing change was 7/23/23). A review of Resident 25's Medication Administration Record (MAR) for 8/1/23 to 8/7/23 indicated no documentation was found for orders on the following dates: Check humidification bottle every shift and change when empty. No documentation - Day shift on 8/6/23 Evening Shift 8/6/23 Night Shift on 8/4/23, 8/6/23 Keep ear saver in place on oxygen tubing to prevent tubing from rubbing behind the resident's ears. No documentation - Day shift on 8/6/23 Evening Shift 8/6/23 Night Shift on 8/4/23, 8/6/23 Change oxygen tubing on Sunday nights. No documentation - 8/6/23 (last documented oxygen tubing change was 7/23/23). In an interview on 8/4/23 at 3:32 PM, the Assistant Director of Nursing (ADON) indicated physician's orders should have been followed. In an interview on 8/8/23 at 1:17 PM the DON indicated there was missing documentation that should have been signed off if the care had been completed and it was not. A current policy, revised 11/2022, titled "Policy and Procedure Physician Orders Policy/Guidelines", provided the DON, was not pertinent to the citation. A current policy, undated, titled "Policy for Oxygen Concentrator", provided the DON, indicated that oxygen tubing was to be changed weekly. No further information was provided by		regulation weekly x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance 9/8/2023**	

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	survey exit. 3.1-47(a)(4)(5)(6)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			
	Based on interview and record, the facility failed to provide assessments before and after dialysis treatments for 2 of 3 residents reviewed. (Residents 144 and 34). Findings include: 1. Resident 144's record was reviewed on 8/2/23 at 2:14 PM. Diagnoses included diabetes and chronic kidney disease. A review of Resident 144's current Comprehensive Minimum Data Set (MDS) indicated their Basic Interview for Mental Status (BIMS) score was 7 (severe cognitive impairment). The MDS indicated the resident received dialysis. A review of physician orders dated 7/26/23 indicated Resident 144's blood pressure and pulse were to be obtained before and after the resident received dialysis treatments. A review of Resident 144's dialysis communication book indicated assessments before and after dialysis were not competed on 7/20/23, 7/21/23, 7/24/23, 7/25/23, 7/26/23, 7/27/23, 7/28/23, 7/31/23, 8/1/23, 8/2/23, 8/3/23 and 8/4/23.	F 0698	**F-698** **Dialysis** **The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** Resident 144 and 34 no longer	09/08/2023

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	In an interview on 8/4/23 at 3:33 PM, the Assistant Director of Nursing (ADON) indicated physician orders for before and after dialysis assessments should have been followed.2. Resident 34's record was reviewed on 8/3/23 at 9:40 AM. Diagnoses included end stage renal disease, acquired absence of left fingers, 3rd 4th, and 5th digits, and type 2 diabetes mellitus with diabetic neuropathy, unspecified. A review of Resident 81 current quarterly MDS dated 7/12/23 indicated his BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact). The MDS indicated the resident received dialysis. A review of Resident 34's current care plan titled Chronic conditions indicated the resident had a problem of dialysis, with a goal date of 7/14/23. Interventions included Resident 34's care should be coordinated in collaboration with the dialysis center. A review of physician orders dated 6/7/23 indicated Resident 34 was to receive dialysis every Monday, Wednesday, and Friday. A physician's order dated 3/22/23 indicated vital signs were to be recorded prior to dialysis session on scheduled dialysis days, Monday, Wednesday, and Friday. A physician's order dated 3/27/23 indicated vital signs were to be recorded post- dialysis session on scheduled days. Pre and post dialysis forms were not available for the months of July and August of 2023.		reside at this facility. **2. How the facility identified other residents:** All residents receiving dialysis have the potential to be affected by practice. Resident in facility requiring dialysis audited for completion of assessments. Communication binders updated for all dialysis residents. **3. Measures put into place/ System changes:** Nursing staff educated on requirements of pre and post assessment completion requirements for all dialysis residents. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing /designee who will audit all residents receiving dialysis treatment for completion of pre and post dialysis assessments weekly. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	Review of the Medication Administration Record for July and August of 2023 indicated: On 7/3/23, no post-dialysis vital signs were recorded. On 7/5/23, no pre-dialysis or post-dialysis vital signs were recorded. On 7/7/23, no pre-dialysis or post-dialysis vital signs were recorded. On 7/10/23, no post-dialysis vital signs were recorded. On 7/12/23, no pre-dialysis or post-dialysis vital signs were recorded. On 7/14/23, no pre-dialysis or post-dialysis vital signs were recorded. On 7/17/23, no post-dialysis vital signs were recorded. On 7/19/23, no pre-dialysis or post-dialysis vital signs were recorded. On 7/21/23, no pre-dialysis or post-dialysis vital signs were recorded. On 7/24/23, no post-dialysis vital signs were recorded. On 7/26/23, no pre-dialysis or post-dialysis vital signs were recorded. On 7/28/23, no pre-dialysis or post-dialysis vital signs were recorded. On 7/31/23, no post-dialysis vital signs were recorded. On 8/2/23, no pre-dialysis or post-dialysis vital signs were recorded. On 8/4/23, no pre-dialysis or post-dialysis vital signs were recorded. A review of progress notes did not indicate any refusals of vital signs in the months of July and August 2023. In an interview on 8/4/23 at 11:40 AM, Registered Nurse (RN) 10 indicated Resident 81 did not have a dialysis book to take to dialysis sessions for		**5. Date of Compliance 9/8/2023**	

