STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155003	A. BUILDING 00 B. WING	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MASON HEALTH CARE CENTER	900 PROVIDENT DRIVE WARSAW, IN 46580

(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, & 26, 2022 Facility number: 000003 Provider number: 155003 AIM number: 100290600 Census Bed Type: SNF/NF: 81 Total: 81 Census Payor Type: Medicare: 7 Medicaid: 51 Other: 23 Total: 81 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 10/3/22.	F 0000	The creation and submission of Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or set of any violation or regulation.	
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The			

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

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	comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observation, interview, and record review, the facility failed to provide a plan of care for a skin condition and oxygen use for 2 of 24 residents reviewed for care planning. (Residents 73 and 46) Findings include:	F 0656	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The care plan for 73 and 46 been updated.	10/26/2022

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	1. During an initial interview, on 9/19/2022 at 10:29 A.M., Resident 73 indicated he had a wound dressing to his buttocks. A clinical record review was completed on 9/21/2022 at 3:02 P.M. Diagnoses included, but were not limited to: left and right below the knee amputations, heart failure, and diabetes mellitus type 2. A Skin and Wound Evaluation, on 8/31/2022, indicated MASD was present to the coccyx upon readmission to the facility. An Admission Minimum Data Set (MDS) Assessment on 9/2/2022, indicated Resident 73 had surgical wounds and moisture associated skin damage (MASD). He received application of non-surgical dressings. A Physician's Order on 9/1/2022, indicated " ...Cleanse buttock with wound cleanser, apply foam dressing every 3 days and as needed ...." A Care Plan could not be located in the medical record for the MASD. During an interview, on 9/22/2022 at 11:28 A.M., the MDS Assistant indicated she could not locate a care plan for the MASD to the coccyx. On 9/22/2022 at 11:34 A.M., the MDS Coordinator reviewed Resident 73's care plans and indicated Resident 73 should have a care plan for the MASD to the coccyx. 2. A clinical record review was completed on 9/21/2022 at 11:03 A.M., for Resident 46. Diagnoses included, but not limited to: lymphedema, major depressive disorder, anxiety, hypertension, hypoxemia, and chronic		2. How be identified and what corrective action(s be taken? An audit was completed for all residents receiving oxygen and all residents with skin conditions and their care plans were reviewed and updated as needed. 3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? The facility policy for care plans was reviewed and no changes necessary. The licensed nurses were and educated on the policy for care plans. DON/designee will complete daily audits during clinical morning meeting X 8 weeks, then weekly X4, then monthly X3 to ensure care plans are updated appropriately for Oxygen orders and skin care. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Audits/findings will be forwarded to QA monthly for review. The facility through the QAPI program, will	

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	pain. A Physician Order, dated 5/6/2022, indicated oxygen 6 liters per nasal cannula to keep SaO2> 90% may titrate every shift. A Care Plan could not be located in the medical record. During an interview on 9/21/2022 at 2:15 P.M., MDS Nurse indicated Resident 46 does not have a care plan for oxygen and she should have had. On 9/22/2022 at 11:36 A.M., the Administrator provided a policy titled, "Care Planning", revised 9/2021, and indicated the policy was the one currently used by the facility. The policy indicated"... It is the policy of this facility to develop a comprehensive plan of care that is individualized, and reflective of the resident's goals, preferences, and services that are to be provided to attain or maintain the resident's highest practical physical, mental, and psychosocial well-being...." 3.1-35(a)		review, update, and make changes to the POC as needed for sustaining compliance for no less than 6 months. Frequency and duration of the reviews will be adjusted as needed. After consecutive compliance is achieved, the DON and/or designee will randomly complete an audit to ascertain continued compliance annually.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the			

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	resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on record review, and interview, the facility failed to ensure a careplan was revised for 1of 24 residents whose careplans were reviewed. (Resident 52) Finding includes: A clinical record review was completed on 9/22/2022 at 12:05 P.M. Resident 52's diagnoses included, but were not limited to: weakness, aphasia, vascular dementia, diabetes mellitus and heart failure. A Quarterly MDS (Minimum Data Set) assessment, dated 4/15/2022, indicated Resident 52 was on a prescribed weight loss regimen. A current care plan, initiated on 2/9/2022 and revised on 9/22/2022, indicated the resident was at risk for malnutrition related to dementia. Interventions included, but not limited to: review labs, meal intake and weights, and will receive diet	F 0657	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 52's care plan was reviewed and updated. 2. How be identified and what corrective action(s be taken? All residents have to be affected by this deficient practice. All care plans were reviewed to ensure the diet plan was properly addressed in the care plan. 3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? The facility policy for care plans was reviewed and no changes necessary. The licensed nurses, Dietary manager and dietician were and educated on the policy	10/26/2022

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	as ordered. Current Physicians orders: Regular diet with diet desserts, regular texture and thin consistency. Glucerna shakes one time a day for supplement. During an interview, on 9/26/2022 at 11:35 A.M., the Dietary Director indicated Resident 52's prescribed weight loss regimen was not on the current careplan. On 9/22/2022 at 11:36 A.M., the Administrator provided the policy titled, "Care Planning", dated, 2/2012, and indicated the policy was the one currently used by the facility. The policy indicated "...18. careplans will be updated with any changes in the residents orders, care or services that change the plan of care...." 3.1-35(d)(2)(B)		for care plans. DON/designee will complete daily audits during clinical morning meeting X 8 weeks, then weekly X4, then monthly X3 to ensure care plans are updated appropriately for diet orders. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Audits/findings will be forwarded to QA monthly for review. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining compliance for no less than 6 months. Frequency and duration of the reviews will be adjusted as needed. After consecutive compliance is achieved, the DON and/or designee will randomly complete an audit to ascertain continued compliance annually.	
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to			

