STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155149	A. BUILDING 00 B. WING	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 19, 20, 21, 22, 23, and 26, 2022. Facility number: 000070 Provider number: 155149 AIM number: 100266190 Census Bed Type: SNF/NF: 72 SNF: 8 Total: 80 Census Payor Type: Medicare: 3 Medicaid: 55 Other: 22 Total: 80 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 4, 2022.	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 10/20/22.	
F 0559 SS=D Bldg. 00	483.10(e)(4)-(6) Choose/Be Notified of Room/Roommate Change §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the			

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

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	same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. Based on interview and record review, the facility failed to ensure the resident or responsible party was notified of a room change before the change occurred for 1 of 1 resident reviewed for room changes. (Resident 39) Finding includes: The record for Resident 39 was reviewed on 9/25/22 at 1:20 p.m. Diagnoses included, but were not limited to, diabetes, end stage renal disease (condition in which a person's kidneys cease functioning) and glaucoma (eye conditions which damage the optic nerve). A significant change in condition Minimum Data Set (MDS) assessment, dated 9/12/22, indicated Resident 39 had a mild cognitive impairment, mild depression and a visual impairment. A Hospital ER (Emergency Room) Transfer Form, dated 7/8/22 at 11:09 a.m., indicated Resident 39 was transferred to the hospital on 7/8/22, and a Bed Hold policy would be provided at the time of hospital transfer. The Hospital ER transfer form further indicated the purpose of the Bed Hold policy was to provide guidance to the facility staff for holding a bed during a resident transfer. The form lacked indication Resident 39 received notification in writing of a notification of a room change. A copy of Resident 39's room change	F 0559	**F 559 Choose/Be notified of Room/Roommate Change** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident 39 was provided with Bed Hold Policy. - Resident 39 reoriented on new room. - Resident 39 was noted without any distress. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** - No other residents have been affected or voiced concerns. All future resident that admit or readmit have potential to be affected by the alleged deficient practice. - Facility to provide education to staff via staff inservicing. Education to include Bed Hold Policy, room move notification, and orientation to room for all new	10/20/2022

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	notifications for 6/15/22, 7/13/22 and 9/15/22 was requested and no copies were provided. The SSD (Social Services Director) indicated the facility did not have written documentation Resident 39 was notified of a room change prior to a room change. The facility used the bed hold policy. During an interview, on 9/19/22 at 9:22 a.m., Resident 39 indicated he had gone to the hospital and when he returned to the facility, he had been moved to a different room. He was upset the facility did not notify him first and when he entered his room, his belongings were just placed in random spots. He had difficulty seeing related to his glaucoma so he had a difficult time finding his clothes and phone charger. He just wanted to be informed prior to moving into a new room and to be able to maintain as much independence as possible. During an interview, on 9/23/22 at 9:27 a.m., Corporate Social Services (CSS) indicated Resident 39 had a few room changes. On 6/15/22, Resident 39 requested to move to a private room. On 7/13/22, Resident 39 was moved to a different room because he was hospitalized and his payment source had changed. Resident 39 was given a bed hold policy but CSS was unable to verify if Resident 39 was given notice he would be moved to a new room. Resident 39 was temporarily moved to another room, on 9/15/22, after he returned from the dialysis center, due to the death of Resident 39's roommate. The CSS indicated residents should be notified of a room change prior to moving a resident. During an interview, on 9/22/22 at 2:30 p.m., the Director of Nursing (DON) indicated a notification		admissions plus readmissions. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Facility to provide education to staff via staff in servicing. Education to include Bed Hold Policy, room move notification, and orientation to room for all new admissions plus readmissions. - IDT will review each admission and discharge for needs on next business day. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** **-** The DNS/designee will be responsible for the completion of the F559 CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee.	

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	of room change would be a verbal notification with the staff documenting in the resident's chart. She was not aware if Resident 39 was notified of the room change when he left or returned to the facility. Resident 39 was moved due to a change in insurance. A copy of the notification of room change policy was requested and was not provided prior to exit. 3.1-3(v)(2)			
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with			

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	other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on observation, interview and record review, the facility failed to ensure a newly admitted resident's advanced directive was obtained from a reliable family member, the hospital or the previous hospice company for 1 of 19 residents reviewed for advance directives. (Resident 78) Finding includes: On 9/19/22 at 12:28 p.m., during a random observation, Resident 78 was confused as to time and place. She was not able to be interviewed. The record for Resident 78 was reviewed on 9/21/22 at 10:07 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance and heart disease. The discharge hospital documentation indicated Resident 78 had been living at home with her husband under hospice care with (Name of Hospice). She had a fall in the home where she	F 0578	**F 578** **Request/Refuse/Discontinue Treatment; Formulate Adv Dir** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Facility noted to have documentation on code status discussion with husband of resident 78 due to post form from the hospital being incomplete and unclear. Husband provided facility with wishes for resident 78 to be a full code upon admission. Husband noted to be care giver for resident 78 prior to admission. **How other residents having the potential to be affected by the**	10/20/2022

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	had sustained multiple injuries which included a fractured knee and finger. The resident had a POLST (physician's orders for life sustaining treatment) form and orders for do not resuscitate. It was decided for comfort care only in the hospital and transfer to a nursing facility upon discharge. The hospice company was contacted to obtain the correct medication list, as the husband was unable to provide. Additional notes from the hospital indicated the family was agreeable to comfort based care while in the hospital. Case Management was to help with discharge plans and admission to (Name of Facility) with DNR/DNI (do not resituate; do not intubate). An admission note, dated 8/29/22 at 3:00 p.m., indicated the resident was transferred to facility via ambulance and was accompanied by 2 paramedics. The resident was alert and oriented to her name, with some confusion noted. The resident was a full code due to no signed DNR (do not resuscitate). The resident's code status, on the physician's orders, face sheet and care plan was listed as full code. A Physician's note, dated 9/1/22, indicated the resident was seen at the facility with her daughter present. The daughter indicated the resident was a DNR but the husband wanted her to be a full code. The daughter expected her to reside at the facility "for life." The resident had been on home hospice. The most recent hospital H&P [history and physical], last progress notes, labs and advanced directive records were requested for assistance with completing/recompleting POLST.		**same deficient practice will be identified and what corrective action(s) will be taken;** -No other residents have been affected. All residents with advanced directives had potential to be affected by alleged deficient practice. -Inservice to be completed by 10/19/2022 educating staff on post form policy. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** -Inservice to be completed by 10/19/2022 educating staff on post form policy. - IDT to review code status of all new admissions and readmissions on next business day. - IDT will review code status and advanced directives with family during initial care plan meeting. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** **-** The DNS/designee will be responsible for the completion of the F578 CQI Tool 5 x/ week for 4	