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	communication with the dialysis center. She indicated she believed the dialysis center would call if there was a problem. She indicated protocol for residents receiving dialysis was to obtain vital signs and weight before departure and upon return from dialysis. She indicated pre and post dialysis forms should be filled out before and after dialysis sessions. At the time of the interview, Resident 81 was observed returning to the facility, dropping off personal items and going to the dining room with no attempt made by staff to offer a weight or vital signs. RN 10 indicated she was not sure exactly when his post dialysis vital signs and weight were normally obtained because he liked to go directly to the dining room for lunch after dialysis. In an interview on 8/4/23 at 12:00 PM, the Director of Nursing indicated pre and post dialysis vital signs should be recorded on the MAR. In an interview on 8/4/23 at 3:32 PM, the ADON indicated the orders for pre and post dialysis vital sign monitoring in the MAR were not entered correctly, so many vital sign readings were not recorded. She indicated the physician's orders should have been followed. A current policy titled Dialysis Monitoring dated 11/1/20 provided by the Administrator on 8/4/23 at 5:09 PM indicated vitals signs should be obtained before and after dialysis sessions. 3.1-37(a)			
F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or			

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	maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure appropriate social service interventions for Notice of Transfer or Discharge, Preadmission Screening and Resident Review (PASRR) for 3 of 4 residents reviewed. (Resident 20, Resident 81 and Resident 34). Findings include: 1. Resident 20's record was reviewed on 8/3/23 at 2:17 PM. Diagnoses included unspecified dementia, unspecified psychosis not due to a substance or known physiological condition, anxiety disorder, recurrent major depressive disorder, and type 2 diabetes mellitus. A review of Resident 20's current quarterly Minimum Data Set (MDS) assessment indicated his BIMS (Basic Interview for Mental Status) score was 11 (mild cognitively impaired). A review of a Notice of Transfer or Discharge form dated 4/29/23 did not contain a resident/representative signature, indicate the resident was unable to sign at the time of transfer or indicate a copy was mailed/given to the resident/representative. A review of progress notes dated 4/29/23 did not contain an indication the resident/representative was notified of the Notice of Transfer or Discharge. In an interview on 8/7/23 at 10:22 AM the Director of Social Services indicated Resident 20's Notice of Transfer or Discharge was not given to the resident/representative at the time of transfer or	F 0745	**F-745 Provision of Medically Related Social Services** **The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** Resident number 34 no longer resides in this facility. Resident number 81 and 20 were provided notices of transfer/discharge. PASRR has been updated and completed. **2. How the facility identified other residents:** All residents at this facility have the potential to be affected should transfer or discharge from the facility.	09/08/2023