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	promote healing, prevent infection and prevent new ulcers from developing. Based on interview, record review and observation the facility failed to implement pressure relieving interventions to prevent an unstageable pressure wound from developing for 1 of 3 residents reviewed for pressure ulcers. (Resident 33) Finding includes: During an interview, on 9/19/2022 at 10:35 A.M., Resident 33 indicated his right heel was not healing. A clinical record review was completed on 9/20/2022 at 2:37 P.M. Resident 33's diagnoses included, but not limited to: coronary artery disease, hypertension, and a fracture right femur. An Admission Assessment, dated 7/13/2022, indicated he had a surgical wound to the Right hip. A Braden Scale, dated 7/13/2022, indicated Resident 33 had a slight limited sensory perception, was chair fast, made frequent slight body changes, had inadequate nutrition and had a potential problem with friction and shear. Resident 33's score of 16 indicated he was at risk for pressure ulcers. A Base Line Care Plan, dated 7/13/2022, indicated Resident 33 was at risk for developing pressure ulcers related to impaired mobility. Interventions included: cushion in wheelchair pressure re-distribution, surface turn and reposition frequently, and weekly skin observations. A Therapy Mobility Form dated 7/14/2022,	F 0686	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Unable to correct due to the occurrence happened in the past. Appropriate preventative measures have been put in place. 2. How be identified and what corrective action(s be taken? An audit was completed and all residents at risk of pressure ulcers based on their Braden Scale score were identified to ensure that appropriate preventative measures are in place. 3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? All nursing staff / Wound Nurse was in serviced on facility policy on Skin Integrity and Pressure Injury. Wound care will complete daily audits during clinical morning meeting X 8 weeks, then weekly X4, then monthly X3 to ensure new admissions have been evaluated for risk of pressure injury and that appropriate preventative measures are in place. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Audits/findings will be forwarded to QA monthly for review. The facility through the QAPI program, will review, update,	10/26/2022

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	indicated the resident required maximum assistance to roll from side to side, and was dependent on staff assistance to change positions. A Nurses Note, dated 7/15/22, at 8:10 P.M., indicated edema to bilateral lower extremities and he tolerated being up in chair. An Admission MDS (Minimum Data Set), dated 7/16/2022, indicated the resident required extensive assist of 2 staff for bed mobility, transfers, dressing and toilet use. Had a limited range of motion to the right leg, and was at risk for pressure ulcers but had none at this time. Resident 33's shower schedule indicated he was to receive showers on Tuesday and Friday. A shower was received on 7/15/2022 but not on 7/19/2022. An Initial Pressure Ulcer Report dated 7/21/2022, indicated the resident had a unstageable pressure ulcer to the right heel which was a blood filled blister. The treatment consisted of application of skin prep, abdominal pad covering, and kerlix twice a day. New care plan interventions included off loading boots while in bed, staff to assist with turning and repositioning frequently and treatment as ordered. The July Treatment sheet indicted no off loading, (elevating) of the resident's heels had been completed until after the area was observed on 7/21/2022. A Nurses Note, dated 7/24/22 at 2:22 A.M., indicated the resident had reported to the staff that the blister to his right heel had popped. Area was assessed, cleansed and covered. Right heel		and make changes to the POC as needed for sustaining compliance for no less than 6 months. Frequency and duration of the reviews will be adjusted as needed. After consecutive compliance is achieved, the DON and/or designee will randomly complete an audit to ascertain continued compliance annually.	

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	elevated. A Physician's Wound Care Note on 7/27/22 at 2:31 P.M., indicated the wound was unstageable. The devitalized tissue was removed with a sharp curette. New orders were obtained to apply a silver foam to the area and a dry dressing, apply heel protectors, and obtain an x-ray of right heel. A Initial Pressure Ulcer Report, dated 8/1/2022, indicated Resident 33, had a stage 2 to the Left heel with an intact fluid filled blister. Treatment was to apply skin prep, and apply a covering. A Skin and Wound Evaluation, dated 8/22/2022, indicated the stage 2 pressure ulcer to left heel was healed. A Braden scale, dated 8/31/2022, indicated Resident 33 walks occasionally,had adequate nutrition, required assistance with moving and had a score of 16 indicating he was at risk for pressure ulcers. A Skin and Wound Evaluation dated 9/19/2022 indicated an unstageable pressure ulcer with slough/eschar (dead tissue) to the right heel, that measured 6.8 cm (centimeters) x 2.4 cm x 3.4 cm. During an interview, on 9/22/2022 at 11:05 A.M., CNA 5 indicated when the resident was admitted "he stayed in bed for awhile." During a wound care observation on 9/22/2022 at 11:20 A.M. LPN 6 indicated the wound is covered with 95% slough (cellar debris), the dressing is done once a day and is measured every Monday. On 9/26/2022 at 11:03 A.M. The Regional Director of Quality Assurance provided the policy, "Skin			

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	Integrity and Pressure Injury." dated 4/20/2022, an indicated the policy was the one currently used by the facility. The policy indicated..."Pressure prevention 1, Interventions will be initiated based on the resident's risk determined by the Braden Risk. 2. Interventions will be initiated based on other risk factors such as incontinence of bowel and /or bladder, immobility, nutritional status, diagnosis that increase risk, medications that increase risk, history of pressure injury, resident refusal of care and treatment, and cognitive deficits... 6 Staff will assist and/or remind the resident to reposition and turn at lease every 2 hours or more frequent depending on the resident risk and skin health...10. Float heels when in bed on residents at high or very high risk of skin breakdown. 11. Observe for edema or swelling in the feet and ankles and observe the fit of their shoes...." 3.1-40			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was			

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	necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview and record review, the facility failed to provide a urinary drainage bag covering to provide dignity for 1 of 1 resident reviewed for urinary catheters. (Resident 73) Finding includes: During an observation, on 9/19/2022 at 10:29 A.M., Resident 73 was observed in his room to have urinary catheter bag attached to the underneath of the wheelchair. The urinary drainage bag, which had a clear facing and a white backing, had a visible light-yellow fluid. Resident 73 indicated while crying, "This catheter is killing me. I've had this [urinary catheter] since I've been here. Why can't they take this out?" On 9/20/2022 at 8:44 A.M., Resident 73 was observed in his room to have urinary catheter bag attached to the underneath of the wheelchair. The	F 0690	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 73, foley catheter was discontinued 2. How be identified and what corrective action(s be taken? All residents with a foley catheter have to be affected by this deficient practice. An audit was completed of residents with a foley catheter to ensure compliance 3. What measures will be put into place or what systemic changes	10/26/2022

