STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155292	A. BUILDING 00 B. WING	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

(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 and Investigation of Complaints IN00422553, IN00425026 and IN00420608. This visit included a State Residential Licensure Survey. Complaint IN00422553 - Federal/State deficiencies related to the allegations are cited at F677 and F880. Complaint IN00425026 - Federal/State deficiencies related to the allegations are cited at F695, 689 and F849. Complaint IN00420608 - Federal/State deficiencies related to the allegations are cited at F677, F687, F692, and F880. Survey dates: January 3, 4, 5, 6, 8, 9, 10, 2024 Facility number: 000189 Provider number: 155292 AIM number: 100267330 Census Bed Type: SNF/NF: 124 Residential: 37 Total: 161 Census Payor Type: Medicare: 9 Medicaid: 76 Other: 39 Total: 124 These deficiencies reflects State Findings cited in	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure survey on January 10, 2024. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Gina Couch	Executive Director	02/01/2024

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	accordance with 410 IAC 16.2-3.1. Quality review completed on January 17, 2024			
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.			

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	§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview and record review, the facility failed to ensure staff provided care services in a manner that promoted privacy, respect, and dignity, and to provide an environment where residents were able to express grievances without fear of reprisal for 11 of 12 residents reviewed for dignity. (Residents' B, C, D, S, T, SS, 45, 69, 80, 85 and an Anonymous Resident) Findings include: 1. During a Resident Council meeting on 1/3/24 at 2:05 p.m., Resident 85 indicated that the staff "treat you like s***" after they are talked to by the management staff about your complaint. The staff that were complained about comes back and treat you badly after you complain about care that was provided. Residents are scared to complain. Resident 69 and Resident 45 indicated agreement to Resident 85's comments. Resident 80 indicated some of the staff were disrespectful, especially on the weekends. The weekend staff appeared not to care what residents needed. 2. An anonymous interview was conducted with a Family Member. They indicated there were issues in the facility due to understaffing. The workload was "unrealistic." They were in the facility on a routine basis. In the dining room, they witnessed how residents were and were not being fed. They didn't think the staff "understand the needs of the	F 0550	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ED held a resident council and all residents were provided with an environment where they express grievances without fear of reprisal. . How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ·All staff re-educated on Resident Rights policy and customer service expectations on or before February 29, 2024. ·ED/ Designee to attend resident council meetings if permission given by council	02/29/2024

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	patients." The facility needed oversight, supervision, and communication. Staff set trays in front of residents and "they're just left there." The food wouldn't be cut up as needed, not considering the resident's needs. They saw a lot of untouched trays being returned to the kitchen. "In this place, poor dispositions are often. Staff are easily irritated." They were in halls when trays were cleared from rooms, and there were trays with no evidence of staff having attempted to feed the residents, residents who have no ability to say yes or no. They'd seen staff feed residents too much and too fast. Residents couldn't finish one bite before being served another, if the resident was fed at all. Staff were constantly on their phones, when they were supposed to be feeding residents. They rarely saw staff take the consideration to microwave a plate. They tried to assist other residents with eating, but the staff didn't want them to, but "it's hard for me to watch people not eat or drink." Some time ago, they were not in the facility for 3 consecutive days, and in that time frame, their family member, who was dependent on staff for changing their brief, had developed inflamed skin, "bloody even." They were upset that "I couldn't be gone for 3 days." There were times staff put 2 briefs on their family member. Staff refer to residents as feeds and "I don't appreciate that ....The aides run the show. I don't think they have sensitivity training." 3. During an interview on 1/04/24 at 9:50 a.m., Resident T indicated that he was hesitant to say anything about how staff treated him because he was worried that the staff wound find out and treat him badly. During the interview, CNA (Certified Nursing Assistant) 21 was observed entering through the closed door without knocking. Resident T indicated that some staff would knock before entering and some would not.		·Care companions to interview residents in relation to dignity, privacy, respect and resident's rights weekly What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? All staff re-educated on dignity utilizing Resident Rights policy on or before February 29, 2024. ·ED/ Designee to attend resident council meetings if permission given by council ·Care companions to interview residents in relation to dignity, privacy, respect and resident's rights weekly, any concerns will be addressed immediately How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality	

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	4. During an interview on 1/04/24 at 2:39 p.m., Resident 69 indicated he felt disrespected, because the staff did not answer his call lights timely and provide the care he needed. 5. During an Anonymous Resident Interview, they indicated some nurses "bark" orders and are "disrespectful bullies." They had asked a nurse one time, why was she was so angry? The nurse in a hateful tone responded, "I am not angry!" Anonymous Resident Interview did not feel comfortable with revealing the nurse's name in fear of retaliation. 6. An interview was conducted with Resident C on 1/04/24 at 10:16 a.m. He indicated some nurses and Certified Nursing Assistants (CNA) staff are unfriendly and rude. 7. An interview was conducted with Resident D on 1/4/24 at 10:26 a.m. She indicated CNA staff are disrespectful. She turned on her call light last evening, CNA 51 came into her room turned off her call light; stated he would be back and then left the room. He never came back to assist with changing her. It happens all the time. 8. During an interview with Resident B's Representative 5 on 1/4/24 at 10:55 a.m., She indicated the nursing staff are rude and disrespectful. The evening shift nurse, License Practical Nurse (LPN) 50 "always has an attitude" when asking questions about the resident's care. 9. The clinical record for Resident SS was reviewed on 1/5/24 at 9:00 a.m. The diagnosis for Resident SS included, but was not limited to, fracture of left femur. The resident was admitted to the facility on 12/30/23. A nutrition care plan dated 1/4/23 indicated		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	

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	Resident SS was to be assisted with feeding. An Activities of Daily Living (ADL)s care plan dated 1/1/24 indicated Resident SS requires assistance with eating, bed mobility, and transfers. The interventions in place for the resident's plan of care was to assist with placement of dentures, hearing aids and eating. A random observation was made of Resident SS and Resident SS's Representative on 1/5/24 at 9:05 a.m. Resident SS was observed lying in bed with a gown on with no dentures or hearing aids in. The resident's breakfast tray was sitting on a bedside table untouched. Resident SS indicated she did want to eat breakfast. Resident SS's Representative indicated she was very upset with the care that was provided in the facility. The resident was admitted to the facility a week ago, and the experience has been on going with long delays to receive care services. She had been asking for assistance with getting Resident SS up in a chair prior to meal delivery for the past 40 minutes, so she can eat her breakfast when it arrived. The physician had stated yesterday, the resident needed to be up in a chair for meals. The staff has ignored her request. She felt like she was "begging" staff to get her up. The meal now has arrived approximately 5 minutes ago, and the resident was still not up in a chair to eat. An observation was made of Resident SS on 1/5/24 at 9:22 a.m., Certified Nursing Aide (CNA) 7 was observed entering Resident SS's room without knocking or introducing herself. CNA 7 had a flat affect facial expression and was not communicating to anyone. She walked over to Resident SS's uneaten breakfast tray, picked it up and turned around to walk out of the room. There was no explanation on why she was removing the			

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	tray. Resident SS's roommate, Resident 21 had stated to CNA 7 as she was walking to the door, "don't take her tray she has not eaten yet." CNA 7 responded in an unfriendly tone she was heating it up, and then continued to walk out of the room. At 9:25 a.m., CNA 7 returned to the resident's room with Resident SS's breakfast tray. As she was assisting the resident with her meal, Resident SS's Representative had spoken to CNA 7 about the resident needing to be up in a chair for meals and requested CNA 7 to introduce herself to Resident SS. CNA 7 with a flat affect facial expression in a harsh tone stated her name to the resident. During that time, CNA 7 had indicated to Resident SS's Representative if she was told to get Resident SS up prior to meals she would have done so at 7:00 a.m. An interview was conducted with Director of Nursing on 1/8/24 at 4:11 p.m. She indicated she had spoken to Resident SS's Representative about the incident with breakfast on 1/5/24, and it was addressed. 10. A random interview with Resident 45 was conducted on 1/6/24 at 1:26 p.m. Resident 45 indicated that morning she was lying in bed while working on a crossword puzzle and had fallen asleep with her pen in her hand, when she was suddenly awakened by CNA (Certified Nursing Assistant) 33 "snatching" the pen out of her hand and saying, "I need that pen". CNA 33 used her pen then returned it to Resident 45's bedside table. Resident 45 indicated, since she was awake at that point, she returned to working on the crossword puzzle and again had fallen asleep with the pen in her hand. While Resident 45 was asleep, CNA 33 returned to her room again and "snatched" the pen out of her hand and startled her awake again saying she needed to use Resident 45's pen. CNA 33 then used Resident 45's pen to date the water cup. Resident 45			