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	mailed out and it should have been. In an interview on 8/8/23 at 10:26 AM the Social Services Director indicated upon discharge from the facility nursing staff should call the resident or their representative and provide discharge/transfer information if they were unable to personally deliver the bed hold policy at the time of discharge. In an interview on 8/8/23 at 10:23 AM, Licensed Practical Nurse (LPN) 3 indicated the management team is notified when a transfer policy is not able to be delivered to a resident or when nurses are not able to hand deliver the notice at the time of discharge. In an Interview on 8/7/23 at 2:15 PM the Administrator indicated the transfer/dischare Policy the facility used was the same as the notice provided to the resident on transfer. A current policy titled "Discharge/ Transfer Notice", undated, provided by the Administrator on 8/7/23 at 2:15 AM provided no pertinent to the citation. No further information was provided by survey exit.2. Resident 81's record was reviewed on 8/2/23 at 2:39 PM. Diagnoses included cerebrovascular disease, unspecified, borderline personality disorder, and bipolar disorder (a serious mental illness). A review of Resident 81's current quarterly Minimum Data Set (MDS) dated 7/3/23 indicated her BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact). A review of a Level of Care Screen dated 11/4/2022 indicated approval for a short-term skilled nursing facility approval with an end date		**3. Measures put into place/ System changes:** Facility Social Services Director (SSD) was educated on the requirements of the transfer discharge policy. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Social Services Director/designee who will monitor all transfers and discharges from the facility 5 x week x 6 months and ensure transfer discharge forms are signed at this of discharge and if not signed are mailed to family. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance 9/8/23**	

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	of 10/26/2022. In an interview with the Administrator on 8/3/23 at 11:01 AM, any further information regarding PASSAR paperwork was requested by the surveyor. A Level 1 Assessment Level of Care form for Resident 81 with a submission date of 8/3/23 at 2:32 PM was provided by the Administrator on 8/4/23 at 8:35 AM. No PASSAR documents between the dates of 11/4/23 and 8/3/23 were available for review. In an interview on 8/4/23 at 10:44 AM, Social Services Director 5 indicated she was new to her position and had not received training on managing the process of obtaining PASARR requests. She indicated she had been hired in October of 2022 and had been told nothing about PASSAR until documents were requested on 8/3/23. In an interview on 8/4/23 at 10:44 AM, Social Services Director 6 indicated she was assisting from another company owned facility and identified a technical denial was received on 11/4/23. She indicated a follow up screening should have been requested at that time. She indicated she did not know why that was not done. She indicated a previous employee in the social service position had a long leave of absence prior to her departure from the company and some of the social service duties may have been missed. A current policy titled Preadmission Screening and Resident Review dated 3/31/20 provided on 8/4/23 at 12:27 PM by the Administrator indicated PASARR screenings should be completed to			

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	ensure optimal services and settings for residents who have a serious mental illness. 3. Resident 34's record was reviewed on 8/3/23 at 2:48 PM. Diagnoses included end stage renal disease, acquired absence of left fingers, 3rd 4th, and 5th digits, and type 2 diabetes mellitus with diabetic neuropathy, unspecified. A review of Resident 34's current quarterly Minimum Data Set (MDS) indicated their BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact). The MDS indicated Resident 34 received dialysis. A review of a Notice of Transfer or Discharge form dated 6/14/23 did not contain a resident signature or indication that the resident was unable to sign at transfer or indication of a copy being given to or mailed to a resident representative. A review of progress notes did not contain any indication of resident or representative notification of the Notice of Transfer or Dsicharge policy between the dates of 6/14/23 and 6/27/23. During an interview on 8/8/23 at 10:23 AM, Licensed Practical Nurse (LPN) 3 indicated the management team is notified when a transfer/discharge policy is not able to be delivered to a resident when nurses are not able to hand deliver the notice at the time of discharge. During an interview on 8/8/23 at 10:26 AM the Social Services Director indicated upon discharge from the facility nursing staff should call the resident or their representative and provide transfr/discharge information if they are unable to personally hand deliver the transfer/discharge			