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	A care plan, dated 9/01/22, indicated the resident/legal representative preferred a full code status and had a history of receiving in home hospice services with name of (Hospice Company) for additional help at home. The goal was the resident/legal representative preferences in regards to code status would be honored. A Social Service note, dated 9/01/22 at 11:03 a.m., indicated spoke with husband who "...stated they live in a condo and [Name of Hospice Company] was providing care 3x/week (ADLs, bathing, etc.)...." A Social Service note, dated 9/12/22 at 11:30 a.m., indicated the resident would like to return home to condo with her spouse and resume hospice services. Social Services (SS) discussed the history of Hospice Services and asked if Advanced Directives were ever discussed, the spouse indicated 'no'. Reviewed Code Status (currently a Full Code). The spouse indicated he wanted her to remain a full code at this time. SS recommended Advanced Directives continue to be discussed with the resident and family due to her age and overall frail condition. A Social Service note, dated 9/20/22 at 10:50 a.m., indicated the resident's family had decided for the resident to remain in long term care and resume services from [Name of Hospice Company]. SS was unable to connect with the spouse and contacted the resident's daughter. The daughter indicated she did not think the resident should return home with the spouse, should stay in the facility and resume hospice service at facility. On 9/22/22, the resident's code status was changed in the medical record to "Code Status: DNR." A new POST form was signed by the		weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee.	

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	resident's spouse on 9/22/22 and scanned into the record. During an interview, on 9/20/22 at 10:15 a.m., the Consultant Social Services (CSS) indicated the facility did not have any Advanced Directives or POST form for the resident. She was not a hospice resident at this facility. She was a full code. The facility did not have a full time Social Service Director. The position had been managed by the corporate office until they had found someone. During an interview via conference call, on 9/21/22 at 10:20 a.m., the (Name of Hospice Company) Nurse and Coordinator indicated Resident 78 came off home hospice (revoked) on 8/25/22 per husband request as he was taking her to the hospital for treatment. The resident had a POST form, signed by the husband on 6/22/22, for a DNR. The hospice company had not been notified she was at a long term facility and they had not been contacted to see her there or provide any information. A current facility policy, titled "Physician's order for Scope of Treatment (POST)," dated August, 2013 and provided by the Director of Nursing (DON) on 9/26/22 at 12:22 p.m., indicated "...For residents admitting with an existing POST form: The admitting nurse will note the existence of the POST form...the current original form is placed in the resident's record...Physician's orders indicating the decisions made on the POST form will be added to the resident's admitting orders...The POST will be honored during the initial comprehensive assessment period (14 days) even if the attending physician has not yet formally reviewed the form...." 3.1-4(f)(4)(A)(ii)			

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	3.1-4(f)(4)(B)			
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe			

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	temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview and record review, the facility failed to provide a safe, clean and comfortable interior environment for 1 of 1 hallway (Willow Bend) and 1 of 2 residents room. (Resident 39 and 72) Findings include: 1. During an observation, on 9/19/22 at 9:30 a.m., the Willow Bend Hallway was found on both sides to be cluttered with patient care transfer equipment, a cleaning cart, a food service cart, a wheelchair, a Broda chair, a delivery cart and personal protective equipment carts. The record for Resident 39 was reviewed. Diagnoses included, but were not limited to, end stage renal disease (kidneys cease functioning), diabetes, visual disturbances, glaucoma (eye condition which damage the optic nerve), heart failure (occurs when the heart muscle doesn't pump blood as well) and muscle weakness. A Functional Assessment, completed on 9/6/22 at 3:42 p.m., indicated Resident 39 used a manual wheelchair and required supervision or touching assistance during activity. A care area assessment (CAA), dated 9/16/22, indicated Resident 39 had mild cognitive impairment, visual impairment and required assistance with all aspects of activities of daily living (ADL's).	F 0584	**F 584** **Safe/Clean/Comfortable/Homel ike Environment** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Facility provided area for safe storage for equipment when not in use. - Facility provided deep cleaning for resident 72 room. -Facility continue to make sure that Resident 39 and resident 72 both continue daily activities without limitations. - Facility contacted Steritech to provide additional pest control. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** - 14 residents had potential to affected d/t residing on this hallway. -Inservice to be completed by 10/19/2022 educating staff on environmental	10/20/2022

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	A care plan, dated 9/21/22 at 9:27 p.m., indicated Resident 39 had impaired vision related to the diagnosis of Glaucoma. The care plan directed staff to provide an environment free of clutter and to ensure the floor was free of foreign objects. A Fall Risk Assessment, dated 9/22/22 at 6:48 p.m., indicated Resident 39 was a high fall risk. A Physician's Order report, dated 9/26/22, indicated Resident 39 used a wheelchair and walker. During observation of the Willow Bend Hallway, on 9/19/22 at 10:26 a.m., to 10:50 a.m., revealed to have multiple pieces of patient care equipment, carts, and personal protective equipment bins blocking the hallway making it difficult for Resident 39 to wheel himself through. a. A Hoyer lift b. A Ez Stand patient lift c. Medication cart d. 22-inch Broda Chair e. Three isolation PPE carts f. Food Service tall metal cart g. A housekeeper and cleaning cart h. Delivery cart with a standing trapeze device i. Wheelchair During an interview, on 9/19/22 at 9:45 a.m., Resident 39 indicated the staff encouraged him to be independent as possible and to propel himself down to the nurse's station when he went out for dialysis. It had become difficult at times because his vision was blurred, it was difficult to see objects until he was right up near them. During an interview, on 9/21/22 at 11:13 a.m., Housekeeper staff indicated she tried to keep the cleaning cart near the door of the resident's room		clutter and storage of equipment. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Inservice to be completed by 10/19/2022 educating staff on environmental clutter, cleaning, and storage of equipment - Management to complete daily rounds to monitor for needs r/t storage, environmental space, and cleaning. - Education to be provided daily as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** - The Housekeeping Supervisor/designee will be responsible for the completion of the F584 CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee.	