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	indicated; she thought CNA 33's behavior was "extremely rude." Resident 45's Quarterly MDS (Minimum Data Set) completed on 12/7/23 indicated, Resident 45 was cognitively intact. An interview with DON (Director of Nursing) conducted on 1/6/24 at 1:51 p.m. indicated, CNA 33 should not have taken a pen out of a resident's hand while they were sleeping and stated, "it was rude". An interview was conducted with the Executive Director (ED) on 1/9/24 at 8:58 a.m. She indicated the facility provides continuous education to the staff related to customer service and resident rights training. She expects the staff to be respectful and provide good care to the residents. A Resident Rights policy was provided by the ED on 1/9/24 at 9:01 a.m. It indicated "...Resident rights. You have the right to a dignified existence, self-determination, and communication with and access to the persons and services inside and outside the facility...Planning and implementing care...You have the right to be informed, and participate in, your treatment. This includes the right to...Receive the services and/or items included in the plan of care....Be informed in advance, of the care to be furnished and the type of care giver or professional that will furnish care...Respect and Dignity. You have a right to be treated with respect and dignity, including...The right to reside and receive services in the facility with reasonable accommodations of your needs and preferences except when to do so would endanger the health or safety of you or your residents...Grievances. You have the right to voice grievances to the facility or other agency or entity			

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	that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment, the behavior of staff and of other residents; and other concerns regarding your facility stay..." 3.1-3(t)			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview and review, the facility failed to timely have the interdisciplinary team (IDT) determine and document that self-administration of medications and treatments were clinically appropriate for 2 of 2 randomly observed residents. (Resident 58 and Resident P) Findings include: 1. The clinical record for Resident 58 was reviewed on 1/3/24 at 3:47 p.m. The diagnosis for Resident 58 included, but was not limited to, type 2 diabetes mellitus. The admissions 12/12/23 Minimum Data Set (MDS) assessment indicated Resident 58 was cognitively intact. A physician order dated 12/6/23 indicated Resident 58 was to receive 1000 milligrams of Tylenol every 6 hours as needed. A physician order dated 1/4/24 indicated Resident	F 0554	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?¿ ul class="BulletListStyle1 SCXW59251270 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" Medications were removed from Resident 58's bedside. Medications were removed from Resident P's bedside. How will you identify other residents having the potential to be affected by the same deficient	02/29/2024

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	58 was to receive ciclopirox topically for toenails daily. A physician order dated 1/4/24 indicated Resident 58 was to receive 1 spray in each nostril of 50 mcg (micrograms) of Flonase twice a day. An observation was made of Resident 58 on 1/3/24 at 3:47 p.m. The resident was lying in bed in her room. The resident's bedside table was observed with a tube of fungal cream, ciclopirox, 2 Tylenol tablets in a medication cup and 1 bottle of Flonase. The resident indicated at that time she had received the ciclopirox cream and the Flonase medications from an outside medical provider. The 2 tablets of Tylenol were administered to her by staff in the morning sometime. The resident did not need to take the Tylenol at that time, so she didn't. She waits until she needs to take them. The staff were aware she has the medications in her room. The resident's clinical record did not indicate assessments were conducted to determine if it was safe for resident to keep medications at bedside and/or self-administer medications. An interview was conducted with the Director of Nursing on 1/4/24 at 9:14 a.m. She indicated Resident 58 did not have an assessment for self-medication administration to determine if it was safe for medications to be in her room. There was an audit, and all residents on the unit was assessed for self-medication administration. Resident 58 has been assessed. 2. On 1/4/24 at 1:52 p.m., a random observation of Resident P's bedside found a Symbicort inhaler (a medication used to treat asthma and chronic obstructive pulmonary disease) on her bedside table and a bottle of loperamide (medication to treat diarrhea)		practice and what corrective action will be taken?¿ ·Licensed nurses and QMAs educated on of medications policy on or before February 29, 2024. ·All residents were reviewed to ensure medications were not left at bedside for residents who are not approved to ¿ What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur?¿ Licensed nurses and QMAs educated on of medications policy on or before February 29, 2024 ·A daily rounding tool including medication left at bedside to be utilized by DNS/designee How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?¿	

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	on her bedside dresser. An interview conducted at the same time as the observation with Resident P indicated, the Symbicort inhaler was from home. An interview with UM (Unit Manager) 27 conducted on 1/4/24 at 1:57 p.m. indicated, she was not able to locate a self-administration of medication assessment for Resident P's Symbicort nor the loperamide. The clinical record for Resident P was reviewed on 1/9/24 at 10:27 a.m. and revealed that at the time of the random observation of medications at her bedside, Resident P did not have a physician's order for the loperamide. A Self Administration of Medications was provided by the Director of Nursing on 1/4/24 at 9:18 a.m. It indicated "...Policy. It is the policy of this facility to respect the wishes of alert, competent residents to self-administer prescribed medications as allowable under state regulations. The facility will provide instruction for all residents choosing to and capable of self-administration...If a resident desires to participate in self-administration, the Interdisciplinary Team will assess the competence of the resident to participate by completing the "Self-Administration of Medication Assessment" observation. A physician order will be obtained specifying the resident's ability to self-administer medications and, if necessary, listing which medications will be included in the self-administration plan...Storage of self-administered medications will comply with state and federal regulations. All bedside medications will be maintained in a secured location in the resident's room. The resident will be assessed for continued self-administration of medications quarterly and with any significant		The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year 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	

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	change of condition..." 3.1-11(a)			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on observation, interview and record review, the facility failed to ensure residents got out of bed and showered as preference for 2 of 2	F 0561	p role="heading" aria-level="1" paraid="55817124" paraeid="{2bac2fc8-b66a-4cda-be50-de275063469b}{216}" >What	02/29/2024

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	residents reviewed for choices. (Resident B and Resident 105) Findings include: 1. The clinical record for Resident B was reviewed on 1/4/24 at 10:00 a.m. The diagnosis for Resident B included, but was not limited to, epilepsy. The quarterly 12/3/23 (MDS) assessment indicated Resident B was severely cognitively impaired. A care plan dated 8/23/23 indicated Resident B " has the following daily routine preferences...The approaches...prefers to get showers, 2x's [twice] weekly in the morning..." A routine and activities preference form dated 11/30/23 indicated it was "very important" to her to choose her bathing. The resident's bathing choice was showers. The resident's clinical record did not indicate the resident refuses showers. The December 2023 and January 2024 shower sheets indicated the resident was provided bathing the following days: December 2023: 12/1/23 - did not indicate the type of bathing, 12/4/23 - complete bed bath, 12/8/23 - complete bed bath, 12/13/23 - did not indicate the type of bathing, 12/20/23 - did not indicate the type of bathing, January 2024: 1/8/24 - full bed bath		corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B's bathing preferences have been updated and are gotten out of bed per preference. ul class="BulletListStyle1 SCXW122266843 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" Resident 105's preference on daily routine has been updated and are gotten out of bed per How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ·All staff re-educated on dignity, bathing preference and daily routine preferences utilizing Resident Rights policy on or before February 29, 2024 ·All residents were interviewed to ensure resident preferences for	