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	policy at the time of discharge. She indicated she did not receive any instruction regarding responsibility of ensuring trandfer/discharge policies were delivered or communicated. 3.1-34(a)(2)			
F 0758 SS=D 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 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			

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	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 interview, and record review the facility failed to ensure non-pharmacological interventions were attempted prior to obtaining orders for anti-psychotic medication for of 1 of 5 residents reviewed (Resident 21). Findings include: Resident 21's record was reviewed on 8/3/23 at 1:58 PM. Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, and anxiety, bipolar disorder, unspecified, and mood disorder due to known physiological condition with depressive features. A review of Resident 21's current quarterly MDS (Minimum Data Set) dated 7/3/23 indicated her BIMS (Basic Interview for Mental Status) score was 14 (cognitively intact). The MDS indicated Resident 21 received antipsychotic medication daily.	F 0758	**F758 Free From Unnecessary Psychotropic Meds/PRN Use The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	09/08/2023

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	A review of Resident 21's current care plan titled Risk for Impaired Psychosocial Well-being indicated the resident had a problem of anxious behaviors with a goal date of 10/24/23. Interventions included encouraging calm conversation in quiet spaces, attempt to redirect when exhibiting behaviors, and monitor and attempt to determine underlying cause of behaviors. A review of progress notes dated 4/22/23 at 5:02 PM indicated a one-time order was received for Clonazepam 0.5 mg (controlled substance for anxiety) due to excessive anxiety. No description of behavior exhibited, or non-pharmacological interventions were noted as attempted and ineffective prior to obtaining the order for Clonazepam. A review of progress notes dated 6/11/23 at 10:38 AM indicated Resident 21 was packing some of her items and putting them in garbage bags. A progress note dated 6/11/23 at 2:47 PM indicated an order for Haldol 5mg (anti-psychotic medication) was received for symptoms of anxiety. No non-pharmacological interventions were noted as attempted and ineffective prior to obtaining the order for Haldol. A review of progress notes dated 6/23/23 at 9:18 AM indicated Resident 21 was agitated and restless, needing constant reassurance. The progress note indicated an order for Haldol 5mg was received. No non-pharmacological interventions were noted as attempted and ineffective prior to obtaining the order for Haldol. In an interview on 8/7/23 at 3:19 PM, Licensed Practical Nurse (LPN) 7 indicated Resident 21 had		**1. Immediate actions taken for those residents identified:** Resident 21 was assessed for side effects of psychotropic medication administration. **2. How the facility identified other residents:** Any resident prescribed prn psychotropic medications have the potential to have be affected. **3. Measures put into place/ System changes:** Nursing administrative staff educated floor nurses and QMA's on giving prn psychotropic medications. 3 non pharmacological interventions without success must be tried before administering PRN. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Director of Nursing/designee who will audit Medication administration record (MAR)/Progress Note for compliance with regulation days 5 a weekly x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance**	

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	escalated at times worrying about family matters and one-time orders for Haldol were obtained as a last resort when she was not able to de-escalate. In and interview on 8/7/23 at 8:54 AM, the Director of Nursing (DON) indicated staff should attempt non-pharmacological interventions and document them when behaviors occur. If non-pharmacological interventions fail, staff should contact the physician or nurse practitioner for medicinal intervention. A current policy titled Behavior and Psychoactive Management Program dated 11/1/20 provided by the Director of Nursing on 8/8/23 at 9:55 AM indicated a resident's medication regimen should be free of unnecessary medications including any drug used without adequate indication for its use. Non-pharmacological interventions previously attempted without success must be documented. 3.1-48(a)(4)		9/8/2023	
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			