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	and not take it inside. During an interview, on 9/21/22 at 11:20 a.m., the Maintenance Director indicated the nursing staff were responsible to storing the equipment after use. During an interview, Registered Nurse (RN) 22 indicated her expectation for staff would be to store equipment at the end of Willow Bend hallway or keep all equipment and carts to one side of the hallway to ensure residents were able to ambulate safely down the hallways. During an interview, on 9/22/22 at 2:30 p.m., The Director of Nursing (DON) indicated her expectation for staff would be to properly store equipment for residents. 2. During an observation, on 9/19/22 at 12:27 p.m., Resident 72's room was found to be visibly dirty. The garage can was overflowing with paper garbage and used paper towels on the floor. The mattress next to Resident 72's bed on the floor had a greater than 12 inch area with a dry fluid and black visible dirt in the center of the mattress. Resident 72's dresser had the bottom two drawers broken fronts which were unable to close all the way. During the observation more than 10 small black tiny flying insects were found landing on Resident 72 and his tube feeding equipment. The floor in Resident 72's room was found to be 50 percent dirty with dried brown color liquid stain, papers, and black colored dirt. During an observation, on 9/19/22 at 12:44 p.m., Resident 72's hospital gown and top and bottom sheet were soiled with a wet brown color substance which had an unpleasant smell. Resident 72's ostomy appliance bag was not			

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	155149	A. BUILDING 00 B. WING	09/26/2022

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	connected to the resident. The facility's Deep Cleaning Calendar for residents room, dated 9/22, indicated Resident 72's room was to be deep cleaned on 9/18/22. The record for Resident 72 was reviewed. Diagnoses included, but were not limited to, dementia, ischemic colitis (constriction of the blood vessels supplying the colon) with ileostomy (where the small bowel (small intestine) was diverted through an opening in the abdomen. A care plan, dated 9/26/22, indicated Resident 72 required assistance with ADL's. During an interview, on 9/19/22, Resident 72's family member indicated she had concerns about the flying insects and the dirty environment in the resident's room. She worried about infection for Resident 72 with his room dirty. Her preference for Resident 72 would be for his room to be kept clean and in good condition. During an interview, on 9/22/22 at 11:13 a.m., Housekeeping Staff 1 verified the Willow Bend hallway and Resident 72's room had small flying bugs and Resident 72's room did not appear to have been deep cleaned. During an interview, on 9/21/22 at 11:20 a.m., the Maintenance Director indicated concerns had been reported around a month ago and the facility had a pest company assess the facility and applied treatment. He had not heard any recent concerns regarding the flying insects. During an interview, on 9/22/22 at 2:30 p.m., the DON indicated she expected staff to clean equipment if it was visibly dirty. The concerns			

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	around a dirty environment or equipment was the bacteria, germs and in general infection control. The facility failed to clean patient care equipment appropriately and everyone was responsible for cleaning equipment or reporting to the appropriate person. The facility Cleaning Guideline, undated, directed staff to clean residents room daily and deep cleaning once a month. The staff were further directed to clean and disinfect horizontal services which included commonly touched items, over the bed light, and bedside table, and remove refuse, and mop floor. The policy further directed staff if the room was missed for deep cleaning it was to be scheduled for the next day or assigned. 3.1-19(f)(4) 3.1-19(f)(5)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to provide assistance with activities of daily living, related to shaving and dressing, in a timely manor, for 2 of 3 residents reviewed for activities of daily living care. (Resident 5 and 43) Findings include: 1. During an observation, on 09/21/2022 at 9:18 a.m., Resident 5 was sitting, in his wheelchair, in the activity room. He was wearing a light gray T-shirt with stains on the front.	F 0677	**F 677 ADL Care Provided for Dependent Residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident 5 noted to have ADLs provided daily without concerns. -Resident 43 noted to have ADLs provided daily without concerns.	10/20/2022

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	During an observation, on 09/22/2022 at 2:51 p.m., the resident was sitting up, in bed, with his eyes closed. He was wearing the same stained light gray T-shirt. During an observation, on 09/23/2022 at 9:57 a.m., the resident was lying, in his bed, resting with his eyes closed. He was wearing the same light gray T-shirt with coffee and other food stains on the front. During an interview, at that time, the Assistant Director of Nursing (ADON) indicated it was her expectation for the CNA (Certified Nursing Assistant) providing ADL (activities of daily living) care to put clean clothes on the residents each day. The record for Resident 5 was reviewed on 09/21/2022 at 11:38 a.m. Diagnoses included, but were not limited to, dementia, stroke and muscle weakness. A quarterly MDS (Minimum Data Set) assessment, dated 09/12/2022, indicated the resident required extensive assistance with dressing. A current care plan, dated 02/04/2020, indicated the resident required assistance with ADL's including dressing, grooming and hygiene as needed. 2. During an observation, on 09/19/2022 at 12:07 p.m., Resident 43 was in his bed, his head was elevated and he was wearing a hospital gown with stains and crumbs on the front of the gown. His chin area had approximately 1/4 inch of facial hair growth noted. A sign above the resident's bed on		-Resident 43's family preferences completed per careplan. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** -Education provided via inservicing by 10/19/22. Education to include ADLs, careplans, resident and family preferences, and resident right. -All residents have potential to be affected by the alleged deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Education provided via inservicing by 10/19/22. Education to include ADLs, careplans, resident and family preferences, and resident right. - Facility will implement daily rounds provided each business day by Management. - IDT to review preference care plans with residents and families at admission, quarterly and as needed for changes and updates. - Facility to provide on going training and skills	

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	the wall indicated "PLEASE SHAVE RESIDENT DAILY!! PER FAMILY REQUEST!" During an observation, on 09/20/22 at 10:11 a.m., the resident had the same amount of facial hair as the day before. The record for Resident 43 was reviewed on 09/20/2022 at 12:06 p.m. Diagnoses included, but were not limited to, stroke, hypertension and contractures (occurs when connective tissue in the body becomes very stiff which greatly restricts movement of the affected area). A MDS assessment, dated 09/04/2022, indicated the resident required extensive assistance with dressing and personal hygiene. A current care plan, dated 12/19/2014, indicated the "Family wants resident shaved every day" starting 07/19/2022. During an interview, on 09/23/2022 at 9:35 a.m., the ADON indicated shaving was part of ADL care. During an interview, on 09/23/2022 at 2:16 p.m., CNA 20 indicated she would shave a resident when they looked like they needed it and it was part of her morning care. A current document, titled "Certified Nursing Assistant (CNA) Position Description," dated as revised 10/2014 and provided by the DON (Director of Nursing) on 09/23/22 at 1:50 p.m., indicated "...Assists in activities of daily living (ADLs) including...grooming, dressing...Grooming - Shaves...." A current document, titled "A.M. Care...Skills Validation - CNA," dated as reviewed on 04/2012		validations for ADLs. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** - The DNS/designee will be responsible for the completion of the F677 CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee.	