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	The December 2023 Certified Nursing Aide plan of care tasks indicated the following days and the bathing type Resident B received: 12/1/23 - complete bed bath, 12/4/23 - complete bed bath, 12/6/23 - complete bed bath, 12/9/23 - complete bed bath, 12/12/23 - complete bed bath, 12/18/23 - complete bed bath, 12/20/23 - complete bed bath, 12/22/23 - complete bed bath, 12/23/23 - complete bed bath, 12/29/23 - complete bed bath, and 12/31/23 - complete bed bath, An interview was conducted with Resident B's Representative on 1/4/23 at 10:55 a.m. She indicated the resident receives bed baths, but showers are preferred. An interview was conducted with Nurse Aide 8 on 1/8/24 at 10:40 a.m. She indicated Resident B receives complete bed baths not showers. An interview was conducted with the Director of Nursing on 1/9/24 at 1:57 p.m. She indicated an audit was completed last week regarding the residents' shower preferences in the building. Resident B had reported she would like bed baths. Families had not yet been notified. 2. The clinical record for Resident 105 was reviewed on 1/8/24 at 10:00 a.m. The diagnosis for Resident 105 included, but was not limited to, heart failure. The quarterly 11/20/23 (MDS) assessment indicated Resident 105 was severely cognitively impaired.		shower and daily routine were obtained. ·A daily rounding tool reviewing dignity, bathing preference and daily routine preferences to be utilized DNS/designee What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? All staff re-educated on dignity, bathing preference and daily routine preferences utilizing Resident Rights policy on or before February 29, 2024. ·A daily rounding tool reviewing Residents Rights including dignity, bathing preference and daily routine preferences to be utilized by DNS/designee How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance	

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	A care plan dated 8/3/23 indicated "the resident has the following daily routine preferences...Approach...Resident prefers to get up before breakfast..." A routine and activities preference form date 11/20/23 indicated Resident 105 preferred to get out of bed before breakfast. An observation was made of Resident 105 and Nurse Aide 8 on 1/8/24 at 10:39 a.m. The resident was in bed with a gown on. Nurse Aide 8 was at the resident's bed side at that time. The resident was observed to be agitated and requested to get cleaned up and get out of bed. Nurse Aide 8 had responded to the resident, she would have to wait until Certified Nursing Aide (CNA) 9 was available. CNA 9 was providing care to another resident at that time. An interview was conducted with Nurse Aide 8 on 1/8/24 at 10:40 a.m. She indicated Resident 105 gets out of bed when she requests. An interview was conducted with Resident 105 on 1/8/24 at 10:42 a.m. She indicated she had been asking to get up for "awhile." She was "tired of waiting." Nurse Aide 8 "keeps pushing me off." She was supposed to get up at 9:00 a.m., but she had not even been "washed up" yet. They came in and cleaned up her roommate a while ago but had not been back to clean her up. A Preference for Daily Routine policy was provided on 1/9/24 at 9:01 a.m. It indicated "...Purpose: to identify and develop a plan of care that reflects a resident's past and current daily customary routines. The Preference for Daily Customary Routines is a tool that can be used to		Improvement Committee overseen by the Executive Director ·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance	

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	gather information about a resident and incorporate this into the interdisciplinary plan of care. Procedure...1...The interview will be conducted with the resident unless they are not able to be understood. If the resident is not able to be understood, the worksheet is completed with the family/significant other, as available...3. The information from the worksheet will be shared with the interdisciplinary team so that each department can address the resident's preferences." A Resident Rights policy was provided by the ED on 1/9/24 at 9:01 a.m. It indicated "...Resident rights. You have the right to a dignified existence, self-determination, and communication with and access to the persons and services inside and outside the facility...Planning and implementing care...You have the right to be informed, and participate in, your treatment. This includes the right to...Receive the services and/or items included in the plan of care....Be informed in advance, of the care to be furnished and the type of care giver or professional that will furnish care...Respect and Dignity. You have a right to be treated with respect and dignity, including...The right to reside and receive services in the facility with reasonable accommodations of your needs and preferences except when to do so would endanger the health or safety of you or your residents..." 3.1-3(v)(1)			
F 0677 SS=E 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			

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	hygiene; Based on observation, interview and record review, the facility failed to ensure timely assistance was provided with eating, nail care, incontinent care, residents getting out of bed, and ensure residents that need assistance with incontinence was provided 1 incontinent brief at a time for 8 of 12 residents reviewed for Activities of Daily Living. (Residents' B, H, J, K, M, R, S and SS) Findings include: 1. The clinical record for Resident SS was reviewed on 1/5/24 at 9:00 a.m. The diagnosis for Resident SS included, but was not limited to, fracture of left femur. The resident was admitted to the facility on 12/30/23. A nutrition care plan dated 1/4/23 indicated Resident SS was to be assisted with feeding. An Activities of Daily Living (ADL)s care plan dated 1/1/24 indicated Resident SS requires assistance with eating, bed mobility, and transfers. The interventions in place for the resident's plan of care was to assist with placement of dentures, hearing aides and eating. A random observation was made of Resident SS and Resident SS's Representative on 1/5/24 at 9:05 a.m. Resident SS was observed lying in bed with gown on with no dentures or hearing aides in. The resident's breakfast tray was sitting on a bedside table untouched. Resident SS indicated she did want to eat breakfast. Resident SS's Representative indicated she was very upset with the care that was provided in the facility. The resident was admitted to the facility a week ago, and the experience has been on going with long	F 0677	p role="heading" aria-level="1" paraid="2025451324" paraeid="{ba05999d-a9d4-4544-afd8-cc6d88014d4f}{80}" >What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B, H, J, K, M, R, S and SS received necessary ADL care. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who require ADL care have the potential to be affected by the alleged deficient practice ·All residents were observed to ensure residents were assisted with feeding, positioned correctly in chair/bed/wheelchair, well groomed, dentures and hearing aides were in, up for meals, incontinent care provided and toileted, nails trimmed, personal hygiene was provided by each resident care companion. Resident profiles were updated as needed.	02/29/2024

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	delays to receive care services. She had been asking for assistance with getting Resident SS up in a chair prior to meal delivery for the past 40 minutes, so she can eat her breakfast when it arrived. The physician had stated yesterday, the resident needed to be up in a chair for meals. The staff has ignored her request. She felt like she was "begging" staff to get her up. The meal now has arrived approximately 5 minutes ago, and the resident was still not up in a chair to eat. Resident SS's Representative was observed holding the resident's oatmeal bowl and indicated the resident's food was now getting cold. At 9:13 a.m., Qualified Medication Aide (QMA) 2 entered the resident's room. She indicated she did not know Resident SS. At that time, QMA 2 was observed asking Resident SS's Representative how does the resident take her medications. She was unaware of the route. Resident SS's Representative responded to QMA 2; the resident takes her medications crushed in applesauce. QMA 2 then left the room. An observation was made of Resident SS on 1/5/24 at 9:22 a.m., Certified Nursing Aide (CNA) 7 was observed entering Resident SS's room and removed the resident's uneaten breakfast tray. She indicated she was heating up the breakfast tray. At 9:25 a.m., CNA 7 returned to the resident's room with the breakfast tray and assisted the resident with her breakfast meal while the resident was in bed. CNA 7 had indicated to Resident SS's Representative if she was told to get Resident SS up prior to meals she would have done so at 7:00 a.m. An interview was conducted with Director of Nursing on 1/8/24 at 4:11 p.m. She indicated she had spoken to Resident SS's Representative about the incident, and it was addressed.		·All nursing staff re-educated on ADL care on or before February 29, 2024. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? ul class="BulletListStyle1 SCXW192167017 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" All nursing staff re-educated on ADL care on or before February 29, 2024. Resident care sheets reviewed daily in morning by care companions. A daily rounding tool including ADL care to be utilized by DNS/designee to ensure good grooming and personal hygiene. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter	