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	practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation, interview, and record review the facility failed to ensure facial hair was properly restrained on staff in the kitchen. 86 of 87 residents currently residing in the building ate food prepared in the dining room. Findings include: During an observation in the kitchen next to a steam table filled with food on 8/2/23 at 11:37 AM, Cook 2 was observed with a full beard wearing no covering. The Regional Director of Operations for Dining Services (RDODS) was also observed with a full beard wearing no covering. In an interview on 8/2/23 at 11:37 AM, the RDODS indicated beard hair should be covered in the kitchen. A current policy title Food and Nutrition Services Quick Resource Tool dated 9/1/21 provided by the RDODS indicated facial hair must be restrained in the kitchen. 3.1-21(i)(3)	F 0812	**F-812 Food Procurement, Store/Prepare/Serve-Sanitary The facility respectfully requests a desk review for this citation** **Preparation, submission, and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** All Residents were indirectly affected. The cook immediately put on a beard covering. **2. How the facility identified other residents:** All residents served meals from the kitchen have the potential to affected by	09/08/2023

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			deficient practice. **3. Measures put into place/ System changes:** Facility staff and dining staff educated on components of F-812 Food Procurement, Store/Prepare/Serve-Sanitary. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Administrator/designee who will monitor compliance with regulation 5 x week x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue weekly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance 9/8/23**	
F 0867 SS=F Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:			

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	§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after			

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implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement

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	projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.			
	Based on interview and record review, the facility failed to ensure a process was in place to identify and correct quality deficiencies from reoccurring. This had the potential to affect 2 of 2 residents residing in the facility. See F698 for additional information regarding Resident 34 and Resident 144.	F 0867	**F867 QAPI/QAA Improvement Activities** **The facility respectfully requests a desk review for this citation** **Preparation, submission, and**	09/08/2023

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	Findings include: A (QAPI) committee member list was provided on 8/2/23 at 11:30 AM by the Administrator. The member list included the Medical Director, Executive Director, Director of Nursing, Assistant Director of Nursing, B/C Wings Unit Manager, Social Service Director, Business Office Manager, Human Resource Director, Admissions Coordinator, Scheduler, Dietary Manager, Laundry/Housekeeper Supervisor, Maintenance Director, Central Supply/Medical Records Director, Minimum Data Set (MDS) Coordinator, Quality of Life Director, and Therapy Director. In an interview on 08/08/23 at 1:43 PM, the Administrator indicated problems and issues in the facility were tracked and trended through the QAPI committee at monthly meetings. She indicated the QAPI process was utilized to improve processes within the facility. The facility had a list of processes to review each month to ensure improvement of operations. The processes focused on the nursing processes, risk management, reportable incidents, grievance, and ancillary services (lab, radiology, pharmacy). She indicated the process for dialysis communication improvement had been completed. In an interview on 8/8/23 at 2:22 PM, the Director of Nursing indicated the Dialysis Program was audited and met the established quality indicator threshold of 90% with a 6-month completion of March. At this time the Dialysis Program was at maintenance and the next audit would be due by 9/1/23. In an interview on 08/08/23 at 2:03 PM with the Administrator, a current policy and procedure for		**implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** **1. Immediate actions taken for those residents identified:** Resident numbers 34 and 144 no longer reside at this facility. **2. How the facility identified other residents:** All residents have the potential to be affected by this practice. **3. Measures put into place/ System changes:** QAPI to be held monthly. Medical director/facility NP and leadership team to attend. Dialysis to be discussed monthly. **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Executive	

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	Quality Assurance Assessment (QAA) and QAPI policy was requested. No documentation was provided by the time of survey exit. The facility annual survey completed 9/29/22 identified noncompliance regarding dialysis pre and post dialysis assessment documentation. The facility was also found to be noncompliant regarding dialysis pre and post dialysis assessment documentation on the following dates: 9/27/22, 9/26/22, 9/23/22, 9/19/22, 9/16/22, 9/15/22, 9/13/22, 9/12/22, and 9/9/22. The facility indicated the Date of Compliance would be 10/14/22. Cross reference F698. 3.1-52(b)(2)		Director /designee who will audit for monthly for compliance with regulation x 6 months. Audits will be reviewed monthly during Quality Assurance. Audits will continue monthly for 6 months and or until 100% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5. Date of Compliance 9/8/2023**	