STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155217	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGBURG, THE	1712 LELAND DR HUNTINGBURG, IN 47542

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 9, 10, 11, 12, 13, 2023 Facility number: 000122 Provider number: 155217 AIM number: 100290560 Census Bed Type: SNF/NF: 44 Total: 44 Census Payor Type: Medicare: 2 Medicaid: 28 Other: 14 Total: 44 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 21, 2023.	F 0000	Deficiency ID:¿F _ 0000 Completion Date:¿8/4/2023 Plan of Correction Text: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws.¿ Facility's date of alleged compliance is 8/4/2023. We cordially request that this plan is considered for desk review.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to provide accommodations for a resident in a timely manner	F 0558	F-558¿ ¿	08/04/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lyn Strauser	HFA	08/04/2023

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	for 1 of 1 resident reviewed for accommodation of needs. The facility failed to provide a bariatric air mattress for a resident, or an appropriate lift for transfers. (Resident 34) Findings include: During an interview on 7/10/23 at 9:52 A.M., Resident 34 indicated he had been waiting six months for an air mattress. He indicated the facility had ordered one, but it did not fit his bed. He indicated the facility staff kept telling him another one had been ordered. On 7/10/23 at 2:05 P.M., Resident 34 was observed lying in bed on a pressure reducing mattress. At that time, Resident 34 indicated a man came in his room earlier to measure his mattress so he could get an air mattress. On 7/11/23 at 10:28 A.M., Resident 34 was observed lying in bed. At that time, he indicated a couple weeks ago the staff tried getting him up with a lift. They didn't think he was back in the seat far enough. When they raised him out of the chair with the lift to pull him back, the lift fell over, hit him on the lip, and he fell about a foot to the wheelchair seat. He indicated he had been afraid to try to get out of bed since then. On 7/11/23 at 3:01 P.M., Resident 34 was observed lying in bed. At that time, he indicated the staff had brought in a new lift, and he was able to sit up in a chair. He also indicated a new air mattress had been delivered today and put on his bed. On 7/10/23 at 1:42 P.M., Resident 34's clinical record was reviewed. He was admitted on 8/29/22. Diagnosis included, but were not limited to, heart failure, morbid obesity, chronic respiratory failure		In accordance with this regulation, the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.¿¿ ¿ All residents who reside in the facility have the potential to be affected by this finding.¿¿ ¿ Resident 34 was provided a bariatric air mattress and appropriate bariatric lift for transfers on 7/11/23.¿ ¿ There was a 100% audit of all residents was completed to ensure reasonable accommodation of resident needs and preferences were met for mattresses and lifts by MDS coordinator on 8/2/24. Administrator was in-serviced by RDO on accommodation of needs policy and how to rent equipment until purchasing approval on 7/10/23.	

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	with hypoxia and other abnormalities with gait and mobility. The most recent quarterly MDS (minimum data set) Assessment, dated 6/8/23, indicated Resident 34 was cognitively intact, required extensive assistance of two staff with bed mobility, transfers and toilet use and was totally dependent on two staff with bathing. The skin assessment indicated he had a stage III pressure ulcer and MASD (moisture-associated skin damage). Resident 34's physician orders included, but were not limited to: Resident may be transferred with mechanical lift as per plan of care, dated 8/29/22 Resident 34's weights included, but were not limited to: 8/30/22 553.0 bed scale 6/15/23 588.4 lift scale 6/22/23 584.0 lift scale 6/27/23 577.0 lift scale 7/10/23 609.4 lift scale 7/11/23 600.5 lift scale A care plan meeting progress note, dated 6/9/2023 at 9:19 A.M., indicated "Resident inquires about high back wheelchair and air mattress. Administrator following up on this." During an interview on 7/10/23 at 9:52 A.M., the administrator indicated the place where they ordered air mattresses from in (city) had closed so they had to order one from a different city, and they only delivered on Thursday. During an interview on 7/11/23 at 2:43 P.M., the administrator indicated Resident 34's mattress was currently in the facility, as well as a new lift		The DNS/Designee will implement audit tool to ensure residents have proper mattress and lifts for transfers. DNS/Designee will audit 3 residents 5x/week x 4weeks, 3x/week x 4weeks, 2x/week x 4 months. Then quarterly in QAPI X 6 months and any concerns will be addressed immediately.¿	

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	brought from another facility. A brand new lift had been received for 650 pounds but the scale on it indicated 750 pounds. She indicated what was ordered was a 700 pound lift, but they sent a 650 pound one. On 7/12/23 at 9:17 A.M., the Administrator provided a manual for Bariatric full body patient lift that the facility bought in 6/23. The manual indicated "allow patients up to 600 pounds to be lifted and transferred safely with minimal physical effort provided by the operator". At that time, the Administrator indicated the scale went to 750 lbs. She indicated when she ordered the lift it was supposed to be for 700 lbs. but when it arrived it was for 600 pounds. She indicated before that they rented a lift for 600 pounds before the resident arrived which had been used for Resident 34 prior to yesterday. She indicated a new lift that arrived yesterday came from a sister facility, but they no longer had the manual. On 7/12/23 at 1:35 P.M., documentation related to when the first air mattress was ordered for Resident 34, when it was returned, and when a new replacement was ordered was requested and not provided. On 7/13/23 at 3:21 P.M. a current, undated Guidelines to Ensure Reasonable Accommodation of Needs policy provided by the Administrator indicated " It is the intent of this facility to provide, at minimum, reasonable accommodations as dictated by CMS (Centers for Medicare and Medicaid Services), for those persons (residents) residing in the nursing home facility. The resident has the RESIDENT RIGHT to receive care and services with reasonable accommodation of needs and preferences except when the health or safety of the resident could be jeopardized."			

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	3.1-3(v)(1)			
F 0576 SS=E Bldg. 00	483.10(g)(6)-(9) Right to Forms of Communication w/ Privacy §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.			

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	(i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. Based on interview and record review, the facility failed to deliver mail to the residents on Saturdays for 4 of 9 residents interviewed about mail service. During a resident council meeting, residents indicated they failed to get mail every Saturday. (Resident 10, Resident 20, Resident 27, Resident 32) Findings include: On 7/11/23 at 12:58 P.M., during a resident council meeting, Resident 10, Resident 20, Resident 27, and Resident 32 indicated if the assistant activity person was not working on Saturday the mail sat in the business office until Monday. During an interview on 7/12/23 at 11:28 A.M., the activity assistant indicated she worked every other weekend. When she worked, she sorted and delivered the mail. If the activity director or herself were not working, there was no one to deliver the mail on the weekend. During an interview on 7/12/23 at 1:35 P.M., the Administrator indicated it was the manager on duty's responsibility to get the mail and distribute it on the weekends. On 7/13/23 at 12:10 P.M. a current undated Postal Services (Mail) policy provided by the administrator indicated "...The resident will be afforded the same USPS (United States Postal Service) delivery services as practiced in the surrounding community..."	F 0576	F-576¿ ¿ In accordance with this regulation, the resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the residents own expense.¿ The facility must protect and facilitate that resident's right to communication with individuals and entities within and external to the facility, including reasonable access to: a telephone, including TTY and TDD services; the internet, to the extent available to the facility; and stationery, postage, writing implements and the ability to send mail.¿¿ ¿ The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service,	08/04/2023

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	3.1-3(s)(1)		including the right to: privacy of such communications consistent with this section; and access to stationery, postage, and writing implements at the residents own expense. The resident has the right to have reasonable access to and privacy in their use for electronic communications such as email and video communications and for internet research.¿ ¿ ¿ All residents who reside in the facility have the potential to be affected by this finding.¿ Mail has been delivered to all residents including resident 10, 20, 27, and 32.¿ ¿ ¿ There was a 100% audit of all residents receiving their mail by Activity Director on 8/3/23. Activity Director/Activity Assistant was in-serviced on 8/1/23 by the Administrator. Activity Director will ask 3 residents daily 5x/week X 4weeks, 3X/week x 4 weeks, 2x/week X 3months. Additionally,	

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			any staff that fails to comply with the points of this in-service will be further educated/or progressively disciplined as indicated. Then quarterly in QAPI and any concerns will be addressed immediately.¿¿¿ ¿ 5x/week X 4weeks, 3X/week x 4 weeks, 2x/week X 3months. Then quarterly in QAPI and any concerns will be addressed immediately.¿¿¿	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this			

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	section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with			

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	intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on interview and record review, the facility failed to ensure a notice of transfer or discharge	F 0623	F-623¿ ¿	08/04/2023