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	2. The clinical record for Resident B was reviewed on 1/4/24 at 10:00 a.m. The diagnosis for Resident B included, but was not limited to, epilepsy. The quarterly 12/3/23 Minimum Data Set (MDS) assessment indicated Resident B was severely cognitively impaired. A care plan dated 8/20/23 indicated "..Resident requires assistance with Activities of Daily Living (ADL)s including bed mobility, transfers, eating and toileting...Approach...Assist with toileting and/or incontinent care as needed..." An interview was conducted with Resident B's Representative 5 on 1/4/24 at 10:55 a.m. She indicated during visits, the resident sits up in her chair and/or in bed for long periods of time without being changed or repositioned. She has observed at times, the resident to be "soaked" with urine. An observation was made of Resident B in her room with Resident B's Representatives 3 and 4 on 1/6/24 at 1:35 p.m. The resident was observed wearing a jogging suit and sitting in her broda chair by her bed. Resident B's Representative 3 indicated she had been visiting the resident since 11:30 a.m., that day. The staff had not come into the room to provide incontinent care during her visit. She had asked the staff approximately 5 minutes ago to change her due to not knowing how long it had been since she had received incontinent care. NA 8 reported to them she needed to go get some help from the resident's assigned CNA, (CNA 9) to change the resident. At that time, they were currently waiting for assistance.		for one year 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	

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	An observation was made of incontinent care to Resident B with Nurse Aide (NA) 8 and Certified Nursing Assistant (CNA) 9 on 1/6/24 at 2:00 p.m. The resident was observed being transferred by hoyer from the broda chair to the resident's bed by NA 8 and CNA 9. After the transfer, urine odor was present coming from the broda chair. CNA 9 indicated at that time, the cloth pad in the broda chair was wet with urine. CNA 9 then removed the resident's jogging pants, and the pants were observed to be wet with urine. After the removal of the soiled brief, a skin tear area was observed an inch in length and red in color on the left side under the resident's abdomen fold. CNA 9 at that time requested NA 8 to leave the room and report to the nurse to come and observe the skin area on the resident. CNA 9 indicated that was the first time she had observed the skin area on the resident. As of Friday, 1/5/24, the resident did not have the skin area. The last time she had provided incontinent care to Resident B was at 12:00 p.m., that day. An interview was conducted with CNA 9 on 1/6/24 at 2:20 p.m. She indicated incontinent care was to be provided to the residents every 2 hours and double briefing the residents was not allowed to be utilized.3. The clinical record for Resident R was reviewed on 1/4/23 at 2:30 p.m. The Resident's diagnosis included, but were not limited to, chronic kidney disease and heart failure. A care plan, initiated 2/12/2020, indicated Resident R needed assistance with ADL (Acts of Daily Living) care, including transfers and toilet use. The goal was for him to improve current functional status. The interventions included, but were not limited to, assist of at least one staff with toileting and/ or incontinent care as needed,			

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	initiated 2/12/2020, and to use a "Hoyer" lift (mechanical lift) for all transfers with assistance of two staff members. A care plan, initiated 3/2/2020, indicated that Resident R required assistance with toileting. The goal was for him to be free from adverse effects of incontinence. The interventions included, but were not limited to, assist with incontinent care and/ or toileting as needed, initiated 3/2/202, and check every 2 hours for incontinence, initiated 3/2/23. A bladder assessment, dated 12/16/22, indicated he was always incontinent of urine. He was aware of his need to void, but unable to hold his urine. A bowel assessment, dated 12/16/22, indicated he was always incontinent of bowel. He was aware of his need to defecate, but unable to delay defecation. An Annual MDS (Minimum Data Set) Assessment, completed 11/15/23, indicated he was moderately cognitively impaired, was able to make himself understood and to understand what was said to him, needed maximum assistance with toileting, and was dependent on staff for transfers from his chair to his bed. On 1/5/23 from 9:33 a.m. until 10:13 a.m., Resident R was observed laying in his bed and indicated he needed to be changed. CNA (Certified Nursing Assistant) 6 walked in to Resident R's room and turned off his call light. CNA 6 indicated Resident R had been asking a couple of times to be changed in the last 10 minutes and that she was not his CNA. During that time, CNA 7, who was Resident R's aide, walked in the Resident R's room and CNA 6 reported to her the resident had been			

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	asking to be changed for a while. CNA 7 stated Resident R was about to get up and walked out of room. Incontinent care had not been provided to Resident R and the call light remained off at that time. Resident R was observed to continue to lay in his bed. At 10:02 a.m., two CNAs walked by his room. At 10:05 a.m., CNA 6 walked by his room. At 10:13 a.m., CNA 7 went to Resident R's room with linen in her hand. CNA 7 indicated she was Resident R's assigned CNA and had been in the dining room assisting another resident to eat. CNA 7 was unaware that Resident R was in need of incontinent care. On 1/6/23 from 12:49 p.m. until 1:40 p.m., Resident R was observed sitting in his wheelchair in his room. At 12:49 p.m., Resident R had his call light on and indicated he had a bowel movement and needed changed. CNA 7 entered his room with his lunch tray and turned off his call light. CNA 7 indicated to Resident R that he would be changed after his meal and sat the lunch tray in front of him on the bedside table. At 12:52 p.m., Resident R turned on his call light. CNA 24 answered his call light and came back to the hallway. Resident R continued to sit in his wheelchair with his meal tray in front of him. At 1:06 p.m., Resident R put his call light back on and indicated that he had not been changed. At 1:13 p.m., CNA 24 was observed going into Resident R's room with the mechanical lift and linens. CNA 24 indicated that she was going to change Resident R and lay him down. CNA 24 exited the room and returned with CNA 7, and then assisted Resident R into bed for incontinence care using the mechanical lift. CNA 24 then provided incontinent care for Resident R. CNA 24 removed Resident R's sweat pants and undid 2 briefs. CNA 24 indicated that Resident R was wearing 2 incontinent briefs. CNA 24 was unsure why Resident R had 2 incontinent briefs			

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	on and that putting 2 briefs on a resident was not normal practice. The incontinent brief closest to Resident R's skin was observed to be wet and the 2nd brief was dry. Resident R had been incontinent of bowel and was cleansed. During a confidential interview, they indicated aides were using double briefs and bed pads to avoid changing residents as often. During an interview on 1/06/24 at 1:13 p.m., CNA 24 indicated that she and CNA 7 were the two CNAs assigned to the hallway for the first shift. During an interview on 1/06/23 2:30 p.m., the DON (Director of Nursing) indicated that when there are 2 CNAs on the hall and a resident needs fed and another resident who is a Hoyer lift needs changed, how should that be prioritized. During an interview on 1/08/24 at 4:11 p.m., the DON indicated there was no excuse for double briefing. 4. The clinical record for Resident S was reviewed on 1/5/23 at 9:49 a.m. The Resident's diagnosis included, but were not limited to, absence of right eye and dementia. A care plan, last reviewed 1/5/24, indicated Resident S needed assistance with ADL care including eating. The goal was for her to improve current functional status. The interventions included, but were not limited to, provide assist of one with eating and drinking as needed, initiated 7/12/21. During an interview on 1/5/23 at 9:49 a.m., Resident 45 indicated that Resident S was blind and needed help with eating because she would			

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	pour milk all over herself. The staff were not assisting her. Resident 45 and another resident would help her to eat. On 01/09/24 at 1:31 p.m., Resident S was observed sitting at a table in the main dining room with her meal in front of her. There were nursing staff present in the dining room. A male resident gave Resident S her spoon so that she could eat her fruit and salad. The male resident then unwrapped her cookie, and Resident S ate the cookie. He then took her corn bread out of the wrap and put it where she could reach it. 5. On 1/6/24 at 1:37 p.m., an observation of Resident M found her lying in bed with her head all the way down and the upper trunk of her body angled/turned to the right facing the wall. Resident M's lunch which included, but not limited to, a large sausage/bratwurst and a regular plastic cup containing an orange liquid were sitting on a tray on her bedside table uncovered. The bedside table was not within reach of the resident and the meal appeared to be untouched as the silverware was still wrapped in the napkin. A nurse had walked past during the observation and was asked if someone had assisted the resident with her lunch. Within a few moments, CNA (Certified Nursing Assistant) 28 arrived, entered Resident M's room, and began to unwrap the silverware when ADM (Administrator) walked up to the resident's doorway. Unsure of how long Resident M's food had been sitting there, it was requested to obtain a thermometer from the kitchen and take the temperature of her food. ADM then went to the kitchen and came back with a thermometer and handed it to CNA 28, who then took the temperature of the sausage/bratwurst and found it to be 84.4 degrees. An interview with ADM immediately after obtaining the food temperature indicated, Resident M's food was too cold for her			