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	and provided by the MDS Coordinator on 09/23/22 at 2:00 p.m., indicated "...Procedure steps...Shave resident as needed...Assist resident with dressing...." A current facility policy, titled "Resident Rights," dated as revised 11/16 and provided by the DON on 09/23/2022 at 3:06 p.m., indicated "...All staff members recognize the rights of residents at all times...enable personable dignity, well being, and proper delivery of care...." 3.1-38(a)(2)(A) 3.1-38(a)(3)(D)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to provide appropriate positioning for 2 of 22 residents who were reviewed for positioning. (Resident 46 and 72) Findings include: 1. On 9/19/22 at 10:57 a.m., Resident 46 was observed seated, in the lounge, in her Broda chair. Her head was pressed against the left side of chair, her legs were crossed and hung over the leg rest, and her bottom was at the edge of the chair. Her brief was exposed. She was observed to have	F 0684	**F 684 Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident 46 Hospice Broda Chair exchanged with Broda Chair ordered by facility. - Resident 46 noted to have no s/s of discomfort	10/20/2022

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	poor positioning with poor posture. She was slouched and leaning to the left side of the Broda chair. The back of chair was in upright position and the resident appeared unable to reposition herself in the chair. On 9/20/22 at 1:39 p.m., during an observation of the lunch service, Resident 46 was seated in her Broda chair with the back of the chair in an upright position. Her legs hung down over the left side of the chair, her head pressed into the left side, and her left upper arm and elbow pressed into the arm rest of chair. Resident 46's hips were six inches away from the back of the chair. On 9/20/22 at 2:16 p.m., during an observation and interview with Registered Nurse (RN) 15, she indicated the resident was crunched down in the Broda chair, her upper arm was pressed into the arm rest, and her bottom was down to the edge of the chair. RN 15 indicated the resident was not properly positioned in the Broda chair, and the Broda chair was too big for Resident 46. RN 15 indicated she was not aware of the resident being evaluated by occupational therapy or if she had a seating assessment completed. The record for Resident 46 was reviewed. Diagnoses included, but were not limited to, Alzheimer's disease (a progressive disease which destroys memory and other important mental functions) and muscle weakness. A Fall Risk Assessment, dated 7/25/22, indicated Resident 46 was a high fall risk. A Quarterly Minimum Data Set (MDS) assessment, dated 8/1/22, indicated Resident 46 required extensive assist of two staff for transfers.		or pain related to positioning. - Resident 72 provided with new bed that provides 30 degrees elevation of head related to GTUBE feeding. - Resident 72 without s/s of complications related to positioning. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken po;** -All residents requiring assistance with positioning and that have feeding tubes had potential to be affected by the alleged deficient practice. -Education to be provided via inservicing by 10/18/22. Education to include proper positioning of resident's head of bed and their level of assistance with positioning. Staff to notify Hospice and Therapy services for positioning needs including any additional interventions needed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur;** - Education to be provided via	

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	A care plan indicated Resident 46 required assistance with activities of daily living (ADL's) including bed mobility and transfers. The care plan indicated the resident required staff assist of two to use a Hoyer lift for all transfers, to utilize a Broda chair, to place the resident at 75 to 90 degrees when eating and for therapy to screen quarterly and as needed. The Care Profile, printed on 9/21/22 at 6:32 a.m., indicated Resident 46 required a Hoyer lift with all transfers and two staff present and to utilize a Broda chair. During an interview, on 9/21/22 at 8:25 a.m., the Director of Therapy (DOT) indicated she was not aware of any request for a seating or equipment assessment for Resident 46. The resident could be at risk for pressure sores, falls, or injuries if the Broda chair was too big. The DOT indicated staff should contact Hospice regarding her Broda chair to obtain additional orders because currently this was a facility chair. The Broda chair look to big for Resident 46. During an interview, on 9/21/22 at 8:44 a.m., the MDS nurse indicated at the 8/22, care conference with the Hospice agency, the facility requested a Broda chair for positioning to be ordered. The Broda chair Resident 46 was utilizing belonged to the facility and had not been assessed by the therapy department. No staff reported concerns about the resident's positioning while in her chair. 2. During an observation, on 9/19/22 at 12:30 p.m., Resident 72 was observed with his head resting on the wall and scooted down in bed with his hips 6 inches past the crease of the bed. His upper body at less than a 10-degree angle while the bed was positioned at a 80 degree angle. His ankles		inservicing by 10/18/22. Education to include proper positioning of resident's needing assistance with positioning. -Facility will implement daily rounds provided each business day by Management for positioning needs. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** - The DOT/DNS/designee will be responsible for the completion of the F684 CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee.	