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	was completed and given to residents or resident representatives for 2 of 3 residents reviewed for hospitalizations. The clinical records lacked documentation of the residents or representatives receiving a completed notice of transfer or discharge at the time they were transferred from the facility. (Resident 5, Resident 32) Findings include: 1. On 7/11/23 at 10:28 A.M., Resident 5's clinical record was reviewed. Progress notes indicated the resident was transferred out of the facility to the Emergency Room (ER) on 12/17/22, admitted, and returned on 12/17/22. Resident 5 was again transferred out of the facility to the ER on 3/3/23, admitted, and returned on 3/6/23. Resident 5's clinical record lacked documentation that a notice of transfer or discharge was completed and given to the resident or a representative at the time of both transfers. On 7/11/23 at 1:30 P.M., a copy of the completed notice of transfer or discharges given were requested and not made available during the survey. 2. On 7/10/23 at 2:32 P.M., Resident 32's clinical record was reviewed and indicated she did not have a resident representative and was responsible for herself. Progress notes indicated they were transferred from the facility to the ER on 1/15/23 and 6/14/23 and returned back to the facility the same day. Resident 32's records lacked documentation that a notice of transfer or discharge was completed and given to the resident or a representative at the time of both transfers.		In accordance with this regulation, notice before transfer. Before a facility transfers or discharges a resident, the facility must- notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. Timing of notice except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. The written notice specified in paragraph (c)(3) of this section must include the following: reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement of the resident's appeal rights, including the name, address, and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; the name, address, and telephone number of the Office of the State Long-Term Care	

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	On 7/11/23 at 1:30 P.M., a copy of the completed notice of transfer or discharges given were requested and not made available during the survey. During an interview on 7/11/23 at 1:15 P.M., the Administrator indicated when a notice of transfer or discharge form is completed, it should be provided, along with the bed hold policy, to the resident or resident's representative, scanned into the clinical record, and then shredded. At that time she indicated the nurse's were required to complete the forms anytime a resident was transferred somewhere from the facility, and that included doctor's appointments. On 7/13/23 at 2:37 P.M., a current Notice of Transfer or Discharge Policy was requested from the Administrator. At that time, she indicated there was not a policy but they use the form as their policy. The form included boxes that were to be filled in for the following information: resident name and date notice was issued, facility resident was being discharged from and address, transfer or discharge date, name of facility resident was being transferred to and address, reason for discharge, and appeal rights information. 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii)		Ombudsman.¿ ¿ All residents who reside in the facility have the potential to be affected by this finding.¿¿ ¿ Residents 5 and 32 have been communicated to the resident/representative regarding transfer/discharge by SSD on 8/3/23. ¿ There was a 100% audit of transfer/discharges. All nursing staff and SSD were in-serviced on 8/3/23 by the ADON on the “Transfer/Discharges, Involuntary discharges, discharge summary, State forms, Ombudsman Notification”. A full audit of all current residents and those discharged was completed with a 30 day look back by the Medical Records Director by 8/3/23. Any all discharges and transfers from the audit have been given a notice of discharge/transfer notification.¿Additionally, any staff that fails to comply with the points of this in-service will be further educated/or progressively disciplined as indicated.¿ ¿	

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			The Medical Record Director/Designee will be responsible for the Discharge Compliance Audit. We will monitor all discharges/transfers daily 5x/week X 4weeks, 3X/week x 4 weeks, 2x/week X 4 months. Then quarterly in QAPI and any concerns will be addressed immediately.¿¿	
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 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.			

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	155217	A. BUILDING 00 B. WING	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGBURG, THE	1712 LELAND DR HUNTINGBURG, IN 47542

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	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 ensure a bed hold policy was provided to residents or resident representatives for 2 of 3 residents reviewed for hospitalizations. The clinical records lacked documentation of the resident or family representatives receiving a bed hold policy at the time they were transferred from the facility. (Resident 5, Resident 32) Findings include: 1. On 7/11/23 at 10:28 A.M., Resident 5's clinical record was reviewed. Progress notes indicated the resident was transferred out of the facility to the Emergency Room (ER) on 12/17/22, admitted, and returned on 12/17/22. Resident 5 was again transferred out of the facility to the ER on 3/3/23, admitted, and returned on 3/6/23. Resident 5's clinical record lacked documentation that a bed hold policy was given to the resident or a representative at the time of both transfers. On 7/11/23 at 1:30 P.M., a copy of the bed hold policies given were requested and not made available during the survey. 2. On 7/10/23 at 2:32 P.M., Resident 32's clinical record was reviewed and indicated she did not have a family representative and was responsible for herself. Progress notes indicated they were transferred from the facility to the ER on 1/15/23 and 6/14/23 and returned to the facility the same	F 0625	F-625¿ ¿ In accordance with this regulation, notice of bed-hold policy and return- notice before transfer. Before a 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: 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; the reserve bed payment policy in the state plan, if any; 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. At 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.¿¿ ¿	08/04/2023

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	day. Resident 32's records lacked documentation that a bed hold policy was given to the resident at the time of both transfers. On 7/11/23 at 1:30 P.M., a copy of the bed hold policies given were requested and not made available during the survey. During an interview on 7/11/23 at 1:15 P.M., the Administrator indicated when a bed hold policy form is completed, it should be provided, along with the notice of discharge or transfer, to the resident or resident's representative, scanned into the clinical record, and then shredded. At that time she indicated the nurse's were required to do the forms anytime a resident was transferred somewhere from the facility, and that included doctor's appointments. On 7/13/23 at 2:37 P.M., a current Bed Hold Policy was requested from the Administrator. At that time, she indicated there was not a policy but they use the form as their policy. The "Bed Hold Policy" form indicates " ... If a resident leaves the facility for hospitalization or for therapeutic leave, and it is the intent fo [sic] the resident to return to the facility, shall [sic] hold the Resident's bed as follows: ... the facility will not hold bed for Medicaid residents unless resident pays the daily Medicaid rate for the days of on [sic] leave ... Medicare/insurance carries DO NOT reimburse for bed-holds while resident is on leave (i.e. hospital stay). If a resident wants to reserve his/her bed, then resident must pay the facility the private pay rate for his/her bed while on leave from facility ... for private pay residents, if a bed hold is requested, the facility will bill at the current room and board rate for the duration of the leave ... If an		All residents who reside in the facility have the potential to be affected by this finding.¿¿ ¿ Residents 5 and 32 have been communicated to the resident/representative regarding bed-hold policy on 8/4/23 by SSD. ¿ There was a 100% audit of bed hold policy. All nursing staff and SSD were in-serviced on 8/3/23 by the ADON on the “Bed Hold Policy”. Additionally, any staff that fails to comply with the points of this in-service will be further educated/or progressively disciplines as indicated. A full audit of all current residents and those discharged was completed with a 30 day look back by the Medical Records Director by 8/3/23. Any and all residents transferred/discharged from the audit have been given a notice of the bed hold policy.¿¿ ¿ The Medical Record Director/Designee will be responsible for the Bed Hold Compliance Audit. We will monitor all bed hold compliances daily 5x/week X 4weeks, 3X/week x 4	

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	appropriate bed is not available upon time of return to facility, the facility will assist with appropriate transfer to other facility ... If the procedures are not followed and no "BED HOLD" is established then upon the Resident's departure, the facility may treat the Resident's bed as being open an [sic] available for another admission ... ". A line was provided for the date the resident and/or representative were advised of the facility bed hold policy, whether they choose to request a bed hold and agree to submit timely payment or wish not to pay for a bed hold, and their signature. 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii)		weeks, 2x/week X 4 months. Then quarterly in QAPI and any concerns will be addressed immediately.¿	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure MDS (Minimum Data Set) Assessments were accurate for 2 of 5 residents reviewed for unnecessary medications. (Resident 5, Resident 16) Findings include: 1. On 7/11/23 at 10:28 A.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, post traumatic stress disorder (PTSD). The most recent annual MDS Assessment, dated 6/27/23, indicated Resident 5 was moderately cognitively impaired, not a tobacco user, did not have PTSD, and received an anti-anxiety, opiod,	F 0641	Waters of Huntingburg POC Annual Survey Shape Deficiency ID:¿F _ 0000 Completion Date:¿8/3/2023 Plan of Correction Text: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an	08/04/2023

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	and antibiotic for 7 of 7 days during the lookback period. Current physician's orders included, but were not limited to, the following: The resident may smoke in accordance with the facility smoking policy, ordered on 4/14/2023 Effexor XR capsule give 3 capsules by mouth in the morning for PTSD, ordered on 3/7/23 Resident 5's MAR (Medication Administration Record) for June 2023 indicated Resident 5 was not on an anti-anxiety, opiod, or antibiotic during that month. During an interview on 7/12/23 at 10:22 A.M., the MDS Coordinator indicated Resident 5 did have PTSD and was a smoker. At that time, she indicated no anti-anxiety, opiod, or antibiotic had been given to the resident and they were documented on the MDS Assessment in error. 2. On 7/11/23 at 8:31 A.M., Resident 16's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The most recent quarterly MDS Assessment, dated 6/23/23, indicated that Resident 16 was moderately cognitively impaired and had received an antibiotic for 7 of 7 days during the look back period. June 2023 physician's orders included, but were not limited to, the following: Bactrim DS 800-160mg (milligram) tablet give 1 tablet by mouth two times a day for UTI for a total of 5 days, ordered on 6/21/23 at 4:00 P.M. Resident 16's MAR for June 2023 was reviewed		admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws.¿ Facility's date of alleged compliance is 8/4 /2023. F-641 It is the policy of the facility to ensure Accuracy of Assessments. The assessment must accurately reflect the resident's status. Residents who reside in the facility have the potential to be affected by this finding. A modified MDS was completed on 8/4/23 for resident #5 and 16. A 100% Audit was completed for all current to ensure the accuracy of antianxiety, opioid, antibiotic medications were coded accurately for all current residents. Any inaccurate MDS assessments were modified as needed.	