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	to eat and needed to be warmed up. The clinical record for Resident M was reviewed on 1/9/24 at 10:39 a.m. Resident M's diagnoses included, but not limited to, dementia, dysphagia (difficulty with swallowing foods or liquids), cognitive communication deficit, and anxiety disorder. Resident M's quarterly MDS (Minimum Data Set) completed on 12/19/23 indicated, she required substantial/maximal assistance for eating. Resident M's care plan dated 8/25/20 indicated, she required assistance with ADLs including, but not limited to, eating and was at risk for altered nutritional status related to her progression of dementia, increased age, depression, anxiety and difficulty self-feeding. Interventions included, but not limited to, provide the assistance of one person with eating and drinking as needed and to use of a Kennedy cup (a spill-proof drinking cup) at meals. A Feeding a Resident skills competency procedure was provided on 1/9/24 at 12:33 p.m. It indicated, "Procedure Steps...2. Provide privacy and explain procedure. 3. Perform hand hygiene...6. Place resident in a comfortable position. 7. Check meal care for name and diet, confirm correct food, condiments, and utensils. 8. Set tray on over the bed table and describe food..."6. The clinical record of Resident J was reviewed on 1/9/24 at 2:55 p.m. The diagnoses included, but were not limited to, frontotemporal neurocognitive disorder, Alzheimer's disease, dementia, malnutrition, and muscle weakness. An annual minimum data set (MDS) assessment, dated 11/27/23, indicated severe cognitive			

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	impairment, set up assistance and/or clean up assistance with eating, partial to moderate assistance with rolling from left to right, substantial/maximal assistance with sit to lying, and substantial/maximal assistance with lying to sitting. A nutritional status care plan, dated 7/9/21 and revised on 2/16/23, indicated the following, "...at risk for altered nutritional status r/t [related to] progression of Alzheimer's dementia...feeds self slowly; she would benefit with assistance at meals however does not like staff to assist...Approach...Offer substitute if 50% or less of any meal is consumed...." An activities of daily living (ADLs) care plan, revised 1/9/23, indicated the following, "...Resident requires assistance with ADLs including bed mobility, transfers, eating and toileting related to: Dementia...Approach...Up to Dining room for all meals...Assist of one with eating and drinking as needed...." An observation conducted of Resident J, on 1/8/24 at 2:00 p.m., lying in bed with her head of bed elevated and consuming lunch. She was leaning to the right and the bedside table was elevated to the level of her face. She was reaching over the bedside table to reach for the food on her tray. Only bites of her lunch were consumed at the time of observation. She was noted with long nails on 3 out of 5 digits to her left hand and all 5 digits to her right hand. Resident J indicated she didn't mind having longer nails but "not that long". An observation conducted of Resident J, on 1/9/24 at 9:30 a.m., lying in bed with her breakfast tray on her bedside table. The bedside table was to the height of her face and Resident J was			

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	having difficulty trying to reach the cups on her tray. A cup that contained orange juice was consumed but no food was consumed at the time of observation. Resident J attempted to reach upwards towards her tray for the silverware but was unable to reach such so, she moved her hands back on the bed. Her fingernails remained long. An observation conducted of Resident J, on 1/9/24 at 11:36 a.m., with her breakfast tray still located on the bedside table that she was still attempting to consume. There was oatmeal in 2 cups that were not consumed along with eggs and sausage that were scattered on her tray, located off of the plate. Resident J appeared with slouched posture and the bedside table was to the level of her face. She was attempting to reach up towards the tray for the food with her hands. An observation conducted of Resident J, on 1/9/24 at 1:05 p.m., still with a slouched posture in bed with her lunch tray in front of her. She had not eaten anything but was attempting to reach with her arm to the tray. The bedside table was to the level of her face to where she needed to raise her arms to reach for the food on the tray, located on the bedside table. An observation conducted of Resident J, on 1/9/24 at 1:40 p.m., still with a slouched posture. She was reaching upwards for her meal tray on the bedside table. She retried a piece of the side salad and was eating it with her hands. Her nails remain long. An observation conducted of Resident J, on 1/10/24 at 10:05 a.m., slouched in bed with her head facing downwards on the right side of her bed. The head of the bed was elevated but the			

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	bedside table remains at the height to her face. Resident J would have to reach upwards for her food. She only consumed a few bites of her breakfast. A document titled "Fingernail Care", review date of 09/2023, was provided by the Director of Nursing (DON) on 1/10/24 at 11:08 a.m. The document indicated to clean under the nails and clip fingernails straight across and file in a curve. 7. The clinical record for Resident K was reviewed on 1/9/24 at 2:30 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, major depressive disorder, malnutrition, abnormal weight loss, and congestive heart failure. A quarterly MDS assessment, dated 10/26/23, noted severe cognitive impairment, set up or clean-up assistance with eating, substantial/maximal assistance with roll left and right, sit to lying, and lying to sitting. An ADL care plan, dated 10/28/21, indicated Resident K required assistance with ADLs including bed mobility, transfers, eating and toileting. The approach listed, but were not limited to, out of bed to chair with meals, assist of one with bed mobility, transfers, and eating as needed. An observation of Resident K, on 1/9/24 at 1:15 p.m., lying in bed with the head of the bed elevated but her bedside table was to the level of her face. Resident K was having to reach for food. The side salad and bowl of fruit were still covered with clear plastic. An observation conducted of Resident K, on 1/9/24 at 1:42 p.m., lying in bed with the head of the bed elevated but the bedside table was to the			

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	level of her face. The salad and bowl of fruit were still covered with clear plastic. She had eaten a couple of bites of the cornbread. 8. The clinical record for Resident H was reviewed on 1/8/24 at 2:11 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis, anxiety disorder, dysphagia, abnormal posture, and muscle weakness. A significant change MDS assessment, dated 11/22/23, indicated severe cognitive impairment, impairment on one side for upper extremity, impairment on both sides for lower extremity, substantial/maximal assistance with eating, dependent for roll left and right, and dependent for chair/bed to chair transfer. A diet order was noted for regular, honey thick/moderately thick liquids, pureed consistency. Special instructions were to have regular bread, magic cup at lunch and dinner, resident must be in main dining room for lunch and dinner and fed by staff. Another diet order, dated 1/9/24, indicated the following, "...Regular, Thick/Moderately Thick, Pureed...Special Instructions: WITH REGULAR BREAD. Magic Cup at Lunch and Dinner...." An observation of Resident H, on 1/8/24 at 1:55 p.m., lying in bed with her head of bed elevated but the bedside table was to the height of her face. She had a spoon to her right hand and was attempting to scoop food onto but was unsuccessful. Resident H commented on how she can feed herself at times and other times she cannot. She had a Magic Cup on her tray, and it was not opened.			