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	were crossed over each other and his legs hung over the exit side of the bed. Resident 72's ankles or heals were not floated. During an observation, on 9/20/22 at 1:28 p.m., Resident 72 was observed to be scooted down in his bed, his head was resting on the wall and his feet dandling over the exit side of bed. His chin was tucked down to his chest. Two nursing assistants walked by the resident's room and did not enter or offer to reposition the resident. The record for Resident 72 was reviewed. Diagnoses included, but were not limited to, dementia and adult failure to thrive (poor nutrition, weight loss, inactivity, depression and decreasing functional ability). A significant change in status Minimum Data Set (MDS) assessment, dated 8/27/22, indicated Resident 72 required total dependence of two staff with bed mobility and transfers. A Care Profile, printed on 9/21/22 at 6:32 a.m., indicated Resident 72 required the head of the bed to be elevated, off load with wedge cushion or pillows while in bed, wedge cushion while in wheelchair, scoop mattress, and Dycem (Non-Slip products) in the wheelchair. The resident stood and pivoted for all transfers with two staff members. A care plan, dated 3/8/22, indicated Resident 72 was at risk for further skin breakdown due to decreased mobility, incontinence, use of a wheelchair, poor nutrition, potential for friction, and chronic back pain. The resident was non-complaint with care, floating heels, and was non-compliant with turning and repositioning. The approaches included, but were not limited to,			

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	off load with wedge cushion or pillows while in bed, pressure reducing/redistribution mattress on the bed, encourage the resident to turn and reposition at least every 2 hours and provide assistance as needed. Physician's orders, dated 9/22, indicated Resident 72 had the following orders: a. Scoop mattress to be in place. b. Place the resident's bed against the wall and float heels at all times while in bed. c. An order was placed, on 9/22/22, to have occupational therapy (OT) to evaluate and treat. d. An order was placed, on 9/22/22, to have OT to treat five times a week for 12 weeks for positioning. The Treatment Administration Record (TAR), dated 9/22, indicated Resident 46 had his heels floated at all times while in bed with no refusals recorded. During an interview, on 9/21/22 at 1:47 p.m., RN 22 indicated her expectations for staff would be to ensure the resident was repositioned appropriately as needed, at least offer to reposition, manage his pain and behaviors. Resident 72 had been having less refusal of care and less behavior over the last few weeks. During an interview, on 9/22/22 at 2:30 p.m., the Director of Nursing Services (DNS) indicated her expectation for staff would be to position residents for comfort and transfer to a chair if needed. Positioning was important to help prevent skin breakdown, prevent pain and improve circulation. The facility policy, titled "Positioning," dated 4/12, directed staff for a fowler position to ensure			

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	resident was comfortable and to ensure resident's shoulders and hips were aligned and to use supportive padding. 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview and record review, the facility failed to apply a left hand splint and a left ankle/foot splint to prevent further contractures and increase further range of motion for 1 of 3 resident reviewed for range of motion. (Resident 76) Finding includes: During an observation, on 09/19/2022 at 11:37 a.m., Resident 76 was sitting in her wheelchair watching television. She did not have her left	F 0688	**F688: Increase/ prevent decrease ROM/ Mobility** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident 76 was referred to and continues on therapy caseload for evaluation and	10/20/2022

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	hand splint or her left ankle/foot splint in place. During an interview, at that time, the resident indicated her splints were always missing and she had not had it on for months. During an observation, on 09/26/22 at 9:45 a.m., 11:59 p.m., and 2:06 p.m., the resident was observed not to have her left hand splint or her left ankle/foot splint in place. The record for Resident 76 was reviewed on 09/19/2022 at 1:30 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia and hemiparesis (weakness or inability to move one side of the body) following a stroke and contractures. A current physician's order, dated 05/10/2018, indicated the resident was to wear a left ankle/foot splint for 4-6 hours every day to improve range of motion, positioning and comfort. A current physician's order, dated 01/03/2019, indicated the resident was to wear a left resting hand splint with finger separator for 5-7 hours every day and placement was to be checked every day. It was to be placed on at 8:00 a.m., and off at 3:00 p.m. A current care plan, dated 06/27/2011, indicated the resident needed assistance with activities of daily living related to limited range of motion and was to wear a left hand splint with finger separators for 5-7 hours. The hand splint intervention was initiated on 08/12/2020. During an interview, on 09/26/2022 at 2:06 p.m., the resident indicated she has not worn her foot splint in a "long time".		treatment of her hand splint. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** - No other residents currently have orders for hand splints. All future residents with orders for hand splints have the potential to be affected by the alleged deficient practice. - An Inservice will be completed by 10/19/22 educating staff on proper application of prescribed hand splints. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** - An Inservice will be completed by 10/19/22 educating staff on proper application of prescribed hand splints - All new therapy orders will be reviewed in the daily clinical meeting to ensure nursing staff are aware and splints are ordered and available as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date**	

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	During an interview, on 09/21/22 at 2:52 p.m., the Occupational Therapist indicated the resident was supposed to wear her hand and leg splint. During an interview, on 09/26/2022 at 2:38 p.m., the MDS (Minimum Data Set) Coordinator indicated she had not seen the resident wearing her leg splint in the last few days and she did not see her have her hand splint in place today. A current facility policy, titled "Restorative Nursing Program," dated as revised on 11/2018 and provided by the MDS Coordinator on 09/26/22 at 12:13 p.m., indicated "...Process...Programs may also be initiated following cessation of skilled therapy...Restorative nursing programs include...Splint or Brace assistance...." 3.1-42(a)(2)		**the systemic changes for each deficiency will be completed** - The DNS/designee will be responsible for the completion of the F688 CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee.	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment			

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	and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observations, interview and record review, the facility failed to ensure the head of bed (HOB) was properly elevated during infusion of a Gastrostomy tube (GT) feeding for 1 of 1 resident reviewed for tube feeding. (Resident 72) Finding includes: During an observation, on 9/19/22 at 9:30 a.m., Resident 72 was observed in his room, lying in bed, with the bed raised to a 45-degree angle. He had shifted down to the crease of the bed. His upper body had shifted to the left side of his bed with his head rested on the wall and his feet hanging over the right side of the bed. Resident 72 had a tube feeding being administered during this time. The tube feeding pole and pump was caked with dry tan color formula. During an observation, on 9/20/22 at 8:56 a.m., Resident 72 was observed lying in bed connected to a tube feeding. The tube feeding pump was alarming with an error message displayed which indicated a hold error. During an interview, on 9/20/22 at 9:00 a.m., Resident 72's nurse indicated the tube feeding pump had been alarming and indicated a hold error. The hold error message was displayed when the pump had been holding for 10 minutes. During an observation and interview, on 9/21/22 at 8:25 a.m., the Speech Language Therapist (SLP) indicated Resident 72 had a diagnosis of	F 0693	**F693 Tube Feeding Mgmt** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident 72 bed was elevated to the required 30 degrees. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** - No other residents currently have orders for tube feeding. All future residents with orders for tube feeding have the potential to be affected by the alleged deficient practice. - An Inservice will be completed by 10/19/22 educating staff on proper elevation of the head of bed for residents that are receiving tube feeding. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;**	10/20/2022