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	and indicated Resident 16 received an antibiotic on the following dates: 6/21/23 6/22/23 6/23/23 6/24/23 6/25/23 6/26/23 During an interview on 7/12/23 at 10:22 A.M., the MDS Coordinator indicated that Resident 16 only had the antibiotic for 6 days and 7 days was documented on the MDS Assessment in error. On 7/13/23 at 2:42 P.M., the Administrator indicated there was not a policy on MDS Assessments, but it was their policy to follow the Resident Assessment Instrument (RAI) manual. 3.1-31(i)		MDS Coordinator/Designee will monitor the completion of MDS assessments using a MDS Audit Tool for 10 residents weekly for a period of 4 weeks. The tool will then be used for 5 residents weekly for 4 weeks. Then for 1 resident weekly ongoing for a period of 16 weeks for no less than a total of 6 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Regional MDS Consultant on 8/1/2023 for the MDS Coordinator and the following was reviewed: RAI Manual – specific to accuracy of assessments related to medication coding with antianxiety, opioid, and antibiotic medication coding. MDS Coding and accuracy of assessments Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated.	

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			At the monthly QAPI meeting, the monitoring of the MDS Coordinator/Designee will be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	
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			

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	plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to provide care plan conferences quarterly for 2 of 6 residents reviewed for care plan conferences. (Resident 26, Resident 5) Findings include: 1. On 7/11/23 at 8:48 A.M., Resident 26's clinical record was reviewed. Diagnosis included, but were not limited to, dementia and anxiety. The most recent quarterly MDS (minimum data set) Assessment dated 4/2/23, indicated a severe cognitive impairment. The most recent care plan conference was documented on 2/21/23. On 7/12/23 at 9:58 A.M., the Social Services Director (SSD) indicated Resident 26 had a conference scheduled for 5/9/23, and the family called and wished to reschedule. At that time, a handwritten care conference schedule was provided, and indicated a care conference was scheduled for Resident 26 on 7/19/23. 2. On 7/11/23 at 10:28 A.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, stroke with hemiplegia affecting left dominant side, post traumatic stress disorder, and congestive heart failure. The most recent annual MDS Assessment, dated	F 0657	F-657¿ ¿ It is the policy of the facility to ensure all comprehensive care plans conferences are held quarterly. Res 26 care conference has been scheduled for 8/9/23 per family availability. Res 5 care conference has been scheduled for 8/15/23 per family availability.¿¿ ¿ All residents who reside in the facility have the potential to be affected by this finding.¿¿ ¿ A 100% audit was completed by SSD on 7/31/23 for all current residents to ensure that all residents have had a care conference quarterly or with a change of condition.¿	08/04/2023

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	6/27/23, indicated Resident 5 was moderately cognitively impaired. A care plan note, dated 2/21/23, indicated "Resident has requested to reschedule care conference as she is going out with her son for her birthday. She requests son be at care conference". The most recent care plan conference was documented on 4/4/23. The note indicated (name of daughter) was invited but not the son. During an interview on 7/12/23 at 2:30 P.M., the Social Services Director (SSD) indicated that conference was the only one for the 6 month period requested. During an interview on 7/13/23 at 9:11 A.M., the SSD indicated she looked at every resident monthly to see if a care plan conference had been done. She indicated a consultant came in last week and provided her with a spreadsheet to better organize the care conference schedules. At that time she indicated care plan conferences should be done at least once a quarter or with a change of condition. On 7/13/23 at 2:37 P.M., a current non-dated Comprehensive Care Plan policy was provided and indicated "The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum" 3.1-35(c)(2)(C)		¿ SSD/Designee will monitor the completion of care plan conference using a Care Conference Tool for 10 residents weekly for a period of 4 weeks. The tool will then be used for 5 residents weekly X 4 weeks, 3 residents X 4 weeks,¿1 resident weekly ongoing for a period of 3 months. If the facility is within compliance at the end of 6 months; then monitoring can continue quarterly in QAPI. Any concerns will be addressed and correctly immediately.¿¿ ¿ The SSD was in-serviced by the administrator on 8/3/23 and the care plan policy was reviewed.¿ Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated.¿ ¿	
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based			

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	on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview, and record review, the facility failed to provide an ongoing activity program for 1 of 4 units observed and 1 of 1 resident council meetings. (Hope Springs Dementia Unit, Resident 13, Resident 38, Resident 42, Resident 36, Resident 37, Resident 97, Resident 35, Resident 10) Finding includes: 1. The following were observations and interviews regarding Hope Springs: During a continuous observation on 7/9/23 from 9:45 A.M. through 12:07 P.M., no activities were observed on the Hope Springs Dementia Unit. During an observation on 7/10/23 at 9:18 A.M., Qualified Medication Aid (QMA) 3 was observed eating a snack while sitting at a dining room table talking to Resident 13. During a continuous observation on 7/10/23 from 10:48 A.M. through 11:30 A.M., four residents were observed sitting in the dining room. There were crayons sitting on a table, but no one was using them. Resident 13 was observed eating a cookie with a copy of the Daily Chronicle sitting in front of her. During that time, there were no activities observed on the unit.	F 0679	F-679¿ ¿ In accordance with this regulation, the facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.¿¿ ¿ ¿ All residents who reside in the facility have the potential to be affected by this finding.¿ ¿Residents #13, 38, 97, 35, and 10 did not have a negative	08/04/2023

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	During a continuous observation on 7/10/23 from 2:10 P.M. through 3:02 P.M., Resident 13 was observed sitting in a recliner in the common area in front of the TV. Resident 38 was observed sitting in the dining room. At that time, there were no activities observed. During a continuous observation on 7/11/23 from 8:46 A.M. through 10:24 A.M., the Activities Assistant was observed to enter the unit at 8:46 A.M. and pass out a copy of the Daily Chronicle to the residents that were seated in the dining room. She then entered Resident 42's room and read a portion of the Daily Chronicle to that resident. She then came back out to the dining room, and sat with Resident 13, then Resident 38, then Resident 36 and read a portion of the Daily Chronicle to each of them. She then went into the common area and tossed a balloon back and forth with Resident 37 for two minutes, then left the unit at 9:06 A.M. Resident 97 was observed to wander in the hall, dining room, and common area. At 10:14 A.M., the Activities Director and Activities Assistant were observed to enter the unit and begin providing nail care for Resident 13 and Resident 35. During a continuous observation on 7/12/23 from 9:08 A.M. through 10:01 A.M., the following was observed: At 9:08 A.M., the Activities Assistant left the unit Resident 13 was lying in a recliner in the common area in front of the TV with her eyes closed. Resident 17 was sitting in the dining room at a table by himself. Resident 38 was sitting in the dining room at a table by herself. Resident 36 was wandering from the hall to the dining room. From 9:29 A.M. until 9:39 A.M.,		outcome related to this deficient practice.¿ ¿ ¿ There was a 100% audit on resident preference of activities by the activity director. Activity Director and Activity Assistant have been in-serviced on 8/1/23 by the Administrator that they are responsible for activities and the activity policy. Additionally, any staff that fails to comply with the points f=of this in-service will be further educated/or progressively disciplined as indicated. The Activity Director will complete the audit tool, auditing the activities in the facility to ensure that the calendars are followed in each unit at the times scheduled. Both activity calendars will be audited daily 5x/week x 4weeks, 3X/week x 4 weeks, 2x/week X 4months. Then quarterly in QAPI and any concerns will be addressed immediately.¿¿¿ ¿	