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	urinary drainage bag, which had a clear facing and a white backing, had a visible light-yellow fluid. A clinical record review was completed on 9/21/2022 at 3:02 P.M. Diagnoses included, but were not limited to: left and right below the knee amputations, heart failure, diabetes mellitus type 2, and obstructive and reflex uropathy. A Physician Narrative Progress Note, on 8/30/2022 at 11:25 P.M., indicated, " ...On 8/22 he developed urinary retention and a Foley was placed ...." A Physician's Order, on 8/31/2022, indicated " ...Foley Catheter 16 French 10ml [milliliter] balloon dx [diagnosis] urinary obstruction. Change as needed for leakage or obstruction ...." A Care Plan, on 8/31/2022, indicated " ...I have indwelling catheter related to urinary obstruction, urinary retention ...." A Nurse's Note, on 9/2/2022 at 11:20 A.M., indicated " ...According to CNA [Certified Nursing Assistant] bladder documentation on this date resident had an indwelling catheter, 16 Fr [French] with 10 ml balloon related to urinary obstruction. Risks and benefits of indwelling catheter explained to resident ...." During an observation, on 9/22/2022 at 8:38 A.M., Resident 73 was observed in his room with the urinary drainage bag attached to the side of the bed frame. A light-yellow fluid is visible in the drainage bag. During an interview, on 9/22/2022 at 9:45 A.M., LPN 10, observed the catheter drainage bag and indicated the drainage bag should be covered.		will be made to ensure that deficient practice does not recur? Nursing staff were in serviced on facilities Catheter Use Care Policy. DON/designee will complete daily audits during morning rounds X 8 weeks, then weekly X4, then monthly X3 to ensure foley catheter bags are covered appropriately. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Audits/findings will be forwarded to QA monthly for review. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining compliance for no less than 6 months. Frequency and duration of the reviews will be adjusted as needed. After consecutive compliance is achieved, the DON and/or designee will randomly complete an audit to ascertain continued compliance annually.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MASON HEALTH CARE CENTER	900 PROVIDENT DRIVE WARSAW, IN 46580

(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
	On 9/22/2022 at 10:40 A.M., a policy titled, "Catheter Use Care policy", was provided by the Regional Director of Quality Assurance. The policy indicated, "5. The drainage bag should be kept covered with a dignity cover or the use of a drainage bag with a dignity flap should be used ...." 3.1-41(a)(2)			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure oxygen tubing, humidifier storage bags were labeled with dates, track or document the changing of respiratory equipment; removal of oxygen tubing from the oxygen concentrator to the portable oxygen was not performed by non-nursing personel; continuous positive airway pressure (CPAP) equipment, water humidification bottle and tubing were dated and nebulizer masks were not stored in a bag when not in use, for 4 out of 4 reviewed for respiratory care. (Resident's 46, 1, 41and73) Findings include: 1. A clinical record review was completed on	F 0695	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #46-corrective action cannot be taken due to alleged deficiency occurred in the past. Residents # 1, 41, and #73 had respiratory equipment bagged and dated per policy. 2. How be identified and what corrective action(s be taken?	10/26/2022

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	9/21/22 at 11:03 A.M., for resident 46, diagnoses included but not limited to: lymphedema, major depressive disorder, anxiety, hypertension, hypoxemia, and chronic pain. During an observation, on 9/19/2022 at 2:28 P.M., Resident's concentrator was set on 5 liters of oxygen, the tubing, humidifier, and storage bag was undated. During an observation, on 9/20/2022 at 9:47 A.M., the activity aide entered the resident 46's room and asked if she would like to come to activities which she indicated she would. The activity aide removed the tubing from the concentrator and hooked it to the portable tank attached to the back of her chair and set the dial to 6 L. During an observation on 9/21/2022 at 9:18 A.M., there was no date on the tubing or the bag, the humidifier was dated 9/20 with initials, the bottle was full. During an observation on 9/21/2022 at 1:29 P.M., it was noted that the tubing was labeled with the date of 9/20, the bag was not. A Physician Order, dated 5/6/2022, indicated oxygen 6 liters per nasal cannula to keep SaO2>90% may titrate every shift. During an interview on 9/20/2022 at 9:50 A.M., the Activity Aide indicated she was shown how to switch over the oxygen from the concentrator to the portable by one of the nurses and she does it all the time because she is at the end of the hall. She indicated that she probably should not be doing it. During an interview on 9/21/2022 at 1:32 P.M., the		All residents receiving oxygen or utilizing a c pap or bi pap had their tubing changed out, dated and bagged. 3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? All staff were in serviced on facility policies Oxygen Therapy and Cleaning and Changing Respiratory Equipment. Orders for changing out the equipment weekly were initiated on the Treatment Record. DON/designee/Respiratory Therapist will randomly monitor respiratory equipment to ensure that bagged and dated per policy. This will occur weekly for 6 months then followed QA monthly until 100% compliance is achieved. Random observations of staff will occur to ensure only licensed/authorized staff are transferring/initiating oxygen. This will occur weekly for 8 weeks, biweekly for 8 weeks then monthly for 2 months. 4. How will the corrective action(s)	

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	Unit Manager indicated they do not have the storage bag dated and it should have been. The oxygen tubing, humidifier gets changed out every Wednesday. There is no order the Certified Nursing Assistants (CNA's) change it out on Wednesday's. On 9/21/2022 at 1:40 P.M., the MDS Nurse indicated it is in the CNA assignment binder for them to change out the oxygen supplies every Wednesday, they do not have an order in the treatment administration record. On 9/21/2022 at 1:41 P.M., the Regional Director of Quality Assurance indicated it is not in the CNA binder for the changing of the oxygen tubing and they don't have an order. The respiratory therapist came in yesterday and changed and dated all the tubing. During an interview on 9/22/2022 at 10:40 A.M., the Regional Director of Quality Assurance indicated that a non-nursing staff member cannot change tubing from a concentrator to a portable oxygen tank and set the flow. They do not have a policy on this. 2. A clinical record review was completed on 9/21/2022 at 9:40 A.M., for resident 1 and diagnoses included, but not limited to: chronic obstructive pulmonary disease, major depressive disorder, congestive heart failure, atrial flutter, obstructive sleep apnea, type 2 diabetes, anxiety disorder, and dependence of supplement oxygen. During an observation, on 9/19/2022 at 12:28 P.M., there was no date on the tubing, oxygen storage bag and humidifier. During an observation, on 9/20/2022 at 9:59 A.M.,		be monitored to ensure the deficient practice will not recur? Audits/findings will be forwarded to QA monthly for review. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining compliance for no less than 6 months. Frequency and duration of the reviews will be adjusted as needed. After consecutive compliance is achieved, the DON and/or designee will randomly complete an audit to ascertain continued compliance annually.	