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	dysphagia, received tube feeding, and the HOB was at a 20-degree angle and the tube feeding was running. The SLP indicated the resident could be at risk for aspiration pneumonia (occurs when food or liquid was breathed into the airways or lungs, instead of being swallowed). During an observation and interview, on 9/21/22 at 8:30 a.m., the Director of Therapy indicated Resident 72's HOB was elevated to a 20-23 degree angle while the tube feeding was being administered. The resident was at risk for aspiration when bed was not positioned correctly. During an observation, on 9/21/22 at 8:30 a.m., the surveyor prompted Nursing Assistant (NA) 18 to elevate Resident 72's head of bed to a 30 degree angle. The record for Resident 72 was reviewed. Diagnoses included, but were not limited to, dementia, oropharyngeal dysphagia (swallowing problems occurring in the mouth or the throat), and adult failure to thrive (poor nutrition, weight loss, inactivity, depression and decreasing functional ability). A care plan, dated 3/8/22, indicated Resident 72 was at risk for complications related to enteral feeding. The care plan directed staff to elevate the head of bed. A physician's progress note for acute visit, dated 8/25/22, indicated the resident was assessed after return from a hospitalization related to hyperkalemia and treated for acute kidney injury (sudden episode of kidney failure or kidney damage which happens within a few hours or a few days.)		- An Inservice will be completed by 10/19/22 educating staff on proper elevation of the head of bed to 30 degrees. - All tube feeding orders will be reviewed in the daily clinical meeting to ensure nursing staff and maintenance staff are aware of the need to properly elevate the head of bed 30 degrees. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** - The DNS/designee will be responsible for the completion of the F693 CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee.	

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	A significant change in status Minimum Data Set (MDS) assessment, dated 8/27/22, indicated Resident 72 was on a Gastrostomy tube (GT) - (a medical device used to provide liquid nourishment, fluids, and medications by passing the oral intake) feeding. A Care Area Assessment (CAA), dated 8/27/22, indicated Resident 72 was a total assist of two staff for bed mobility and transfers, and received 26 to 50 percent of his calories and 501 cc or more a day of fluids from tube feedings. A Dietitian Review report, dated 8/30/22 at 10:31 a.m., indicated Resident 72 had a significant change related to a hospital visit. Resident 72's weight was 159 pounds. An Enteral Administration History, dated 9/22, indicated Resident 72 had the following orders: a. Enteral feeding continuous of Osmolite 1.5 90 milliliter (ml) per hour on at 6:00 p.m., and off at 10:00 a.m., with 180 ml of water flushes every three hours during feedings. b. To check for placement of tube, check residual and hold if residual was greater than 100 ml. c. To flush the G-tube with at least 60 ml of water before and after medication administration. A care plan, with a revised date of 9/22/22, indicated Resident 72 was at risk for aspiration related to enteral feeding and directed staff to elevate the head of bed to at least 30 degrees. A Care Profile, printed date of 9/21/22 at 6:32 a.m., directed staff to elevate the head of bed. The Care Profile lacked indication the HOB was to be elevated at a 30-degree angle. A nursing progress note, dated 9/24/22 at 6:00			

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	p.m., indicated Resident 72 had not been completely chewing his food and begun to pocket his food on the side of his mouth. A nursing progress note, dated 9/25/22 at 10:38 a.m., indicated Resident 72 was found lethargic (lack of energy), altered mental status, poor skin turgor, and oxygen saturations (blood oxygen) level of 88 percent on room air (normal level of oxygen is 95% or higher). The resident was sent to the emergency room (ER) for evaluation. During an interview, on 9/21/22 at 1:42 p.m., Registered Nurse (RN) 15 indicated the resident's head of bed should be elevated to a 45 degree angle. During an interview, on 9/21/22 at 1: 47 p.m., RN 22 indicated her expectation for staff would be to ensure the resident's head of bed was elevated to 30 to 45 degrees while connected to tube feeding. The NAs should review the resident profile list for guidance on activities of daily living and care before providing care. RN 22 indicated the resident's care profile lacked direction to elevate the head of bed to 30 to 45 degrees while the tube feeding was running. During an interview, on 9/22/22 at 2:30 p.m., the Director of Nursing Services (DNS) indicated she expected staff to position Resident 72 with the head of the bed elevated to a 30-45-degree angle while the tube feeding was running. During an interview, on 9/23/22 at 9:39 a.m., the MDS nurse indicated Resident 72 received most of his calories from his tube feeding. The resident was sent to the hospital in 8/22, due to the resident stopped eating, was not taking fluids and was not waking up.			

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	The facility's policy, titled "Enteral Therapy," with a revised date of 1/16, indicated the licensed nurse with other healthcare team members must carefully monitor the resident's response to the enteral feedings and feeding techniques. The facility policy directed staff to observe closely for any adverse effects to the feeding procedures but lacked direction for positioning of the resident during tube feeding. 3.1-44(a)(2)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort			

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	to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to follow their own policy for Federal guidelines for admission medication regimen review related to an appropriate diagnosis for use of an anti-psychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 78) Finding includes: The record for Resident 78 was reviewed on 9/21/22 at 10:07 a.m. Diagnoses included, but were not limited to, dementia and heart disease. The admission date was 8/29/22. An admission order indicated "May receive psych services."	F 0758	**F758 Free from Unnecessary psychotropic meds** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** - Resident 78s spouse consented for the resident and her medication regime to be evaluated by psych services to evaluate this medication. Resident discharged prior to evaluation being performed.	10/20/2022