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	QMA 3 was observed playing dominoes with Resident 36. Resident 97 was observed sitting in the common area with a visitor. They both were observed walking in the hall, and sitting in the dining room. At that time, the visitor indicated she was Resident 97's daughter, and did not get to visit often but had been there to visit the previous two evenings as well as that day. She indicated every time she had visited, she had not seen any activities on the unit. On 7/10/23 at 10:30 A.M., a July 2023 Activity Calendar was provided for the Hope Springs Dementia Unit. The Activity Calendar included, but was not limited to: 7/9/23 Chronicles (no time) 7/9/23 Porch time (no time) 7/9/23 10:00 A.M. Hydration 7/9/23 11:00 A.M. Lotion 7/9/23 Therapy (no time) 7/10/23 11:00 A.M. Birdwatching 7/10/23 2:00 P.M. Mens group 7/10/23 2:30 P.M. Ringtoss 7/10/23 3:00 P.M. Sensory time 7/11/23 Chronicles (no time) 7/11/23 Porch time (no time) 7/11/23 9:00 A.M. Washers 7/11/23 10:00 Nail care 7/12/23 Chronicles (no time) 7/12/23 9:30 A.M. Washers 7/12/23 12:00 P.M. Birthday party 2. On 7/10/23 at 3:15 P.M., QMA 17 indicated there was no designated activity person on the Hope Springs Dementia Unit, and it was the staff working the floor who were responsible for doing activities with the residents. On 7/12/23 at 10:07 A.M., the Activities Director			

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	indicated she was currently the only staff member that transferred residents to appointments on the bus. She indicated when she was the only activities person in the building, and there were appointments, activities were canceled. There were sometimes several appointments a week, and could be gone for three to four hours at a time. She indicated the activities department consisted of her and an assistant who rotated weekends, so they were off every other Monday and Friday. If there were appointments on those days, activities did not get done. She indicated the Hope Springs Dementia Unit did their own activities, as they could not be in two places at once. On 7/12/23 at 12:08 A.M., Certified Nurse Aid (CNA) 15 was observed passing out lunch trays. At that time, she indicated once a month there was a birthday party activity that consisted of bringing in a couple of large cakes for the residents, and the celebration was on the calendar for today. On 7/12/23 at 1:28 P.M., CNA 15 indicated the Activities Director had forgotten about the birthday celebration and was currently out getting the cakes. At that time, Resident 13 was observed sitting in a recliner in the common area in front of a TV with her eyes closed, Resident 36 was wandering in the hall and dining room, and Resident 38 and Resident 97 were observed sitting in separate areas of the dining room by themselves. At that time, the Activities Director was observed taking cupcakes to the Hope Springs Dementia Unit and indicated staff and residents liked having the birthday celebration at lunchtime because they were all up and together in the dining room at that time, but since she had been out of the facility during that time, they might have them during dinner that evening.			

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On 7/13/23 at 9:26 A.M., CNA 15 indicated the Activities Assistant would come to the unit in the mornings and read the Daily Chronicle and devotions to the residents, and staff working the unit would entertain the residents the rest of the time. She indicated when there were three staff on the unit, they were able to take the residents outside, but most of the time there were only two staff on the unit at a time.

On 7/13/23 at 9:35 A.M., the Activities Assistant indicated she usually read the Daily Chronicle about four residents in the morning on the Hope Springs Dementia Unit, and the Activities Director would make sure they had plenty snacks and drinks. She indicated she would like to do a small group activity in the morning, and if she had time go back in the afternoon, but that didn't happen a lot because she had activities to do on the other units.

3. During the resident council meeting on 7/11/23 at 12:58 P.M., several residents indicated they would like to go on outings as activities, but the bus would only hold a couple of wheelchairs and not everyone could go. At that time, Resident 10 indicated there were no activities on the weekends.

On 7/13/23 at 2:37 P.M., a current non-dated Activities Program policy was provided and indicated "It is the policy of the facility to provide an ongoing program of Activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of the residents"

3.1-33(a)

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F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to provide an environment that was free from accident hazards, and ensure residents received adequate supervision and assistive devices to prevent accidents for 3 of 4 residents reviewed for accidents, and 1 of 4 units reviewed for hot water. The water temperature in resident areas exceeded 120 degrees Fahrenheit, care plans were not updated with new interventions following falls, neurological checks were not completed following falls, and interventions were observed out of place. (Hope Springs Dementia Unite, Resident 35, Resident 13, Resident 38) Findings include: 1. On 7/9/23 between 10:38 A.M. and 11:27 A.M., the following water temperatures were obtained on the Hope Springs Dementia Unit: Shower room 121.5 degrees Fahrenheit Room 309 (private bathroom) 124.1 degrees Fahrenheit Room 302 (private bathroom) 123.7 degrees Fahrenheit Room 303 (shared with room 304) 121.8 degrees Fahrenheit Room 310 (shared with room 311) 124.2 degrees	F 0689	F-689¿ ¿ It is the policy of the facility to provide an environment that is free from accident hazards, and ensure residents receive adequate supervision and assistive devices to prevent accidents.¿ ¿ All residents who reside in the facility have the potential to be affected by this finding.¿¿ ¿ A 100% audit was completed by DNS and ADNS for all current residents to ensure that all residents care plans were updated with current fall interventions, neurological checks were completed per policy and current fall interventions are in place.¿ Res 35 no longer resides in the	08/04/2023

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	Fahrenheit On 7/9/23 at 12:07 P.M., Licensed Practical Nurse (LPN) 21 indicated all residents on the Hope Springs Dementia Unit used the shower room in the hall to shower. On 7/9/23 between 1:40 P.M. and 1:50 P.M., the following water temperatures were obtained with the Social Services Director (SSD) with the facility's thermometer on the Hope Springs Dementia Unit: Shower room 127.0 degrees Fahrenheit Room 309 121.3 degrees Fahrenheit Room 302 121.5 degrees Fahrenheit Room 303 121.8 degrees Fahrenheit Room 310 124.7 degrees Fahrenheit At that time, the SSD indicated she was unaware what the water temperatures should have been, and indicated it was the housekeeping supervisor that usually took the water temperatures. At that time, the housekeeping supervisor indicated she was unsure how often the maintenance supervisor took the water temperatures, but thought it was daily. She indicated she would look for the logs of the temperatures, but could not locate them. On 7/9/23 at 2:15 P.M., the housekeeping supervisor indicated she was unaware of how to lower the water temperatures. She indicated the maintenance supervisor was currently out of town, but was on his way back. She also indicated the regional maintenance person was just in two days prior and had turned the water temperatures down. On 7/9/23 at 2:56 P.M., the maintenance supervisor arrived at the facility. He indicated the water temperatures should be below 120 degrees Fahrenheit. He indicated when he checked the		facility, res 13 and 38 have updated fall care plans and interventions in place on 8/2/23. An audit was completed of all water temperatures by the Maintenance Director and a new mixing valve was replaced on the hot water heater on 7/10/23.¿ All licensed nurses were in-serviced on fall policy and neuro check policy by ADNS and DNS on 8/3/23. Any staff who fail to comply with the policy will be further educated/or progressively disciplined as appropriate.¿ ¿ DNS/Designee will monitor the completion of neuro checks, fall care plans and fall interventions using a Fall Audit Tool for 5 residents weekly for a period of 4 weeks, 3 residents weekly for 4 weeks, then for 1 resident weekly ongoing for a period of 4 months. Maintenance Director/ designee will monitor water temps daily 2x/day 5 days a week X 6 months.¿ If the facility is within compliance at the end of 6 months; then monitoring can continue quarterly in QAPI. Any concerns will be addressed and correctly immediately.¿¿	

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	water temperatures two days prior (7/7/23), he got a temperature of 121 degrees Fahrenheit, and the regional maintenance person instructed him how to turn the valve down. There was a mixing valve that was adjusted to increase or decrease the temperature and after decreasing the temperature and letting the water run for an hour, they were able to get the water to 105 degrees Fahrenheit. He indicated the water temperatures were not checked on the weekends, and was unsure who took the temperatures prior to him taking the position. He indicated had just taken the maintenance position on 6/26/23. On 7/9/23 at 2:56 P.M., the maintenance supervisor checked the shower room water temperature on the Hope Springs Dementia Unit. Once the temperature was at 122.5 degrees Fahrenheit and still rising, he indicated it was too hot. He went to the room where the water heater was kept and untightened the mixing valve and attempted to turn the valve to the right. He indicated turning it that way should have lowered the water temperature, but it was turned as far as it would go. The thermometer at the top of the valve indicated 141 degrees Fahrenheit. On 7/10/23 at 8:30 A.M., a copy of the water temperature logs were provided for May, June, and July, 2023. All entries were written in the same handwriting. The temperatures documented on 7/7/23 were 101.7 degrees Fahrenheit, 110.4 degrees Fahrenheit, 102.1 degrees Fahrenheit, and 110.9 degrees Fahrenheit. A copy of the original temperature logs were requested on 7/10/23 at 9:45 A.M. and not provided. On 7/10/23 at 3:20 P.M., the maintenance supervisor indicated since he had been there, he had been the one to fill out the water temperature			