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	the CPAP mask was lying on the sheets of an unmade bed, the concentrator was turned on, the storage bag, tubing and humidifier were undated. A Physician Order, dated 7/12/2022, indicated CPAP EPAP6-20 Home Unit, at bedtime for OSA. During an interview on 9/21/2022 at 1:50 P.M., the Unit Manager indicated there was no date on the tubing and humidifier and the mask was lying across the machine and should have been in a bag with a date on all items. 3. A clinical review was completed on 9/21/2022 at 10:39 A.M., for resident 41, diagnoses included, but not limited to: chronic respiratory failure, congestive heart failure, type 2 diabetes, peripheral vascular disease, anxiety, and hypertension. During an observation, on 9/20/2022 at 10:24 A.M., there was no date or initials on the oxygen tubing or humidifier. He was currently wearing his CPAP, he sleeps during the day. During an observation, on 9/21/2022 at 1:59 P.M., the CPAP mask was lying over the concentrator not in a storage bag and a gallon of distilled water with ¼ used was without an open date. A Physician Order, dated 6/13/2022, indicated CPAP 10 facility unit, at bedtime for OSA aerosllzed precautions. A Physician Order, dated 3/1/2022, indicated oxygen 4 liters per n/c to keep SAO2> 90% may titrate every shift. During an interview, on 9/21/2022 at 2:02 P.M., the Unit Manager indicated the CPAP mask is lying			

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	across the CPAP machine and the gallon of water that is ¼ gone does not have an open date, the mask should have been placed in a dated storage bag and an open date on the distilled gallon of water.4. During an initial observation on 9/19/2022 at 10:29 A.M., an oxygen concentrator was observed at the bedside. The oxygen tubing was wrapped around the oxygen humidification bottle. A date could not be observed on the oxygen tubing or the humidification bottle. A nebulizer machine was observed on the bedside table in a respiratory bag. A date could not be located on the respiratory bag nor the nebulizer mask. On 9/20/2022 at 8:44 A.M., the oxygen concentrator remains at bedside and is not currently in use. A date could not be observed on the oxygen tubing or the humidification bottle. The nebulizer machine was observed on the bedside table in a respiratory bag. A date could not be located on the respiratory bag nor the nebulizer mask. A clinical record review was completed on 9/21/2022 at 3:02 P.M. Diagnoses included, but were not limited to: left and right below the knee amputations, heart failure, diabetes mellitus type 2, and obstructive and reflex uropathy. A Nurse's Note, on 9/18/2022 at 5:00 A.M., indicated, " ...Resident with complaints of shortness of breath, with coarse lung sounds upon auscultation, moist cough, encouraged to elevate head of bed ...PRN [as needed] breathing treatment given without relief. On call [Nurse Practitioner] notified and ordered. O2 [oxygen] at 2LPM [2 liters per minute] ... Oxygen was administered and after an hour resident stated he feels better ...."			

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	A Physician's Orderx, on 8/31/2022, indicated, " ...Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML [milligrams per milliliter] 3 ml inhale orally four times a day for Bronchodilator ...." On 9/18/2022, a Physician's Order indicated, oxygen at two liter per nasal cannula to keep oxygen saturation above ninety percent. On 9/21/20022, a Physician's Order indicated, " ...Change Nebulizer Hand Held/ Mask and Tubing, Place in a new bag with date changed Weekly every night shift every Wed [Wednesday] ...." A Care Plan, on 9/22/2022, indicated, " ...I have chronic obstructive pulmonary disease [COPD] ...." During an observation, on 9/26/2022 at 9:33 A.M., the nebulizer mask was observed to be atop of the respiratory bag. The nebulizer mask and respiratory bag did not have a date that was observed. During an interview, on 9/26/2022 at 9:38 A.M., QMA 9 indicated, the nebulizer equipment should be stored in the resident's room with the mask and tubing in a respiratory bag, and the tubing and bag should be labeled with the date. She indicated the tubing was ordered to be changed every Wednesday on third shift. On 9/21/2022 at 2:25 P.M., the Regional Director of Quality Assurance provided a policy titled, "Cleaning and Changing Respiratory Equipment", dated 2/2022, and indicated the policy was the one currently used by the facility. The policy indicated " ...1. Hand Held Nebulizers and mask a. The nebulizer will be changed weekly and as needed, c. The nebulizer will be kept in a plastic			

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	bag when not in use. D. A new bag will be provided with each new set up and will be marked clearly with the date the set up was changed. 2. Nasal Cannula a. Nasal cannulas are to be changed weekly and as needed. b. A clean plastic bag will be kept at bedside to place the nasal cannula in when not in use. C. The bag will be marked with the date the nasal cannula was changed. 4. Oxygen Humidifiers a. Will be changed weekly and as needed, b. The bottle will be marked clearly with the date it was changed. On 9/22/2022 at 10:40 A.M., the Regional Nurse of Quality Assurance provide a policy titled, "Oxygen Therapy", revised 6/2021, and indicated the policy was the one currently used by the facility. The policy indicated " ...6. "No Smoking Signs" are not required outside of a resident's door when the facility has it clearly posted on all entrances that are used by the public that the facility is a non-smoking resident facility ...." And a policy titled, "CPAP/BI-PAP", revised 8/2020, and indicated the policy was the one currently used by the facility. The policy indicated " ...4. Masks are to be cleaned weekly and replaced every 6 months. c. Tubing will be replaced every 30 days ...." 3.1-47(a)(6)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility	F 0698	1. What corrective action(s) will be	10/26/2022