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	An observation of Resident H, on 1/9/24 at 1:05 p.m., lying in bed, leaning to the right. The head of the bed was elevated but Resident H was slouched downwards with her head at the height of the bedside table where her lunch tray was. A Magic Cup was on the lunch tray but not opened. Another observation of Resident H, on 1/9/24 at 1:40 p.m., lying in bed with her right hand on the meal tray with nothing being eaten. The Magic Cup remained unopened. Resident H was still slouched downwards with her head at the height of the bedside table. Another observation of Resident H, on 1/9/24 at 2:07 p.m., laying in bed with her head elevated by the width of a standard pillow. There was no staff in the room and Resident still had not eaten anything off of the lunch tray. Therapy Staff 35 came into the room and asked if Resident H needed help to being raised in the bed. Resident H indicated yes. Therapy Staff 35 indicated they would like for Resident H to be up in the dining room and proceeded to explain the risk of choking to resident related to her leaning over and not sitting up straight in the bed. Therapy Staff 35 indicated it has been a hit or miss if Resident H was up for meals. The call light was pressed, and another staff member assisted Therapy Staff 35 on pulling Resident H up in her bed. Resident H indicated she felt better after being repositioned and nodded her head "yes" to it being easier to eat. An interview conducted with the DON, on 1/10/24 at 2:40 p.m., indicated the diet order for Resident H was an old order. A document titled "Feeding a Resident", review date of 09/2023, was provided by the DON on			

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	1/10/24 at 11:08 a.m. The document indicated the following, "...6. Place resident in a comfortable position...8. Set tray on over the bed table and describe food...11. Food should be in bite sized pieces or with the spoon half full...12. Allow resident time to chew food and swallow...." A Resident Rights policy was provided by the ED on 1/9/24 at 9:01 a.m. It indicated "...Resident rights. You have the right to a dignified existence, self-determination, and communication with and access to the persons and services inside and outside the facility...Planning and implementing care...You have the right to be informed, and participate in, your treatment. This includes the right to:...Receive the services and/or items included in the plan of care....Be informed in advance, of the care to be furnished and the type of care giver or professional that will furnish care...Respect and Dignity. You have a right to be treated with respect and dignity, including:...The right to reside and receive services in the facility with reasonable accommodations of your needs and preferences except when to do so would endanger the health or safety of you or your residents..." This citation relates to complaint IN00422553 and IN00420608. 3.1-38(a)(2)(A) 3.1-38(a)(2)(C) 3.1-38(a)(2)(D) 3.1-38(a)(3)(E)			
F 0684 SS=E 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			

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	facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to administer medications as ordered for 1 of 5 residents reviewed for unnecessary medications and 4 of 5 randomly reviewed residents' for medications administrations; ensure physician orders were followed regarding elevation of bilateral lower extremities (BLE) for 1 of 1 resident reviewed for pressure ulcers, and to timely update and administer a physician's order for a wound treatment and to apply podus (pressure relief) boots as ordered by a physician for 1 of 3 residents reviewed for urinary catheters. (Residents' B, H, T, 40, 44, 83 and 118,) Findings include: 1. The clinical record for Resident B was reviewed on 1/4/24 at 10:00 a.m. The diagnosis for Resident B included, but was not limited to, epilepsy. A care plan dated 8/19/23 for the resident indicated the "resident was risk for injury related to seizure activity; has potential for seizure activity." The intervention included but was not limited to, the staff was to administer medications as ordered. A physician order dated 8/18/23 indicated Resident B was to receive 15 milliliters of Brivact for seizures twice a day. The December 2023 Medication Administration Record (MAR) indicated the 15 milliliters of	F 0684	p role="heading" aria-level="1" paraid="2043314792" paraeid="{ba05999d-a9d4-4544-afd8-cc6d88014d4f}{191}" >What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B, 40, 44, 83, 118 receiving all current medications per order ·Resident T receiving wound treatments as ordered and boot has been discontinued by MD. ·Resident H heels being floated per MD order How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice	02/29/2024

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	Brivact was not administered the day or evening dosages on 12/31/23 due to the medication was not available. The January 2024 MAR indicated the 15 milliliters of Brivact was not administered on the followings days due to the medications was not available: 1/1/24 - day and evening dosages, and 1/2/24 - day and evening dosages An interview was conducted with the Director of Nursing on 1/9/24 at 12:10 p.m. She indicated Resident B had ran out of her Brivact medications. The pharmacy shipment summary for Resident B's Brivact medication was provided by the Director of Nursing on 1/9/24 at 12:17 p.m. It indicated the medication was filled and shipped on 1/2/24. The facility received the medication on 1/3/24 at 4:29 a.m. 2. The clinical record for Resident T was reviewed on 1/4/23 at 9:49 a.m. The Resident's diagnosis included, but were not limited to, obstructive uropathy and diabetes. A care plan, initiated 9/19/23, indicated Resident T had an abrasion to his right lateral (outer) foot. The goal was the abrasion would heal without complications. The approaches included, but were not limited to, protective clothing, initiated 9/19/23, and to provide treatment as ordered, initiated 9/19/23. A physician's order, dated 9/26/23, indicated he was to have a podus boot to right foot, on while in bed as tolerated. A Significant Change in Status MDS (Minimum Data Set) Assessment, completed 11/17/23, indicated Resident T was able to make himself		·Full audit of medication administration to be completed by DNS/Designee. ·Full audit of wound interventions to be completed by DNS/Designee ·DNS/Designee will conduct an in-service with all nursing on staff on medication administration and skin management policy on or before February 29, 2024 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? DNS/Designee will conduct an in-service with all nursing on staff on medication administration and skin management policy on or before February 29, 2024 ·A daily rounding tool including wound interventions to be utilized by DNS/designee ul class="BulletListStyle1 SCXW134655875 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text;	

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	understood and to understand what was said to him. He was cognitively intact and received ointment or medication to his feet. A physician's order, dated 12/20/23, indicated to cleanse right lateral foot would with normal saline, apply Santyl (wound care ointment) and cover with a bordered gauze daily. A wound care visit report, dated 1/2/23, indicated the wound on Resident T's right lateral foot was open and had a foul odor after cleansing. The plan was to treat the right foot wound by cleansing with normal saline, to apply Santyl followed with calcium alginate (absorbent wound dressing) and cover with foam. On 1/4/23 at 9:49 a.m., Resident T was observed laying in his bed. He was not wearing a podus boot on his right foot and his right foot was touching the foot board. On 1/8/23 at 10:31 a.m., Resident T was observed laying in his bed. He did not have a podus boot on and the dressing on his right lateral foot was coming off. During an interview on 1/08/24 at 10:35 a.m., LPN (Licensed Practical Nurse) 22 indicated that she was going to change Resident T's dressing because she had noticed it was coming off. On 1/08/24 at 10:50 a.m., LPN 22 was observed changing Resident T's right foot dressing. LPN 22 indicated the current treatment order was to cleanse the wound and apply Santyl covered with a bordered gauze dressing. LPN 22 removed the old dressing, cleansed the wound with normal saline and applied Santyl to the wound. She then covered the wound with a bordered gauze		-webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" Medication Administration report to be run daily in clinical to ensure residents are receiving medications as prescribed. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year 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	

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	dressing. She did not apply the podus boot to Resident T's right foot. LPN 22 indicated that the CNA (Certified Nursing Assistant) would apply the podus boot after she provided care. The January 2024 TAR (Treatment Administration Record) indicated Resident T had received Santyl covered with a bordered dressing on the following days: 1/1, 1/2, 1/3, 1/4, 1/5, and 1/8/23. The treatment was not initialed as having been completed on 1/6/23 and 1/7/23. On 1/08/24 at 3:05 p.m., Resident T was observed laying in bed. His left foot was touching the foot board of the bed. His right foot was laying on the mattress. A green podus boot was located on the top a bedside table by the window in the room. Resident T indicated that the nursing staff had not put the podus boot on his foot in a long time. He had not refused to have the boot put on his right foot. During an interview on 1/08/24 at 3:30 p.m., the ADON (Assistant Director of Nursing) indicated that the treatment order for Resident T's right foot should have been updated on 1/2/24 and his podus should be applied as ordered. 3. The clinical record for Resident 40 was reviewed on 1/10/24 at 11:58 a.m. Resident 40's diagnoses included, but not limited to, major depressive disorder, anxiety disorder and chronic pain. A physician's order dated 2/19/22 indicated, to give Resident 40 one 5 mg(milligrams) tablet of Eliquis (an anticoagulant) by mouth twice a day. A physician's order dated 12/5/23 indicated, to give Resident 40 one Ensure Plus carton three times a day at 8 a.m., 2 p.m. and 8 p.m.			