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	logs, and if he wasn't there, the housekeeping supervisor would do it. He indicated he did not know who filled them in prior to his employment. On 7/10/23 at 2:00 P.M., The Administrator indicated there was not a specific policy for water temperatures, but the staff should have followed the maintenance orientation checklist. At that time, the checklist was provided, and indicated "Water Temperatures ... Check daily to maintain between 105 - 115 degrees ..." 2. On 7/9/23 at 10:06 A.M., Resident 35 was observed sitting in the dining area. At that time, Licensed Practical Nurse (LPN) 21 indicated Resident 35 repeatedly placed himself on the floor. On 7/10/23 at 2:35 P.M., Resident 35's clinical record was reviewed. Admission date was 1/5/23. Diagnosis included, but were not limited to, dementia, anxiety, and depression. The most recent quarterly MDS (minimum data set) Assessment, dated 4/12/23, indicated a severe cognitive impairment. Resident 35 required extensive assistance of one staff with bed mobility, transfers, and toileting. Resident 35 had experienced two or more falls with no major injury since the prior assessment. A falls risk assessment, dated 1/5/23, indicated Resident 35 was a high risk for falls. A baseline care plan, signed 1/10/23, indicated Resident 35 was a falls risk. A current falls care plan, initiated 1/9/23, indicated, but was not limited to, the following interventions: Nursing to place multiple floor mats on resident floor due to behavior of crawling and sitting self			

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	on floor, dated 6/29/23. Replace batteries in fall mat, dated 6/19/23. Wheelchair in locked position within reach while resident is in bed, dated 3/9/23. Nursing will ensure that wheelchair remains at bedside in locked position, dated 4/25/23. Nursing will place dysem underneath fall mat, dated 4/25/23. Resident 35 had experienced 17 falls since admission on 1/5/23 that included the following: Fall 1 1/7/23 at 3:00 A.M. Unwitnessed. Resident was heard calling for help. Resident was in his room lying on his back in the middle of the floor. No documentation of neuro checks were found. At that time, a falls care plan was not in place, and an intervention to prevent future falls was not documented. Fall 2 1/8/23 at 10:00 A.M. Witnessed. Resident was in the dining room when the nurse was at the medication cart. The resident yelled out "ohh", and when the nurse turned around, the resident was leaning towards the right side. The resident fell out of the chair before he could be reached, and hit the right side of the head. Resident was sent to the hospital for evaluation, and all tests were negative for injury. Neuro checks were completed from the time of the fall until he left for the hospital. Upon returning, the resident's pupils and extremities were not checked with the rest of the neuro checks. At that time, a falls care plan was not in place. The following day, a care plan was initiated.			

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	Fall 3 2/7/23 at 9:28 A.M. Unwitnessed. Resident observed lying on the floor on his back next to the bed. No documentation of neuro checks were found. The falls care plan was updated to include bed in lowest position (intervention was discontinued on 6/26/23). Fall 4 2/26/23 at 3:15 A.M. Unwitnessed. Resident was found sitting next to the bed attempting to get out of bed without assistance. No documentation of neuro checks were found. An Interdisciplinary Team (IDT) note, dated 2/27/23, indicated a new intervention for mat beside bed. The falls care plan was not updated at that time. Fall 5 3/3/23 at 5:00 A.M. Unwitnessed. Resident was heard calling for help from his room. Resident was found sitting on the floor beside the bed on top of his pad. Resident indicated he slid off of the bed and denied hitting his head. A nurses note, dated 3/3/23, indicated in the future will only put one pad on the bed instead of two. No documentation of neuro checks were found. At that time, the falls care plan was updated with interventions for perimeter mattress, closer to nurses station, and for the resident to be up in the wheelchair in the dining room. Fall 6 3/8/23 at 10:22 A.M. Unwitnessed. Resident was heard calling for help from his room. Resident was found sitting on the floor next to the bed and wheelchair. Neuro checks were initiated, but the last three checks were not completed on 3/9/23 at 1:45 A.M., 9:45 A.M., and 5:45 P.M. An IDT note, dated 3/9/23, indicated a new intervention to have			

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	wheelchair within reach at the bedside when resident was in bed. The falls care plan was updated 3/9/23 with the new intervention wheelchair locked and within reach. Fall 7 3/9/23 at 10:45 A.M. Unwitnessed. Resident was found sitting on the floor next to his bed. Neuro checks were initiated, but not completed on 3/10/23 at 6:30 A.M., 10:30 A.M., 6:30 P.M., 3/11/23 at 2:30 A.M., 10:30 A.M., and 6:30 P.M. The care plan was updated with a new intervention for an alarm call light mat. Fall 8 3/23/23 at 1:33 P.M. Unwitnessed. Resident was heard calling for help from his room. Resident was found in the room beside the bed. No documentation of neuro checks were found. The falls care plan was not updated with a new intervention. Fall 9 3/25/23 at 11:30 P.M. Unwitnessed. The QMA heard resident's walker fall over in his room. Resident was found sitting on his floor mat alarm with his back against the bed and feet straight out. The floor mat was not alarming. The floor mat alarm and call light had come disconnected from the alarm. Neuro checks were initiated, but not completed on 3/26/23 at 7:30 A.M., 11:30 A.M., 3:30 P.M., 3/27/23 day, evening, or night shift. The falls care plan was not updated with a new intervention. Fall 10 4/4/23 Unknown if witnessed. A nurses note, dated 4/4/23 (did not indicate a time), indicated "...Resident fell. Mat was at bedside but resident moved mat. Dycem placed under mat to prevent			

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	mat from being moved". Neuro checks were not completed. The falls care plan was not updated with the new intervention. Fall 11 4/17/23 at 3:30 P.M. Unwitnessed. Resident was found on the floor in front of his door holding onto the handle. Resident complained of right shoulder pain, but an x-ray was negative for injury. No documentation of neuro checks were found. The falls care plan was updated on 4/25/23 to include toileting before and after meals, check the floor alarm, the bed to be at the same level as the wheelchair, wheelchair to be locked at the bedside, Dycem under the floor mat, and work on transferring in and out of the bed. Fall 12 6/19/23 at 1:48 P.M. Unwitnessed. Resident was found sitting on the floor in the middle of the bedroom. The floor mat alarm did not go off, and the batteries were changed. Neuro checks completed. The falls care plan was updated to include replace the batteries in the floor mat alarm. Fall 13 6/23/23 at 4:12 P.M. Unwitnessed. Therapy staff found the resident sitting in the middle of the bedroom on his knees. Neuro checks completed except for one 8 hour check on 6/24/23 at 11:00 P.M. A nursing progress note, dated 6/23/23, indicated placed Dycem between floor and mat to prevent mat from being pushed/kicked away from bed. The falls care plan was not updated with a new intervention. Fall 14 6/25/23 at 1:00 P.M. Unwitnessed. Resident found laying on the floor on his right side. A resident that was sitting beside him indicated he did not			

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	fall. He got on his knees and laid down on the floor. Neuro checks were initiated, but not completed on 6/26/23 at 12:45 A.M., 4:45 A.M., or 6/27/23 at 4:45 A.M. The falls care plan was updated at that time to include a psychiatric evaluation, non-skid strips in front of the bed, and replace Dycem under the mat (discontinued 6/28/23) Fall 15 6/27/23 at 9:33 A.M. Unwitnessed. Resident's floor mat alarm was sounding. Resident was found sitting on the floor mat leaning against the wall. Neuro checks were completed. The falls care plan was updated with a new intervention to obtain a urinalysis. Fall 16 6/28/23 at 1:14 P.M. Unwitnessed. Resident was found crawling on the bedroom floor near the door. Neuro checks were initiated but not completed on 6/30/23 at 12:20 P.M. or 8:30 P.M. The falls care plan was updated with a new intervention to have multiple mats on the floor, and resident has behaviors. Fall 17 7/10/23 at 4:45 P.M. Unwitnessed. A resident's family member notified staff that a gentleman was on the floor in the dining room. Resident was found lying semi-prone on the right side with wheelchair wheels unlocked. Neuro checks were provided 7/12/23 at 9:27 A.M. The had been initiated, but not completed on 7/10/23 at 9:30 P.M., 7/11/23 at 1:30 A.M., 3:30 A.M., or 3:30 P.M. None of the three 8 hour checks had been completed. The falls care plan was updated to include anti roll back on the wheelchair. On 7/10/23 at 3:00 P.M., Qualified Nurse Aide			