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	failed to ensure post dialysis assessments and dialysis communication to the dialysis center were completed for 1 of 1 resident reviewed for dialysis services. (Resident 64) Finding includes: During an initial interview, on 9/19/2022 at 11:55 A.M., Resident 64 indicated she received dialysis services on Tuesday, Thursday, and Saturday mornings. A record review was completed on 9/21/2022 at 11:16 A.M. Diagnoses included, but were not limited to: anemia, heart failure and renal failure. A Quarterly Minimum Data Set (MDS) Assessment on 8/27/22 indicated the resident was cognitively intact and received dialysis services. A Physician's Order, on 6/25/2018, indicated, " ...Dialysis Tuesday, Thursday, Saturdays at 0615 [6:15 A.M.] ...." A Care Plan, on 11/12/2015, indicated, " ...I have end stage kidney disease requiring dialysis at [Dialysis Center name] in [city name] ...My weights and vital signs will be obtained as ordered and as needed ...." A three-month review of the post dialysis documentation indicated a post dialysis assessment was not completed on: 9/242022, 8/27/2022, 8/18/2022, 8/11/2022, 8/9/2022, 7/21/2022, 7/19/2022, 7/16/2022, 6/28/2022, and 6/21/2022. On 9/23/2022 at 1:26 P.M., the dialysis communication book was reviewed. Pre-dialysis assessments and communication from the nursing		accomplished for those residents found to have been affected by the deficient practice? Corrective action cannot be taken due to the alleged deficiency occurred in the past. 2. How be identified and what corrective action(s be taken? • All residents receiving dialysis have the potential to be affected. 3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? Nurses were in on the facility policy for Dialysis and the use of the communication tool. DON/designee will monitor for completion of the pre/post dialysis assessments and the dialysis communication form. This will occur 2 times per week for 8 weeks then monthly for 4 months monitored in QA until 100% compliance is achieved. 4. How will the corrective action(s) be monitored to ensure the	

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	facility was provided on the following dates: 9/17/2022, 9/13/2022, 9/8/2022, 9/3/2022, 8/30/2022, 8/27/2022, 8/25/2022, 8/20/2022, 8/16/2022, and 8/13/2022. No other pre-dialysis communication to the dialysis center could be located. A copy of the Resident 64's February 2022 orders and face sheet where included in the binder. During an interview, on 9/23/2022 at 1:38 P.M., the Unit Manager indicated, the communication book had not been sent with every appointment. On 9/23/2022 at 1:42 P.M., Resident 64 indicated, the facility does not send the dialysis communication binder every time she goes to dialysis. She indicated the facility would the communication book religiously, but not of recent. She indicated the communication was kept in her bag she takes to dialysis. On 9/26/2022 at 9:44 A.M., Licensed Practical Nurse 8 (LPN) indicated dialysis assessment should be completed before and after each dialysis session. On 9/22/2022 at 10:40 A.M., a policy titled, "Dialysis", was provided by the Regional Director of Quality Assurance. The policy indicated, " ...Communication between SNF and Dialysis Center: Information that will be communicated between the SNF [Skilled Nursing Facility] and dialysis facility, will include, but not limited to the following: 1. Medication changed ...2. Abnormal lab values ...3. Code Status ...4. Fluid management ...Pre and Post Dialysis: 1. A [Corporation Name] pre-dialysis assessment will be completed before dialysis ...2. A [Corporation Name] post dialysis form will be completed after dialysis and compared to the pre-assessment. Any abnormal assessment findings will be reported to the physician or NP		deficient practice will not recur? Audits/findings will be forwarded to QA monthly for review. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining compliance for no less than 6 months. Frequency and duration of the reviews will be adjusted as needed. After consecutive compliance is achieved, the DON and/or designee will randomly complete an audit to ascertain continued compliance annually.	

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	[Nurse Practitioner] ...." 3.1-37(a)			
F 0758 SS=E Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic			

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	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 observations, interviews and record reviews, the facility failed to monitor for adverse side effects of psychotropic medication and failed to complete an AIMS timely for 4 of 5 residents reviewed for unnecessary medications. (19,25,31 and 2) Findings include: 1. A clinical record review on 9/21/2022 at 9:44 A.M., indicated Resident 19's current physician orders included Seroquel 100 mg (milligram)(anti psychotic) for Psychosis, and Trazodone 125 mg (anti depressant) for insomnia at bedtime. A Quarterly MDS (Minimum Data Set) assessment dated 7/12/2022, indicated Resident 19 received antipsychotic and antidepressant medications. Resident 19's current care plan dated 4/11/2022, and revised on 7/25/2022, indicated he was at risk for side effects related to the use of antipsychotics and antidepressants. Interventions included, but were not limited to: Staff will observe for adverse side effects related to the need for an antidepressant and	F 0758	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? New for # 19, 25, and 31 have been initiated to monitor for side effects for use of an anti-psychotic drug. Resident # 2 had an AIMS assessment completed. 2. How be identified and what corrective action(s be taken? All residents receiving -psychotic medication were audited and have had side effects monitoring added to their orders and AIMS assessments completed. 3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? Nurses have been in serviced on Psychoactive medications/unnecessary medications policy. DON/designee will monitor all new admissions and new orders for the use of	10/26/2022

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	antipsychotics, side effects included but not limited to: nausea, drowsiness, fatigue, and dry mouth. The September 2022, Medication Administration Record lacked the documentation to show that side effects of seroquel and trazadone were being monitored. During an interview, on 9/22/2022 at 2:04 P.M., the Regional Director of Quality Assurance indicated there were no side effect's being monitored and there should have been. 2. A clinical record review on 9/21/2022 at 9:44 A.M. indicated Resident 25's current Physician Orders included fluoxetine 40 mg (milligram) for depression. An Admission MDS dated 7/22/2022, indicated Resident 25 received an antidepressant medication. Resident's 25 current care plan dated 7/22/2022 and revised on 7/29/2022 indicated she was at risk for side effects related to the use of antidepressants. Interventions included, but were not limited to:Staff will observe for adverse side effects related to the need for an antidepressant side effects included but not limited to: blurred vision, drowsiness, fatigue, and dry mouth. The September 2022, Medication Administration Record lacked the documentation to show that side effects of fluoxetine were being monitored. During an interview, on 9/22/2022 at 2:04 P.M., the Regional Director of Quality Assurance indicated there were no side effect's being monitored and there should have been.		antipsychotic medications to ensure a side effects order has been initiated for effective monitoring and AIMS assessment completed. This will occur daily in clinical . Results will be forwarded to the QA committee. 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Audits/findings will be forwarded to QA monthly for review. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining compliance for no less than 6 months. Frequency and duration of the reviews will be adjusted as needed. After consecutive compliance is achieved, the DON and/or designee will randomly complete an audit to ascertain continued compliance annually.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155003	A. BUILDING 00 B. WING	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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3. A clinical record review, for Resident 31 was completed on 9/22/22 at 2:33 P.M., and indicated current Physician Orders include BuPROPion 100 mg (milligram) for depression.