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	Resident 40's December 2023 MAR (medication administration record) received on 1/10/24 at 12 p.m. from DON (Director of Nursing) indicated, on 12/31/23, Resident 40 did not receive his Eliquis, which was scheduled to be given between 4 p.m. and 8 p.m., nor his Ensure Plus (dietary supplement), which was scheduled to be given at 8 p.m. 4. The clinical record for resident 44 was reviewed on 1/10/24 at 1:27 p.m. Resident 44's diagnoses included, but not limited to, malignant neoplasm of bladder (bladder cancer), chronic obstructive pulmonary disease (COPD), anemia, emphysema, congestive heart failure (CHF) and hypertension. A physician's order dated 10/30/23 indicated to give Resident 44 one 20 mg tablet of atorvastatin (medication for high cholesterol) at bedtime. A physician's order dated 11/1/23 indicated to administer 400 mg of magnesium oxide by mouth twice a day to Resident 44. A physician's order dated 11/9/23 indicated to administer 5 mg of Marinol (a man-made form of cannabis used to treat loss of appetite) twice daily by mouth to Resident 44. A physician's order dated 10/31/23 indicated, to administer melatonin 3 mg at bedtime for insomnia to Resident 44. A physician's order dated 12/19/23 indicated, to administer olanzapine 2.5 mg at bedtime to Resident 44 for mood/behavior. Resident 44's December 2023 MAR received on 1/10/24 at 12 p.m. from DON indicated, on 12/31/23, Resident 44 did not receive the following			

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medications: atorvastatin, magnesium oxide, olanzapine, or melatonin (all were to be administered between 7 p.m. and 11 p.m.); and Marinol (was to be administered between 4 p.m. and 11 p.m.).

Resident 44's Controlled Substance Record for his Marinol 5 mg tablets provided by DON on 1/10/24 at 1:22 p.m. indicated, he was to receive one tablet 1 hour prior to dinner daily. The first administration on this record was noted to be 1/2/24 and the last administration was on 1/10/24. The remaining quantity after the last administration recorded was 13 tablets. DON had not provided any other Controlled Substance Records for the Marinol.

A medication storage observation completed on 1/9/24 at 3:06 p.m. with ADON (Assistant Director of Nursing) indicated, Resident 44's Marinol tablets were located inside a metal, lock box in the 100/200/300/400 hallway's medication room fridge. There were 15 tablets left in the pill bottle. The count on the controlled substance record and the physical number of pill of Marinol did not match.

5. An interview with Resident 83 conducted on 1/4/24 at 11:40 a.m. indicated, he did not receive all his medications at times. He added, last weekend there was a QMA (Qualified Medication Assistant) on and she was not able to give him his insulin and was told the nurse was on a different hallway. He did not receive his insulin that night.

The clinical record for Resident 83 was reviewed on 1/10/24 at 11:44 a.m. Resident 83's diagnoses included, but not limited to, right leg AKA (above knee amputation), type II diabetes, congestive heart failure (CHF), neuropathy (weakness,

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	numbness, and pain from nerve damage), muscle spasms, pain, and insomnia. Resident 83's clinical record contained physician orders for the following medications: gabapentin 300 mg, three times a day for nerve pain (dated 8/11/22); hydrocodone-acetaminophen 5-325 mg (Norco) twice a day for pain (dated 9/21/23); Lantus Solostar 5 units at bedtime for diabetes (dated 9/7/23); melatonin 3 mg tablet at bedtime for insomnia (dated 2/25/21); metformin 500 mg tablet twice a day for type II diabetes (dated 7/25/23); methocarbamol 500 mg tablet every 12 hours for muscle spasm (dated 8/9/23); nortriptyline 50 mg at bedtime to be given with melatonin and Norco for pain (dated 3/17/22). Resident 83's December 2023 MAR received on 1/10/24 at 12 p.m. from DON indicated, he was not administered the following medications: -blood sugar check at 10 p.m. on 12/31/23 -lantus at 8 p.m. on 12/2/23 and 12/31/23 -Norco at 11 p.m. on 12/11/23; at 10 a.m. on 12/14/23; and 12/31/23 at 11 p.m. -melatonin on 12/11/23 and 12/31/23 at 11 p.m. -metformin on 12/31/23 due between 7 p.m. and 11 p.m. -methocarbamol on 12/31/23 at 8 p.m. -nortriptyline on 12/11/23 and 12/31/23 at 11 p.m. -lasix on 12/31/23 at 8 p.m. Resident 83's Controlled Substance Record for his Norco (hydrocodone) 5-325 mg tablets was received on 1/10/24 at 1:22 p.m. from DON indicated, the only administration of Norco on 12/31/23 was at 10 a.m. 6. The clinical record for Resident 118 was reviewed on 1/10/24 at 11:53 a.m. Resident 83's diagnoses included, but not limited to, type II			

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	diabetes, cirrhosis of the liver, and myocardial infarction (heart attack). The clinical record for Resident 118 contained physician medication orders for Baclofen 10 mg tablet three times a day for muscle spasms dated 12/14/23 and hydrocodone-acetaminophen 10-325 mg tablets every 6 hours for pain. Resident 118's December 2023 MAR received on 1/10/24 at 12 p.m. from DON indicated, on 12/31/23, he was not administered his Baclofen tablet at 8 p.m. nor his hydrocodone-acetaminophen 10-325 tablet at 6 p.m. yet, he received other evening/night medications. Resident 118's Controlled Substance Record for his hydrocodone-acetaminophen 10-325 mg tablets was provided by DON on 1/10/24 at 1:22 p.m. It indicated, on 12/31/23 at 6 p.m. the tablet count was decreased by one tablet but did not contain a signature. A staffing schedule for 12/31/23 provided by DON on 1/3/23 at 2:12 p.m. indicated, LPN (Licensed Practical Nurse) 26 was the nurse on duty that evening and night shift for Residents 40, 44, 83 and 118. An interview with LPN 26 was conducted on 1/10/24 at 3:19 p.m. indicated, she was typically agency staff at the facility and each facility uses different types of medication charting systems. She stated, there are some residents that may or may not take their medications. She indicated, when going back into the electronic medication charting system to sign off medications sometimes they "fell-off" and she could no longer see the medication in the system to chart on it.			

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	She stated, she is still trying to acclimate to their system..."'it sometimes kicks the med out and I can't find where it went". When asked if she asked any other nurses to assist her, she indicated, on the weekends there was not as many managers available and lots of times there's a lot of agency staff working and they don't know the system well either. When asked if she informed the DON of issues she indicated, this issue is not something she thinks could be explained to her by talking it out on the phone, but rather by showing her. An interview with DON and ED (Executive Director) conducted on 1/10/24 at 3:27 p.m. indicated, LPN 26 had not informed either of them of her issues with using the EMAR system. A Medication Administration procedure received on 1/10/24 at 2 p.m. from DON indicated, "1. Medications administered within 60 minutes before and/or after time ordered...12. Refusal of medication document as appropriate...19. Medication administration will be recorded on the MAR/EMAR [sic, electronic medication administration record] or TAR [sic, treatment administration record]after given...33. Administration and inventory of controlled substances were documented according to facility policy..."7. The clinical record for Resident H was reviewed on 1/8/24 at 2:11 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis (Hemiplegia is paralysis of one side of the body. Hemiparesis is weakness of one side of the body), chronic obstructive pulmonary disease, peripheral vascular disease, chronic kidney disease, anxiety disorder, dysphagia (difficulty in swallowing food or liquid), and muscle weakness. A significant change minimum data set (MDS)			