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	(QMA) 17 and Certified Nurse Aide (CNA) 8 were observed to assist Resident 35 from the bed to a wheelchair. CNA 8 had a gait belt tied around her own waist, and did not remove it and apply to the resident during the transfer. Two total mats were observed on the floor in front of the bed. Under the mat closest to the bed, non-skid strips were observed on the floor. Neither mat was observed with Dycem under them. On 7/12/23 at 9:57 A.M., Resident 35 was observed lying in bed. The bed was observed lower than the height of the wheelchair, and the wheelchair was not locked. On 7/13/23 at 9:16 A.M., Registered Nurse (RN) 7 indicated in the last month, Resident 35 had been threatening to put himself on the floor. At that time, she was unsure of any fall interventions that should have been in place for Resident 35. 3. On 7/9/23 at 9:50 A.M., Resident 13 was observed in her room sitting on her bed. Resident 13 was unable to verbalize anything. The bed she was in was observed to be in the middle of the room, not against any wall, and no mats were observed on the floor on either side of the bed. On 7/10/23 at 2:54 P.M., Resident 13's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety, Bipolar disorder, psychotic disorder, and schizophrenia. The most recent quarterly MDS Assessment, dated 5/2/23, indicated a moderate cognitive impairment. Resident 13 required extensive assistance of one staff with bed mobility, transfers, and toileting. A current falls care plan, initiated 5/2/20, indicated, but was not limited to, the following			

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	interventions: Mat to the right side of the bed, dated 3/3/23. Resident 13 had experienced five falls since 9/2022 that included the following: Fall 1 9/16/23 at 3:10 P.M. Unwitnessed. Resident found on the floor by the bathroom. Not utilizing walker or call light. Neuro checks were completed. An IDT note, dated 9/19/23, indicated a new intervention for a sign to walker to remind resident to use for ambulation. The falls care plan was not updated with a new intervention. Fall 2 9/27/23 at 11:40 A.M. Unwitnessed. Resident was found on the floor on her left side in the doorway. Resident was attempting to self ambulate with walker. No documentation of neuro checks were found. The falls care plan was not updated with a new intervention. Fall 3 3/3/23 at 1:45 A.M. Unwitnessed. Resident was found sitting on the floor between the beds and had stripped down to an incontinence brief. No documentation of neuro checks were found. An IDT note, dated 3/3/23, indicated a new intervention to have a mat on the floor in between the beds. The falls care plan was updated with the new intervention. Fall 4 6/29/23 at 7:47 A.M. Unwitnessed. Resident was heard yelling for help. Staff found resident on the floor wanting up. Resident was unable to verbalize what had happened. No documentation of neuro checks were found. An IDT note, dated 6/29/23, indicated a new intervention to have left side of the bed against the wall, and evaluate for			

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	memory care unit. The falls care plan was updated with the new intervention for evaluation for memory care, but not to move the bed. Fall 5 7/9/23 at 4:45 P.M. Unwitnessed. Resident was found lying on the floor in her room beside the bed. Resident had been incontinent of bowel. Neuro checks were initiated, but not completed on 7/10/23 at 12:30 A.M., 4:30 A.M., or on 7/11/23 at 4:30 P.M. An IDT note, dated 7/10/23, indicated a new intervention to encourage resident to stay in common area in recliner and to participate in group activities prior to meals after toileting. On 7/12/23 at 9:39 A.M., Resident 13's bed was observed to be against the wall. At that time, QMA 3 indicated Resident 13's bed was moved against the wall after a fall on 7/10/23 as a preventative measure related to that fall. On 7/13/23 at 9:17 A.M., RN 7 indicated she was unaware of any fall interventions Resident 13 had in place. 4. During an observation on 7/12/23 at 11:22 A.M., Resident 38 was observed holding a baby doll in the hallway sitting in a highback wheelchair with shoes on. On 7/12/23 at 8:35 A.M., Resident 38's clinical record was reviewed. Diagnosis included, but were not limited to, Alzheimer's disease, weakness, and unsteadiness on feet. The most recent quarterly MDS, dated 4/25/23, indicated Resident 28 had severe cognitive impairment, and required extensive assistance of 2 staff members for bed mobility, transfers, and toileting.			

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	Resident 38's care plan included, but was not limited to, "Resident is at risk for falls D/T [due to] history or recent fall. Resident has dx [diagnosis] weakness, unsteady gait, lack of coordination, abn [abnormal] gait," dated 11/8/22. Interventions included the following: "Attempt to keep areas free of clutter," dated 11/8/22 "bed in lowest position while in bed," dated 11/8/22 "Coordinate care with hospice services," dated 1/22/23 "Enabler bar x1 [times 1] for positioning," dated 2/8/23 "Ensure resident has non slip slippers on while in wheel chair," revised 6/26/23 "fall mat beside bed," dated 11/29/22 "highback wheelchair," dated 2/20/23 "Keep call light in reach," dated 11/8/22 "Notify and update MD [medical doctor] as needed," dated 11/8/22 "offer to lay down after meals," dated 12/30/22 "Res [resident] to remain in high back w/c [wheelchair] when sitting in tv [television]/ lounge area," dated 2/28/23 "Resident to have activity blanket to distract when agitated," revised 6/26/23 "Resident to use body pillow while in bed," revised 6/26/23 "Room re-arranged with bed against the wall for safety," revised 11/8/22 "stuffed mechanical cat for comfort," revised 2/21/23 "Therapy screen as indicated, quarterly and prn [as needed]," dated 11/8/22 "Toilet before and after meals," dated 1/3/22 Resident 38's fall history included the following: Fall 1:			

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	On 11/23/22 at 5:39 P.M., Resident 38 was found sitting on the floor by her roommates bed. Fall 2: On 12/29/22 at 2:00 P.M., Resident 38 was heard yelling out, and staff found her on the floor in the lounge. Fall 3: On 12/30/23 at 3:45 P.M., staff witnessed Resident 38 stand up and before staff made it to the resident, she fell on the floor. She did not hit her head. Fall 4: On 2/19/23 at 6:11 P.M., staff heard Resident 38 yelling, "please help me," and found her laying on the floor. The new intervention at that time was to utilize a highback wheelchair. Fall 5: On 2/27/23 at 3:54 P.M., staff witnessed Resident 38 land on her buttocks when she attempted to move from the couch. She did not hit her head during that fall. The new intervention at that time was to remain in a highback wheelchair when sitting in the lounge area. Fall 6: On 3/20/23 at 8:00 P.M., Resident 38 called for help and she was found sitting on her floor mat beside her bed. The facility failed to document vital signs (blood pressure, temperature, heart rate, respiration rate, and oxygen saturation) during 2 of the 15 minute neurological checks (8:15 P.M. and 8:45 P.M.). The facility failed to document any neurological checks were completed after 9:00 P.M. on 3/20/23. There was not a new care plan intervention implemented.			

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	Fall 7: On 3/27/23 at 6:08 P.M., staff witnessed Resident 38 fall on the ground in the lounge area. She did not hit her head. The new intervention at that time was an activity blanket if the mechanical cat was not working, dated 4/25/23. The facility failed to update their care plan immediately. Fall 8: On 4/13/23 8:20 P.M., Resident 38 was found on the floor mat beside the bed. The facility failed to complete the neurological check on 4/15/23 at 4:45 A.M. Fall 9: On 4/28/23 at 7:00 P.M., staff found Resident 38 in the lounge area on the floor. There was not a new care plan intervention put into place at that time. Fall 10: On 6/15/23 at 5:10 P.M., staff found Resident 38 laying on her right side on the dining room floor. During an interview on 7/12/23 at 11:21 A.M., CNA (Certified Nurse Aide) 15 indicated the following interventions are utilized to prevent Resident 38 from falling: fall mat by her bed, a bird feeder, candy jar, jelly beans, and assisting resident to her recliner. At that time, she indicated Resident 38 had not used the mechanical cat recently. During an interview on 7/13/23 at 12:18 P.M., the Administrator indicated the same care plan intervention would be utilized 2 different times as a new intervention if the intervention worked well several months before and it was a similar fall. On 7/12/23 at 9:19 A.M., QMA 3 indicated neuro checks were supposed to be completed with every			

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	unwitnessed fall. They were filled out on paper, and were supposed to be fully completed as indicated on the form. On 7/13/23 at 12:13 P.M., the Administrator indicated the morning after a resident fall, it was supposed to be discussed at the clinical meeting. The meeting consisted of discussing interventions that had been tried previously, what was in place currently, and what other interventions could be initiated. She indicated the care plan should be updated by MDS staff after every fall, and at no time would the care plan not be updated. The facility staff would call their regional nurse consultant if needed to decide on a new intervention. On 7/13/23 at 3:40 P.M., a current non-dated Falls policy was provided, and indicated "... residents who have an unwitnessed fall must have neuro check started and continued per policy. Neuro checks will be initiated even if the resident states they did not hit their head in an unwitnessed fall ... Based on the results of the incident/accident/fall, the resident's care plan will be addressed to ensure that any needed points of focus have measurable goals with appropriate interventions in place" 3.1-45(a)(1) 3.1-45(a)(2)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date.			