A 5 day MDS (Minimum Data Set) Assessment, dated 7/26/22, indicated resident 31 received antidepressant medication.

Resident's 31 current care plan dated 4/11/2022 and revised on 7/25/2022 indicated she was at risk for side effects related to the use of antidepressants. Interventions included, but were not limited to: Staff will observe for adverse side effects related to the need for an antidepressant side effects included but not limited to: blurred vision, drowsiness, fatigue, and dry mouth.

The September 2022, Medication Administration Record lacked the documentation to show that side effects of fluoxetine were being monitored.

During an interview, on 9/22/2022 at 2:04 P.M., the Regional Director of Quality Assurance indicated there were no side effect's being monitored and there should have been.4. A clinical record review was completed on 9/22/2022 at 10:33 A.M., for Resident 2, diagnoses included, but not limited to: Alzheimer's disease, dementia with behavioral disturbances, transient ischemic attacks and cerebral infarction, major depressive disorder, chronic obstructive pulmonary disease and vascular dementia with behavioral disturbances.

During an interview, on 9/23/2022 at 11:14 A.M., the Regional Director of Quality Assurance indicated that Resident 2 does not have an AIMS and should have had one done this year. The last

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	155003	A. BUILDING 00 B. WING	09/26/2022

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	one was completed on 12/6/2021, they do them twice a year and he should have had one done in June. On 9/23/2022 at 1:45 P.M., the Regional Director of Quality Assurance provided a policy titled, "AIMS - Side Effect Monitoring", revised 6/2021, and indicated the policy was the one currently used by the facility. The policy indicated "...4. AIMS testing will be completed every 3 months and when there has been a significant change...." On 9/26/2022 at 9:40 A.M. The Director of Nursing provided the policy titled, "Psychoactive Medication/Gradual Dose Reduction (GDR)/ Unnecessary Medications Policy", and indicated the policy is one currently used by the facility. The policy indicated "... 3 Nursing will observe for adverse side effects of psychoactive medications every shift and document on the electronic MAR (Medication administration record)... 13. Every resident's drug regimen is to be free from unnecessary drugs. An unnecessary drug is any drug when used without adequate monitoring...." 3.1-48(a)(3)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.			

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	(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure foods were dated when opened, sealed appropriately after opening, labeled with resident identifiers and failed to ensure refrigerators were in a clean and sanitary manner in 1 of 1 kitchens and 2 of 2 pantries observed. Findings include: 1. During an observation of the kitchen, on 9/19/2022 at 9:39 A.M. with the Dietary Manager the following were observed: in the freezer was a previously opened bag of pepperoni dated 4/20/2022, an opened box of butter fly shrimp not sealed, an opened bag of pre-made cookies undated and not sealed. In the dry storage area was a dented can of pumpkin, opened packages of carrot cake mix, ginger bread mix, a large bag of marshmallows, bags of noodles, macaroni and spiral pasta all undated and not sealed appropriately. During an interview, on 9/19/2022 at 9:54 A.M. the Dietary Manager indicated the foods should have been dated and sealed appropriately, and the left overs should have been used in 4 weeks.	F 0812	11. No residents identified 2. All residents have the potential to be affected 3. Dining Services staff will be educated on the facility policies, “Digital Food Labeling and Leftovers” by 10-26-22. No revisions will be made to the policies. Any failure to comply with the policies may result in corrective action and even termination of the employee. The policy, “Non-Kitchen Refrigerator Care & Food Storage” was reviewed with the following responsible parties Nursing, Dining Services, Activities and Housekeeping on 10-26-22. Based on CDC guidelines, an in-service entitled “Food Storage” from Health Technologies 2017 was given to all Dining Services staff on 10-26-22. The test will be given until each employee receives a 100% score. Any failure to comply with these guidelines may result in corrective action and even termination of the employee.	10/26/2022

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	155003	A. BUILDING 00 B. WING	09/26/2022

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	2. During an observation of the 100/200 hall pantry, on 9/26/2022 at 10:22 A.M., with the ADON (Assistant Director of Nursing), the following were observer: the unit refrigerator had a brownish colored spill in the freezer, 4 pints of ice cream with no opened dates or resident identifiers. A hot pocket sandwich not labeled and a box of french toast sticks not labeled or dated. Propel water bottle, an iced coffee bottle, a container of oriental chicken all not dated or labeled. A pizza box with dried up slices with no label or date. A sub sandwich with no date, and a container of french vanilla creamer undated and unlabeled with a sell by date of July 22, 2022. A small microwave with brown stains and crumbs. During an interview, on 9/26/2022 at 10:28 A.M., the ADON indicated the foods should have been labeled, dated and the refrigerator was dirty and should have been cleaned. 3. During an observation of the 300/400 hall pantry, on 9/26/2022 at 10:29 A.M., with the Unit Manager, the following was observed: 7 containers of ice creams not labeled or dated, a square of butter not labeled, dated or sealed, and 3 packages of cheese not labeled. During an interview, on 9/26/2022 at 10:30 A.M., the unit manager indicated the foods should have been labeled, dated and sealed. On 9/26/2022 at 9:40 A.M., the Director of Nursing provided the policy titled," Leftovers", dated 2/2020, and indicated the policy was the one currently used by the facility. The policy indicated"...2. All foods stored for later use shall be covered, labeled with food name, and dated with the current date, as well as a "used by" date, then stored appropriately (refrigerated or frozen if		4. The Dining Services Director, Dietitian Consultant or Designee will complete an Audit Tool 5x per Week x 2 Weeks; 4 x per Week x 2 Weeks; 3 x per Week x 2 Weeks; 2 x per Week x 2 Weeks; 1 x per Week until compliance is maintained. All audit forms will be secured in a binder for Administration access. The Audits will be reviewed during the facilities Quality Assurance meetings monthly for 6 months. Then as needed to ensure compliance.	