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	The medical record did not contain any notes from a psych doctor's visit. Resident 78's medication list included, but were not limited to, an order, dated 8/30/22, for risperidone (an anti-psychotic medication) 0.25 mg (milligram) tablet, once a day. The indication for use was listed as cachexia (a general state of ill health involving weight loss and muscle loss). A second order, dated 8/30/22, for the same medication, indicated risperidone 0.5 mg tablet, at bedtime for vascular dementia with behavioral disturbance. A monthly pharmacy review note, dated 9/12/22 at 4:40 p.m., indicated the medication regimen was reviewed by the consultant pharmacist. "See report for any noted irregularities." Upon request the facility provided a copy of the consultant pharmacy's report. The report indicated for the anti-psychotic drug risperidone, if the current therapy continued the resident needed a supportive diagnosis, to keep the facility within compliance. During an interview, on 9/23/22 at 11:27 a.m., the Director of Nursing (DON) indicated the resident had only had one pharmacy review, because she was a new admission. They could not change the diagnoses on the record without an evaluation from the psych doctor. The psych doctor came into the facility every week and would see Resident 78 on the next visit. A current facility policy, titled "Medication Regimen Reviews and Pharmacy Recommendations," dated as revised 10/18 and provided by the facility on 9/26/22 at 12:14 p.m.,		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** - No other residents currently have orders for antipsychotic medications without appropriate diagnosis. - An Inservice will be completed by 10/19/22 educating staff on the requirement for proper supporting diagnosis for antipsychotic medications. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** - An Inservice will be completed by 10/19/22 educating staff on the requirement for proper supporting diagnosis for antipsychotic medications - All future admissions from the hospital with antipsychotic medications will be reviewed at the time of admission to ensure psych service consults are obtained if needed, and appropriate diagnosis is present or obtained, or the medication will be discontinued. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	indicated "...The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist...The Consultant Pharmacist recommendations will be reviewed by the Director of Nursing and the Attending Physician will be notified promptly of any recommendations needing immediate attention...Admission Medication Regimen Review: An admission drug regimen review must be conducted upon admission, or as close to the actual time of admission as possible on a Medicare Part A stay. This will be done to identify, prevent, and address 'in a timely manner' any potential or actual clinically significant medication issues. Clinically significant means a potential or actual issue that warrants physician communication and completion of the physician's prescribed/recommended actions by midnight of the next calendar day...." 3.1-48(a)(4)		**into place; and by what date the systemic changes for each deficiency will be completed** - The DNS/designee will be responsible for the completion of the F758 CQI Tool 5 x/ week for 4 weeks, then weekly for 5 months, with results reported to the Quality Assurance and Performance Improvement Committee.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing,			

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	identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.			

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	§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to develop and implement written policies and procedures for infection control, to contain the spread of the Covid-19 virus, when the facility failed to ensure staff and a vendor wore appropriate personal protective equipment (PPE) when entering a resident's room who was on precautions in accordance with the Center for Disease Control (CDC) and Centers for Medicare & Medicaid Services (CMS) guidelines for COVID-19. This had the potential to affect all the residents who resided on the Willow Bend Hallway. Finding includes: During an observation, on 9/19/12 at 10:00 a.m., Resident 331's room was open and had signs taped on the door for droplet precautions and PPE was required to enter the room. A PPE storage bin was outside the door to the left side of door frame. No garbage can was on Resident 331's side of the room to put used PPE in after removing. The resident's privacy curtain was pulled to separate him from his roommate.	F 0880	**F880: Infection prevention and Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · DME vendor was shown the signage on resident 331's door, as well as the PPE storage bin in the hallway adjacent to the residents door. PPE expectations were reviewed. · RN 11 was immediately educated on doffing and disposal of appropriate PPE when working in droplet plus isolation rooms. · A trash can was placed on resident 331's side of the room. · An audit was conducted for all isolation rooms to ensure trash cans were present for each	10/20/2022

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

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	During an observation, on 9/19/12 at 10:39 a.m., a durable medical equipment (DME) vendor was found outside Resident 331's room. The resident was lying in bed not wearing a mask. The DME vendor proceeded to walk into Resident 331's room multiple times carrying in pieces of a floor standing trapeze bar for Resident 331. The DME vendor was within four feet of Resident 331 and when he left the resident's room he did not sanitize his hands. During an interview, on 9/19/22 at 10:50 a.m., the DME vendor indicated he was not directed he needed to wear PPE to enter Resident 331's room or he was on precautions. During an observation, on 9/19/22 at 11:25 a.m., Registered Nurse (RN) 11 was observed assisting Resident 331 to reposition his personal items within reach next to his bed. RN 11 walked out of Resident 331's room into the hallway, wearing a yellow gown, N95 mask, gloves, and face shield. RN 11 was directed by RN 15 to go back into Resident 331's room to remove her PPE. RN 11 indicated "there are no garbage cans in the room to throw PPE away in." The record for Resident 331 was reviewed. Diagnoses included, but were not limited to, osteonecrosis (painful condition which occurred when the blood supply to the head of the femur (thighbone) was disrupted) due to previous trauma of right femur, acute respiratory failure (respiratory system cannot adequately provide oxygen to the body), with hypoxia (low levels of oxygen in your body tissues). A care plan, dated 9/17/22, indicated the resident was at risk for COVID-19 infection related to national pandemic and directed staff to encourage		resident in isolation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** · All residents in isolation have the potential to be affected by alleged deficient practice. · An in-service will be completed on or before 10/19/22 by IP and DNS for all staff to include proper infection control practices regarding donning and doffing personal protective equipment (PPE) for droplet plus isolation using “Standard and Transmission-Based Precautions (Isolation) Policy”. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** ·A Root Cause Analysis will be conducted with a consultant Infection Preventionist, with input from the facility Medical Director/IP/DNS to identify the root cause and develop solutions/systemic changes to address the root cause by 10/19/22. ·The facility LTC Infection Control Self-Assessment will be reviewed with the consultant IP to determine accuracy. · An in-service will be	