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	(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure completed nurse staffing sheets were posted daily for 4 of 5 days during the survey. Findings include:	F 0732	F732¿ ¿ In accordance with this regulation, it is the policy of the facility to ensure the BIPA is posted in a clear and readable format, as well	08/04/2023

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	On 7/9/23 at 9:26 A.M., a staff posting sheet was observed on the wall by the nursing station at the entrance. It was dated 7/3/23, did not have the facility name on the sheet, and the actual working hours of nursing staff were not included. On 7/11/23 at 11:15 A.M., staff posting sheets were provided for the following dates: 7/9/23 7/10/23 7/11/23 7/12/23 Each staff posting sheet indicated the date, census, and number of hours worked for each shift. Disciplines included RN (Registered Nurse), LPN (Licensed Practical Nurse), CNA (Certified Nurse Aide), and QMA (Qualified Medication Aide). Actual hours worked and the facility name were not included on the postings. During an interview on 7/12/23 at 11:23 A.M., the Administrator indicated the DON (Director of Nursing) was responsible for completing and posting the nurse staffing sheets daily and they should be posted everyday for the current day. At that time, she indicated the nurse staffing sheets for the weekend should be placed behind Friday's sheet. On 7/13/23 at 8:27 A.M., the Administrator indicated that was the way they have always done nurse staffing sheets and she was unaware the actual working hours should be on the form. She indicated that the forms given were bad copies and that's why they did not include the facility name on them. On 7/12/23 at 1:35 P.M., an undated Posted Nurse Staffing policy was provided by the Administrator and indicated "SNFs and NFs must post daily, at		as in a prominent place for residents and visitors to be able to view staffing hours. BIPA is to be posted for the current day, and changes made to it if/when the staffing discipline and/or the actual hours working change. The campus name is to be on the BIPA, the current date, current census, all nursing disciplines, and the actual hours worked.¿ ¿ All residents who reside in the facility have the potential to be affected by this finding.¿¿ ¿ The scheduler was in-serviced by the DNS on 8/1/23 on the BIPA policy.¿¿ A 100% audit was completed by the scheduler for daily BIPA with look back period of 30 days to ensure that all BIPA forms were complete and accurate.¿¿ ¿ DNS/designee will monitor the completion of the BIPA utilizing the daily staffing audit tool¿¿ ¿5 days a week x 4 weeks, 3 days a week X 4 weeks, then 2 days a week x 4 weeks, then for 2 days weekly for a total of 3	

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	the beginning of each shift, the facility specific shift schedule for the 24 hour period, the number and category of nursing staff employed or contracted by the facility for each 24 hour period, as well as the total number of hours worked by licensed and licensed nursing staff [sic] who are directly responsible for resident care ... 3. Other required posted data includes: a. facility name ... ". The policy did not indicate regulation requirements for the actual worked hours to be on the form.		months. If the facility is within compliance at the end of 6 months; then monitoring can continue quarterly in QAPI. Any concerns will be addressed and correctly immediately.¿¿	
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. §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			

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	dose can be readily detected. Based on observation and interview, the facility failed to ensure proper storage of medications in 1 of 2 medication storage rooms. Discontinued/expired medications were stored in the storage room and not appropriately disposed. (100 Hall Medication Storage Room) Findings include: On 7/12/23 at 10:00 A.M., a plastic container was observed sitting on the counter in the Medication Storage Room on the 100 Hall with the following medications for residents no longer residing in the facility: Resident discharged on 7/3/23 ducosate sodium 100 mg (milligrams)-9 capsules ibuprofen 600 mg-30 pills epinephrine 0.3 mg-3 pens chloraseptic lozenges-18 lozenges Hospice resident, passed on 6/2/23 acetaminophen 650 mg suppositories in a prescription bottle-3 suppositories Hospice resident, passed on 6/20/23 haloperidol 5 mg in a prescription bottle-9 pills Hospice resident, passed on 7/3/23 saline enema-4 boxes A tied plastic bag of expired medications from the Emergency Medication System contained the following medications: diltiazem 30 mg-15 unit dose packages amoxicillin/clavulanic acid 875/125 mg-14 unit dose packages ciprofloxacin 250 mg -12 unit dose packages cefuroxine 250 mg -6 unit dose packages halsperidol 2 mg -24 unit dose packages	F 0761	F-761¿ ¿ In accordance with this regulation, it is the policy of the facility to ensure that discontinued/expired meds are not left in the medication storage room greater than 72 hours and are disposed of/ returned per policy.¿¿ ¿ All residents who reside in the facility have the potential to be affected by this finding.¿¿ ¿ All licensed nurses were in-serviced on medication storage/disposal by the ADNS on 8/3/23.¿¿ A 100% audit of both medication storage rooms was completed by the ADNS all medications that were expired or discontinued have been returned or disposed of properly on 8/3/23. Any staff who fail to comply with the policy will be further educated/or progressively disciplined as appropriate.¿ ¿ DNS/designee will monitor the	08/04/2023

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	meloxicam 15 mg-11 unit dose packages cephalexin 250 mg-17 unit dose packages furosemide 20 mg-14 unit dose packages Vitamin C 500 mg-13 unit dose packages During an interview on 7/12/23 at 10:00 A.M., RN 7 indicated the facility pharmacy had to be notified when there were medications to be picked up after a resident had been discharged or passed away. The facility pharmacy came to the facility two times a day between 1:00 P.M. to 3:00 P.M. and 12:00 A.M. to 1:00 A.M. If the medication was not from the facility pharmacy, the medication had to be destroyed which was done by the night shift nurse. During an interview on 7/12/23 at 1:35 P.M., the Administrator indicated when a resident passed while they were on hospice, the hospice nurse needed to notify their DME (Durable Medical Equipment) provider to come to the facility to get any medications left over. During an interview on 7/13/23 at 8:30 A.M., the Administrator indicated when a resident was discharged, the night shift nurse filled out a form for the facility pharmacy to pick up medications and rubber banded the form to the medications for the pharmacy to pick up when they came to the facility. A current Discontinued Medications policy, dated March 2023, provided by the Administrator on 7/13/23 at 12:10 P.M. indicated "All non-scheduled medication discontinued by the physician will be returned to the (pharmacy name) for a credit if completely unused or will be destroyed in accordance with local, state, and federal regulations"		Medication Disposal audit tool completion.¿¿ ¿5 days a week x 4 weeks, 3 days a week X 4 weeks, then 2 days a week x 4 weeks, then for 2 days weekly ongoing for a period of 12 weeks for no less than a total of 6 months. If the facility is within compliance at the end of months; then monitoring can continue quarterly in QAPI. Any concerns will be addressed and correctly immediately.¿¿	

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	A current undated Medication Storage in the Facility policy provided by the Administrator on 7/13/23 at 12:10 P.M. indicated "...14. Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled or without secure closures will be immediately withdrawn from stock. They will be disposed of according to drug disposal procedures, and reordered from the pharmacy if a current order exists. 15. Medication storage areas are kept clean, well lit, and free of clutter..." 3.1-25(o) 3.1-25(q) 3.1-25(r)			
F 0812 SS=D 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			

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	standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food items were properly labled and not expired during 1 of 2 kitchen observations. Findings include: During the initial tour of the kitchen on 7/9/23 at 9:23 A.M., the following was observed: Dry storage: An undated plastic 22 quart container with 4 quarts of cereal. Refrigerator: An undated block of cheese. A bag of cheddar shredded cheese, dated 6/27/23 and 7/6/23. A bag of mozzarella shredded cheese, dated 7/4/23 and 7/5/23. A container of chicken base, dated 7/2/23 3 bags filled with ham. 2 bags dated 7/6/23 and 1 bag was unreadable. A container of tomato soup, dated 7/2/23. A container of garlic gin oil, dated 6/28/23. Freezer: A bag of mixed vegetables, dated 6/1/23. A container of tomato sauce, dated 4/20. The label lacked a year. 2 apple pies, 1 was dated 2/26/23 with a use by date of 3/1/23, and the other pie was dated 4/23/23 and did not have an expiration date on it. During an interview on 7/9/23 at 9:28 A.M., cook 5 indicated food items are are dated when they are opened and discarded 3 days later. The evening cook is supposed to go through the items and discard the expired items, but she was unsure how	F 0812	F-812¿ ¿ In accordance with this regulation, it is the policy of this facility to follow the professional standards for food service safety. This includes ensuring food items are properly dated, labeled, stored properly and are not expired per facility policy and State and Federal guidelines.¿ ¿ All residents who reside in the facility have the potential to be affected by this finding.¿¿ ¿ There was a 100% audit of food item labels and dates by Food Service Director on 8/1/23. The dietary department was in-serviced on 8/1/23 on the food safety and sanitation policy and storage of refrigerated/frozen foods by corporate dietician and dietary director.¿ Any staff who fail to comply with the policy will be further educated/or progressively disciplined as appropriate. ¿ Dietary Director/ designee will monitor the daily kitchen	08/04/2023