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	necessary) immediately after the end of the meal service. ...6. All leftovers may be stored labeled, sealed, and dated in the freezer for no more than 5 weeks. ...8. Left overs that have not been properly stored will be discarded, (When in doubt, throw it out)...." 3.1-21(i)(1)(3)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to			

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	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. §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			

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	necessary. Based on observation, interview and record review, the facility failed to ensure medication was not touched by bare hands, gloves were removed after removing a pressure ulcer dressing with handwashing being performed, and Personal Protective Equipment (PPE) worn when entering a room with a aerosol generating procedure in progress for 3 out of 3 residents reviewed for infection control. (Resident 41, 25 and 23) 1. A clinical review was completed on 9/21/2022 at 10:39 A.M., for resident 41, diagnoses included, but not limited to: chronic respiratory failure, congestive heart failure, type 2 diabetes, peripheral vascular disease, anxiety, and hypertension. During an observation, on 9/21/2022 at 10:03 A.M., Certified Nursing Assistant 13 (CNA) entered Resident 41's room and closed the door to answer his call light. She did not stop and donn PPE prior to entering she just wore her surgical mask. She was in the room less than a minute applied alcohol based had rub (ABHR) as she exited the room. Observed on 9/21/2022 at 10:04 A.M., outside of Resident 41's room is signage posted on the door trim that indicates : Aerosol generating procedure in progress PPE required to wear to enter: hand hygiene, gown, gloves, eye wear, N-95. Keep door closed during use and hour post treatment. During an observation on 9/21/2022 at 11:23 A.M., a Qualified Medication Aide 11 (QMA) entered Resident 41's room to answer a call light. He did not stop and donn PPE prior to entering. He had a surgical mask and used ABHR when he exited the room.	F 0880	1) Residents # 41, 25, and 23 had no adverse reactions as a result of the alleged deficient practices and required no intervention. 2) All residents residing in the facility have the potential to be affected by staff not donning and doffing appropriate PPE when entering a room in Aerosol Generated Precautions. All residents receiving wound care have the potential to be affected by the alleged deficient practice observed during a clean dressing change. All residents receiving medications have the potential to be affected by the alleged deficient practice observed during a med pass observation. 3) The facility policy and procedures for appropriate PPE for rooms observing aerosol generated precautions, Clean Dressing Change and Medication Administration was reviewed and no changes were indicated at this time. All staff were re-inserviced by the Infection Preventionist on the appropriate use of PPE in rooms observing aerosol generated precautions and on following the directions of the posted signage on resident room indicating type of PPE required to enter. Nurses were re-inserviced on doing a clean dressing change	10/26/2022

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	During an interview, on 9/21/2022 at 10:07 A.M., Certified Nursing Assistant 13 indicated she entered Resident 41's room, he was on his Continuous Positive Airway Pressure (CPAP) and she did not wear the proper PPE that's posted and she should have. He requested his urinal. During an interview, on 9/21/2022 at 11:25 A.M., QMA 11 indicated the resident was wearing his CPAP, and he did not don PPE prior to entering the room, should have worn glove , gown, n-95 and shield prior to going in the resident room. 2.. During a wound observation, on 9/21/2022 at 10:01 A.M., Licence Practical Nurse (LPN) and Registered Nurse (RN) 7 completed a wound treatment on Resident 25's left buttocks and sacrum. LPN 6 washed her hands, applied gloves and removed the old dressings. LPN 6 then cleansed the wounds and applied santyl (debriedment agent) to both areas. LPN 6 then applied a foam dressing to the left buttocks and an abdominal pad to the sacrum and removed her gloves. LPN 6 applied new gloves and dated both dressings. LPN 6 did not wash her hands or change her gloves after removing the soiled dressing. During an interview, on 9/21/2022 at 10:15 A.M., LPN 6 indicated she thought she had changed gloves, but did not wash her hands.3. A medication administration observation was completed for Resident 23 on 9/22/2022 at 7:12 A.M. RN 7 prepared the following medications for administration in the first medication cup: acetaminophen 650 mg (milligrams), ibuprofen 75 mg, escitalopram 20 mg, omeprazole 20 mg, bumetanide 2 mg, hydroxyzine 25 mg, metolazone 10 mg and, potassium chloride 20 meq (milliequivalents). Gabapentin 100 mg was placed		and appropriate medication administration. 4) The IP/DON/Designee will visually observe 2 resident rooms in aerosol generated precautions to ensure proper PPE/infection control practices are maintained. This will occur 5 times per week for 6 weeks, 2 times per week for 2 weeks, weekly for 4 weeks then monthly thereafter until 100% compliance, then monitoring on a routine quarterly basis. This monitoring will be random and cover all shifts. The IP/DON/Designee will observe a clean dressing change to ensure proper infection control practices are maintained. This will occur 5 times per week for 6 weeks, 2 times per week for 2 weeks, weekly for 4 weeks then monthly thereafter until 100% compliance, then monitoring on a routine quarterly basis. This monitoring will be random and cover all shifts. The IP/DON/Designee will conduct a Medication Pass observation 5 times per week for 6 weeks, 2 times per week for 2 weeks, weekly for 4 weeks then monthly thereafter until 100% compliance, then monitoring on a routine quarterly basis. This monitoring will be random and cover all shifts. All monitoring above will continue until 100% compliance is achieved for no less than 6 months and as determined by the Quality	

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	155003	A. BUILDING 00 B. WING	09/26/2022