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	and assist the resident with mask usage and social distancing. The resident was restricted to his room in droplet isolation for ten days due to potential exposure to COVID-19 prior to admission. The care plan directed staff to provide droplet precautions for 10 days with all services provided in the room, educate the resident and visitors on droplet precautions. A Care Profile, date printed 9/21/22 at 6:32 a.m., indicated Resident 331 was on droplet precautions for at least 10 days with all services provided in the room. During an interview, on 9/22/22 at 8:47 a.m., the Executive Director (ED) indicated it was the responsibility of the staff to remind vendors of the precautions required to enter a room. It was hard for people to see the precautions and PPE signage when it was printed on white paper and placed on a white door. During an interview, on 9/22/22 at 9:20 a.m., the Infection Preventionist (IP) and Assistant Director of Nursing (ADON) indicated she had made new stop signs and hung on the doors of residents who required precautions to help with reminding staff of the appropriate PPE usage. It was an ongoing battle to remind and educate staff of the use of PPE. The nursing staff should have informed the DME vendor and the nursing staff of required precautions when observed. A gown, mask, gloves and goggles should be worn by any staff or visitor who entered the room. During an interview, on 9/22/22 at 2:30 p.m., the Director of Nursing (DON) indicated she expected staff to correct staff or vendors to wear the appropriate PPE and follow the precautions as indicated on the door. Coaching and counseling		completed by IP/designee for all staff to include proper infection control practices regarding donning and doffing personal protective equipment (PPE) for droplet plus isolation using "Standard and Transmission-Based Precautions (Isolation) Policy" · The consultant IP will provide ongoing training, oversight, resources and competencies as needed. · IP/designee will complete 10 observations per week using the PPE observation tools. · The consultant IP will provide ongoing training, oversight, resources and competencies as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** · The IP/DNS/Designee will monitor each solution/systemic change identified in the RCA daily or more often as necessary for 4 weeks and until compliance is maintained. · Infection Control/Transmission Based Precautions QA tool will be completed daily by IP/designee	

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	would be provided to individuals not following precaution. Education was provided at skills upon hire, at skills validation monthly, and education was provided daily if needed. The facility failed to ensure proper PPE was used in rooms where residents were on precautions or on isolation. During an interview, on 9/26/22 at 10:00 a.m., the DON and IP ADON indicated the county had a high transmission rate and the facility was testing twice a week for COVID-19. The IP ADON indicated one facility staff person had tested positive recently who had demonstrated symptoms. The facility policy, titled "Infection Prevention System of Surveillance," dated 3/22, indicated the facility would identify infections and prevent the spread of infections. The facility policy indicated the staff would implement actions or intervention necessary to prevent the spread of infections which included standard and transmission-based precautions. 3.1-18(b)		x6 weeks and until compliance is maintained. · The IP/designee will be responsible for the completion of the Infection Control/Transmission-Based Precautions QA Tool daily for 4 weeks, then weekly for 5 months with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. · The facility will review, update and make changes to the DPOC as needed with input and oversight from the Consultant Infection Preventionist for sustaining substantial compliance for no less than 6 months. After six months the QAPI committee will re-evaluate the continued need for the audit.	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure appropriate interventions were taken to reduce the risk for infection for a resident who used a tube feeding and the equipment was observed soiled while the resident was administered the tube feeding for 1 of 1 resident observed for a sanitary environment (Resident 72)	F 0921	F921- Safe/ Functional/ Sanitary/ Comfortable Environment **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** · Resident 72's tube feeding	10/20/2022

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	Finding includes: On 9/19/22 at 9:30 a.m., Resident 72 was observed connected to his tube feeding. The tube feeding pole, base and infusion pump were soiled with dry caked on tan colored tube feeding formula. On 9/19/22 at 12:36 p.m., Resident 72 was observed lying in bed and not connected to his tube feeding. The tube feeding pole, base and infusion pump were soiled with dry caked on tan colored tube feeding formula. On 9/20/22 at 8:56 a.m., Resident 72 was observed lying in bed, connected to his tube feeding, and a hold error message was displayed on the infusion pump. The tube feeding pole, base and infusion pump were soiled with dry caked on tan colored tube feeding formula. On 9/20/22 at 1:30 p.m., during an observation and interview of Resident 72's tube feeding equipment, RN 15 verified the equipment was soiled with dry tube feeding formula and it was all staffs responsibility to clean the equipment when dirty. The record for Resident 72 was reviewed. Diagnoses included, but were not limited to, dementia, oropharyngeal dysphagia (swallowing problems occurring in the mouth or the throat), and adult failure to thrive (poor nutrition, weight loss, inactivity, depression and decreasing functional ability). A significant change in status Minimum Data Set (MDS) assessment, dated 8/27/22, indicated the resident was on a gastrostomy tube (GT) (a medical device used to provide liquid nourishment, fluids, and medications by passing		pole, base and infusion pump were cleaned by 9/20/22. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** · All residents receiving tube feeding have the potential to be affected by alleged deficient practice. · An in-service will be completed on or before 10/19/22 by DNS and IP for all staff to include proper cleaning of equipment. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** · An in-service will be completed on or before 10/19/22 by DNS and IP for all staff to include proper cleaning of equipment. · DNS/ designee will audit every tube feeding pole, base and pump in use 5 x per week x 4 weeks, and then bi weekly for 5 months to ensure proper cleaning techniques are followed. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	the oral intake) feeding. A Care Area Assessment (CAA), dated 8/27/22, indicated the resident was a total assist of two staff for bed mobility and transfers, and received 26 to 50 percent of his calories and 501 cc or more a day of fluids from tube feeding. A care plan, with a revised date of 9/22/22, indicated Resident 72 was on a tube feeding for nutritional needs but lacked direction to staff to ensure the tube feeding equipment was kept clean. A Care Profile, printed date of 9/21/22 at 6:32 a.m., lacked indication Resident 72 was to have tube feeding as prescribed and to ensure the tube feeding equipment was kept clean. During an interview, on 9/21/22 at 1:47 p.m., the Registered Nurse (RN) 22 indicated her expectation for staff would be to ensure if you spilt something or it leaked, it would be cleaned up when it happened or as needed. RN 22 indicated the night shift should be cleaning the tube feeding equipment. During an interview, on 9/22/22 at 2:30 p.m., the Director of Nursing Services (DNS) indicated her expectations for all staff was to ensure the resident equipment including tube feeding equipment was kept clean and when visibly soiled with formula to clean it up immediately. Concerns regarding not keeping the equipment clean would present an infection control risk for the resident. A facility policy on cleaning of tube feeding and patient care equipment was requested on 9/25/22 and 9/26/22 and was not provided by the time of exit.		**recur, i.e., what quality assurance program will be put into place; and by what date the systemic changes for each deficiency will be completed** · Equipment inspection checklist CQI tool will be completed by DNS/ designee 5 x week x 4 weeks, and then bi weekly for 5 months · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. After six months the QAPI committee will re-evaluate the continued need for the audit.	

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	3.1-19(f)(5)			