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	often they check those items and discard of expired items. During an interview on 7/9/23 at 9:43 A.M., the dietary manager indicated when items are received, they are dated and when they are opened, an open date is wrote on the item. They do not write an expiration date on items. At that time, he indicated he checked the items weekly and discarded expired items. On 7/13/23 at 10:00 A.M., the Administrator provided the Food Storage policy, revised 4/2017, that indicated "Label all food items. The label must include the name of the food and the date by which it should be sold, consumed, or discarded...If the item has not been used by the determined date, the remaining product is discarded...Store leftover contents of cans and prepared food in clean, sanitized containers with proper and secure covers. The new container shall be labeled with the name of the food item and the original expiration date..." 3.1-21(i)(2) 3.1-21(i)(3)		sanitation checklist daily 5x/week X 4weeks, 3X/week x 4 weeks, 2x/week X 4months. Then quarterly in QAPI and any concerns will be addressed immediately.¿¿¿	
F 0882 SS=F Bldg. 00	483.80(b)(1)-(4) Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;			

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	§483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. Based on interview and record review, the facility failed to designate one or more individual(s) as the Infection Preventionist with qualifying training or certification. The facility did not have a current certified Infection Preventionist for 5 of 5 days of the survey. Finding includes: On 7/10/23 at 8:15 A.M., the Administrator indicated the ADON (Assistant Director of Nursing) was the Infection Preventionist and provided a certificate that indicated the ADON had successfully completed CDC (Centers for Diesease Control and Prevention) Train Module 1 Infection Prevention and Control Program from the Nursing Home Infection Preventionist Training Course, dated 3/28/23. During an interview on 7/13/23 at 11:26 A.M., the ADON indicated she was the Infection Preventionist and started that role in April of 2023. At that time, she indicated she wasn't sure if she had to be certified but thought completing Module 1 of the CDC training meant her certification was complete. She was unaware there were 23 other modules needed to complete her certification. On 7/13/23 at 3:50 P.M., a current Infection Preventionist policy, dated 12/1/14, was provided	F 0882	F-882¿ ¿ In accordance with this regulation, it is the policy of the facility to designate one or more individuals as the Infection Preventionist with qualifying training or certification.¿ ¿ All residents who reside in the facility have the potential to be affected by this finding.¿¿ ¿ DNS was in-serviced by the Administrator on Infection Preventionist requirements on 8/3/23. DNS and ADNS completed training to meet regulation requirements for Infection Preventionist. Additionally, any staff that fails to comply with points of this in-service will be further educated/or progressively disciplines as indicated. ADNS	08/04/2023

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	by the Administrator and indicated " The Infection Preventionist is responsible for coordinating the implementation and updating of our established infection control policies and practices ... ". The policy lacked information about the regulation requirements.		designated as Infection Preventionist and DNS designated as back up.¿ ¿ Administrator will monitor the Infection Preventionist audit tool 1 day a month x 6 months.¿ If the facility is within compliance at the end of 6 months; then monitoring can continue quarterly in QAPI. Any concerns will be addressed and correctly immediately.¿¿¿	
F 9999 Bldg. 00	3.1-13 ADMINISTRATION AND MANAGEMENT (w) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six	F 9999	Deficiency ID:¿F _ 0000 Completion Date:¿8/3/2023 Plan of Correction Text: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws.¿ Facility's date of alleged compliance is 8/3/2023. We	08/04/2023

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	(6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. This state rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure a Dementia Disclosure Agreement had been submitted 5 of 5 days of the survey, and failed to ensure the Dementia Director completed the required dementia-specific hours during the first 30 days of employment. (Dementia Director) Findings include: 1. On 7/10/23 at 11:40 A.M., a "Schedule Z" form was provided in place of a Dementia Disclosure Agreement. At that time, the Administrator indicated when the dementia unit was opened in September 2022, she asked her corporate staff as well as the state what forms she needed to fill out, and was only given the "Schedule Z" form. She was unaware the a Dementia Disclosure Agreement was required annually. On 7/13/23 at 3:17 P.M., the Administrator indicated they did not have a policy to include requirements for a Dementia Disclosure Agreement form, but the policy of the facility would be to follow regulation. 2. The employee files were reviewed on 7/13/23 at 9:00 A.M. The Dementia Director's employee file included a form titled "Inservice Attendance Record" with three columns for the date, time, and topic to be written in. This form indicated the Dementia Director had 0.5 hours of dementia training 5/4/22 and 4.5 hours of [name of person]		cordially request that this plan is considered for desk review. F-9999¿ ¿ In accordance with this regulation, it is the policy of this facility to ensure a dementia disclosure agreement has been submitted and will be submitted annually, the dementia director has completed the required 12 hours of dementia training and all staff who have regular contact with residents have received the required six hours of dementia-specific¿ training and the three hours of annual training.¿ ¿ All residents who reside in the facility have the potential to be affected by this finding.¿¿ ¿ Administrator in-serviced on dementia disclosure agreement by Regional VP of Operations on¿¿ 7/13/23 and form submitted per	

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	dementia training on 8/10/22. The employee file lacked the remaining 7 hours of the required 12 hours of dementia training within 3 months of initial employment as the director of the locked dementia unit. On 7/13/23 at 3:30 P.M., the specific content and hours of dementia inservices were requested from the Administrator and when provided, the information lacked the specific content and hours of inservices. During an interview on 7/13/23 at 2:37 P.M., the Administrator indicated she was unsure how many hours of dementia training were required for the Dementia Care Director. On 7/13/23 at 3:50 P.M., a current Guidelines for Dementia Training policy, dated 6/30/23, was provided by the Administrator and indicated " It is the intent of this facility to ensure that staff who render care and services to residents who have a diagnosis of Dementia--have adequate training to meet the needs of these residents who have been affected by the process of Dementia ... For Alzheimer's Unit Director in a designated Alzheimer's Unit 5. The Alzheimer's Unit Director will have 12 hours of Dementia Training within 3 months of hire ... Failure to comply with taking the required Dementia Training timely may result in being taken off of the schedule until compliance with this training is achieved ... " 3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with		regulation on 7/13/23 electronically.¿ SSD in-serviced on required dementia training by RDO on 7/13/23 and SSD dementia training completed by 8/1/23. Audit of personnel files by HR and all staff requiring dementia training completed dementia in-servicing completed 8/3/23.¿ Any staff who fail to comply with the policy will be further educated/or progressively disciplined as appropriate.¿ ¿ Administrator/designee will monitor the dementia disclosure agreement quarterly in QAPI and submit annually. Administrator will audit SSD dementia training monthly X 12 months. Administrator /designee to monitor 3 new hires for dementia training 1 X week X 4 weeks, then 1 X month x 6 months. If the facility is within compliance at the end of 6 months; then monitoring can continue quarterly in QAPI. Any concerns will be addressed and correctly immediately.¿¿	

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	residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of the cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure all required dementia training hours were obtained for 4 of 5 new employee records reviewed. Employees with potential to work on the dementia unit did not receive the required six hours of dementia-specific training within the first 30 days of employment. (Registered Nurse (RN) 7, Certified Nurse Aide (CNA) 20, Qualified Medication Aide (QMA) 17, and CNA 30) Findings include: The employee files were reviewed on 7/13/23 at 9:00 A.M. The employee files lacked the 6 hours of dementia training within 30 days of employment for personnel assigned to the locked dementia unit. 1. RN 7's hire date was 9/15/22. 0 hours of dementia training were provided. RN 7 was working day shift on the locked dementia unit during the survey period. 2. CNA 20's hire date was 3/1/23. 0 hours of dementia training were provided. 3. QMA 17's hire date was 10/19/22. 0 hours of dementia training were provided. QMA 17 was			

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	working day shift on the locked dementia unit during the survey period. 4. CNA 30's hire date was 4/10/23. 0 hours of dementia training were provided. During an interview on 7/13/23 at 10:08 A.M., the Human Resources Director (HR) indicated all staff have potential to work both on skilled and in the locked dementia unit. During an interview on 7/13/23 at 3:38 P.M., the Administrator indicated she was unsure of the requirements for staff dementia inservice training, but staff was sent a message twice through their individual phones that their training needed to be completed. At that time, she indicated that the next step was to set a deadline for dementia inservices to be completed and restrict them from working until their hours were completed. On 7/13/23 at 3:50 P.M., a current Guidelines for Dementia Training policy, dated 6/30/23, was provided by the Administrator and indicated " It is the intent of this facility to ensure that staff who render care and services to residents who have a diagnosis of Dementia--have adequate training to meet the needs of these residents who have been affected by the process of Dementia ... For staff assigned specifically to a Dementia/Alzheimer's unit 3. Staff assigned specifically to a Dementia/Alzheimer's Unit will receive 6-hours of Dementia Training as part as [sic] their on-boarding process. This training must be completed within 30 days of hire ... Failure to comply with taking the required Dementia Training timely may result in being taken off of the schedule until compliance with this training is achieved ... "			