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MASON HEALTH CARE CENTER	900 PROVIDENT DRIVE WARSAW, IN 46580

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	in a second medication cup. All medications in the first medication cup were transferred to a medication sleeve to crush and placed in applesauce. RN 7 then took the gabapentin in the second medication cup and opened the capsules with her bare hands and placed the medication in the applesauce. During an interview, on 9/22/2022 at 7:20 A.M., RN 7 indicated, she should probably not have opened the capsules with bare hands. On 9/22/2022 at 10:40 A.M., a policy titled, "Medication Administration", was provided by the Regional Director of Quality Assurance. The policy indicated, " ...k. Crushing medication(s)/Opening capsules ...8. Apply gloves to open capsule(s) ...." On 9/26/2022 at 11:03 the Director of Quality Services provided a policy titled "Clean Dressing Change," dated 1/2019, indicated the policy was the one currently used by the facility. The policy indicated "...General Guidelines: Perform hand hygiene and put on gloves, Remove the soiled dressing and pull the soiled gloves off over dressings and dispose of in a moisture proof bag, Perform hand hygiene and put on clean gloves...." On 9/22/2022 at 10:40 A.M., the Regional Director of Quality Assurance provided a policy titled, "CPAP/BI-PAP", revised 8/2020, and indicated the policy was the one currently used by the facility. The policy indicated "...For Use of BI-PAP or CPAP: If physician deems that the use of the CPAP or BI-PAP is necessary for the treatment of the resident then the following will be followed: Staff entering resident room while resident using CPAP/BI-PAP must wear full PPE including but		Assurance Performance Improvement Committee to discontinue. After compliance is achieved the DON and /or designee will implement monitoring on a routine quarterly basis. This monitoring will be random and cover all shifts for proper PPE usage in designated rooms, clean dressing changes and proper medication pass administrations to ascertain continued compliance at least biannually. Any concerns noted will receive immediate follow-up for monthly Quality Assurance Performance Improvement review. 5) The program will be overseen by DCS/IP/Designee The facility will ensure this requirement is met through application of the following Directed Plan of correction. No residents were negatively affected by these practices. All residents have the potential to be affected by improper use of PPE in resident's rooms observing Aerosol Generated Precautions. All residents receiving clean dressing changes and/or oral medications have the potential to be affected. **Root Cause Analysis:** Findings: During the facility visit for Recertification and State Licensure Survey, the surveyors	

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	155003	A. BUILDING 00 B. WING	09/26/2022

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MASON HEALTH CARE CENTER	900 PROVIDENT DRIVE WARSAW, IN 46580

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	not limited to N-95 respirator and eye protection...." 1.3-18(a)		observed: · Problem Statement: The facility failed to ensure the proper Personal Protective Equipment (PPE) was worn when entering a room with an aerosol generating procedure (AGP) was in progress. § (Incident) During an observation, a Certified Nursing Assistant (CNA) and a QMA entered a Resident's room and closed the door to assist a resident receiving an aerosol generating procedure (AGP) without donning proper PPE prior to entering the room, they wore only their surgical mask. § (What) Staff are to don with appropriate PPE to enter the room of a resident receiving an AGP. • The appropriate PPE is to be donned prior to entering and doffed when exiting room. § (Why) Staff entered the room of resident receiving an AGP, in just a surgical mask. • Staff failed to follow the AGP sign posted on the resident's door indicating the required PPE prior to entering the room while the resident was receiving an AGP. § (Immediate Corrective Action) All staff, including the 2 staff identified in the 2567, were inserviced on facility policy and procedure for proper PPE usage when entering a room observing aerosol generated procedures and to follow the resident posted signage with return demonstration.	

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	155003	A. BUILDING 00 B. WING	09/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MASON HEALTH CARE CENTER	900 PROVIDENT DRIVE WARSAW, IN 46580

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			· (Problem Statement) The facility failed to ensure medication was not touched by bare hands in an observed medication pass. § (What) A medication administration observation was completed for a resident with a RN, and it was observed that the nurse opened the capsules with her bare hands and placed the medication in the applesauce. § (Why) Nurse touched capsule medication with bare hands. • Nurse forgot to perform hand hygiene and put on gloves before puncturing the capsule medication. § (Immediate Corrective Action) All nursing staff (including identified nurse and all QMA's) were re-educated on the medication pass policy and training on not touch resident medication with bare hands. · (Problem Statement) The facility failed to ensure that proper infection control practice was followed during wound care by not washing her hands or changing her gloves after removing the soiled dressing and applying the new dressing. § (What) During an observation of wound care a nurse (LPN) completed a wound treatment on a residents' left buttocks and sacrum. LPN washed her hands, applied gloves, and removed the	

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	155003	A. BUILDING 00 B. WING	09/26/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			old dressings. LPN then cleansed the wounds and applied Santyl to both areas. LPN then applied a foam dressing to the left buttocks and an abdominal pad to the sacrum and removed her gloves. LPN then applied new gloves and dated both dressings. LPN did not wash her hands or change her gloves after removing the soiled dressing and applying the new dressing. § (Why) LPN forgot to wash her hands between removing the old dressing and applying new gloves before placing on the new dressing due to being nervous. § (Immediate Corrective Action) All licensed nurses (including the identified LPN) were re-inserviced on procedure for completing a clean dressing change. Auditing Tools: · Direct observation with return demonstration (PPE and hand hygiene and gloving) · Tools and assistance from the QIO will be provided as needed · Med pass audits performed randomly, overseen by DCS/Designee · Root Cause Analysis (RCA) and LTC infection control self-assessment reviewed and completed as indicated. Corrective Measures: · Re-education and inservicing with all staff including: • Facility policies and procedures on Isolation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155003	A. BUILDING 00 B. WING	09/26/2022

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			procedures for aerosol generated precautions, medication administration and clean dressing change. • Audit tools initiated with skill check offs to ensure proper infection control techniques are being utilized when entering rooms in aerosol generated precautions, during medication pass and clean dressing changes. Summary: • Root cause analysis determined the need for the Facility IP nurse and/or DCS/designee to ensure a persistent increase in frequency of reeducation and auditing to assure the appropriate utilization and management of PPE in aerosol generated precaution rooms to prevent the spread of infection. • Root cause analysis determined the need for the Facility IP/DCS/designee to ensure a persistent increase in frequency of re-education and auditing to assure the appropriate infection control measures are being utilized during medication pass and clean dressing change to prevent the spread of infection. • The DCS/designee will complete the infection control audits related to PPE/infection control in aerosol generated precaution rooms, medication pass and clean dressing change.	

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			• This will occur 5 times per week for 6 weeks, 2 times per week for 2 weeks, weekly for 4 weeks then monthly thereafter until 100% compliance, then monitoring on a routine quarterly basis. This monitoring will be random and cover all shifts. • All monitoring will continue until 100% compliance is achieved for a period of three consecutive months (a minimum of monitoring for 6 months) as determined by the Quality Assurance Performance Improvement committee. After consecutive compliance is achieved the DCS/designee will randomly observe for proper PPE usage in designated rooms, clean dressing changes and proper medication pass administrations to ascertain continued compliance at least biannually. Any concerns noted will receive immediate follow- up for monthly Quality Assurance Performance Improvement review and the plan of action will be adjusted accordingly. Survey findings, root cause analysis reviewed with Corporate IP, Medical Director, Administrator, Facility IP nurse and DCS. The plan of action was agreed upon.	