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	assessment, dated 11/22/23, indicated severe cognitive impairment, impairment on one side for upper extremity, impairment on both sides for lower extremity, dependent to roll left and right, and dependent on chair/bed to chair transfer. A care plan for skin, dated 1/4/24, indicated Resident H had a pressure area to the right buttock. A physician order, dated 12/4/19, noted to elevate both lower extremities WIB (while in bed) for pressure relief/prevention. An observation conducted of Resident H, on 1/8/24 at 10:28 a.m., lying in bed with the head of bed elevated. The bilateral lower extremities were elevated, but only to her knees to where her lower legs were in a downward position. An observation conducted of Resident H, on 1/8/24 at 1:55 p.m., with her bilateral lower extremities in the same position. An observation conducted of Resident H, on 1/9/24 at 9:28 a.m., with her lying in bed and bilateral lower extremities were not elevated or floated. An observation conducted, on 1/9/24 at 11:35 a.m., of Resident H lying in bed with bilateral lower extremities not elevated or floated. An observation conducted, on 1/9/24 at 1:05 p.m., of Resident H lying in bed with bilateral lower extremities not elevated or floated. A policy titled "SKIN MANAGEMENT PROGRAM", revised 5/22, was provided by the Director of Nursing (DON), on 1/10/24 at 11:08			

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	a.m. The policy indicated the following, "...PROCEDURE FOR WOUND PREVENTION...3. Interventions to prevent wounds from developing and/or promote healing will be initiated based upon the individual's risk factors to include but not limited to the following...Redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.)...." 3.1-37(a)			
F 0687 SS=D Bldg. 00	483.25(b)(2)(i)(ii) Foot Care §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. Based on observation, interview, and record review, the facility failed to ensure a resident was provided the necessary foot care for 1 of 6 residents reviewed for ADLs (activities of daily living.) (Resident G) Findings include: The clinical record for Resident G was reviewed on 1/3/24 at 2:30 p.m. His diagnoses included, but were not limited to, dementia, hypertension, and chronic kidney disease. He was admitted to the facility on 4/24/22.	F 0687	div=""> What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident G's toenail care was immediately tended to by nurse and has been referred to Podiatry. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All clinical staff	02/29/2024

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	The ADL care plan, revised 12/21/23, indicated to provide assistance with bathing, dressing, grooming, and hygiene, as needed. An observation of Resident G was made on 1/3/24 at 2:36 p.m. He was lying in bed and was not wearing any socks. His lift great toenail was very long and thick, extending significantly past the end of his toe. His right great toenail was very thick. The other toenails were also long and thick, with some of them curling around the tips of his toes. The 5/9/22 Request for Service form included in his admission agreement indicated He requested to be seen for podiatry services. The physician's orders read, "May be seen by Podiatrist, Dentist, Optometrist, Audiologist," starting 4/24/24. There were no podiatry consultations in Resident G's clinical record. An observation and interview was conducted with Resident G on 1/8/24 at 10:33 a.m. He was wearing socks and lying in bed. He indicated his toenails were long and he'd like for someone to cut them. An observation of Resident G's feet was made with LPN (Licensed Practical Nurse) 15 on 1/8/24 at 10:35 a.m. LPN 15 removed both of his socks and assessed his feet. The third and fourth toenail on his left foot was very long and thick, curling around the tips of his toes. The left great toenail was still very long and thick. An interview was conducted with LPN 15 on 1/8/24 at 10:35 a.m. during the above observation.		re-educated on dignity and foot care utilizing Resident Rights policy on or before February 29, 2024. All residents were observed to ensure care has been offered and provider per resident preference A daily rounding tool reviewing dignity and foot care to be utilized by DNS/designee. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? All clinical staff re-educated on dignity and foot care utilizing Resident Rights policy on or before February 29, 2024. A daily rounding tool reviewing Residents Rights including dignity and foot care to be utilized by DNS/designee. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year 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	

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	LPN 15 indicated his toenails looked "awful" and informed Resident G that they "must be uncomfortable for you." They were "so thick." She indicated she could work on a couple of the toenails, but podiatry would need to do the rest. She was going to tell the MCSS (Memory Care Support Specialist) to put him on the list to be seen by podiatry. She was also going to contact Resident G's hospice company about his toenails, because they needed to know. The 1/8/24, 12:44 p.m. nurse's note, written by LPN 15, read, "Nurse assessed bilateral feet and toenails. SS [Social Services] director notified of the need for podiatry to see resident. Hospice was notified of toenails needing to be trimmed by Podiatrist. Awaiting call back. This nurse trimmed some toenails and applied lotion to bilateral feet." An interview was conducted with the DON (Director of Nursing) on 1/9/24 at 10:28 a.m. She indicated Resident G never received podiatry services in the facility. Podiatry informed them they were waiting on "some form" to come back, but they never received it, so they were getting that taken care of, and he was going to be put on the podiatry list. The Podiatry Services policy was provided by the ED (Executive Director) on 1/9/24 at 9:01 a.m. It read, "Residents are provided with proper treatment and care for foot disorders. PROCEDURE: The facility maintains an outside resource to provide podiatry services to meet the needs of each resident. Podiatry care is provided as ordered by a physician. Podiatry services are available on a routine and as needed basis." This citation relates to Complaint IN00420608.			

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	3.1-47(a)(7)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a resident's wheelchair had 2 functioning anti-tippers and ensure fall interventions were in place for 3 of 4 residents reviewed for accidents. (Residents' K, L and Y) Findings include: 1. The clinical record for Resident Y was reviewed on 1/5/24 at 10:00 a.m. His diagnoses included, but were not limited to, hemiplegia, hemiparesis, and vascular dementia. The 11/20/23 unwitnessed fall event indicated Resident Y was sitting in his wheelchair prior to falling in his room. The 12/14/23 unwitnessed fall event indicated Resident Y was lying in bed prior to falling in his room. The fall care plan, last revised 1/10/24, indicated an intervention was anti-tippers to his wheelchair, starting 12/28/23.	F 0689	What corrective action(s) will be accomplished for those residents found to have been affected by deficient practice: Resident Y's fall prevention orders have been updated and in place per order ·Resident L's fall prevention orders have been updated and in place per order. ·Resident K's fall prevention orders have been updated and in place per order. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective	02/29/2024

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	An observation was made on 1/5/24 at 10:15 a.m. He was sitting in his wheelchair in the common area of the facility during an activity. He was missing the right anti-tipper to the back of his wheelchair. The left anti-tipper was present. An observation was made on 1/9/24 at 11:28 a.m. He was sitting in his wheelchair in the common area of the facility during an activity. His right anti-tipper was still missing the back of his wheelchair. An observation and interview was conducted with the ADON (Assistant Director of Nursing) on 1/10/24 at 11:03 p.m. Resident Y's wheelchair was in his room. It was still missing the right anti-tipper. The ADON indicated she was unsure why he didn't have 2 anti-tippers on his wheelchair but would look into it. An interview was conducted with the ADON on 1/10/24 at 11:19 a.m. She indicated there was no good reason Resident Y's wheelchair did not have 2 anti-tippers. She told maintenance about it, and they were going to put the other one on his wheelchair, as he should have two. 2. The clinical record for Resident L was reviewed on 1/8/24 at 11:48 a.m. The diagnoses included, but were not limited to, dementia, major depressive disorder, muscle weakness, and cerebral ischemia. A care plan for fall risk, dated 6/8/21 and revised on 12/4/23, indicated Resident L was at risk for falls due to history of one or more falls within the previous 6 months. The approaches included, but were not limited to, bed in lowest position with fall mattress next to bed, flat panel call light, scoop mattress, and body pillow.		action(s) will be taken: Any residents that have fall prevention orders have the potential to be affected by the alleged deficient practice ·An audit will be completed of all residents with fall prevention orders to identify anyone else that might be affected ·All nursing staff will be in- on Adaptive devices and fall prevention on or before February 29, 2024. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur: All nursing staff will be in- on utilizing fall prevention devices including adaptive devices on or before February 29, 2024. ·A daily rounding tool including fall interventions and adaptive devices to be utilized by DNS/designee How will the corrective action(s) be monitored to ensure the deficient practice will not recur, what quality	

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	A quarterly minimum data set (MDS) assessment, dated 11/22/23, noted severe cognitive impairment, dependent for roll left and right, substantial/maximal assistance with sit to lying, and substantial/maximal assistance with chair/bed to chair transfer. An observation conducted, on 1/9/24 at 9:30 a.m., of Resident L lying in bed with the bed control in her hand. There was no body pillow or a mattress next to her bed. The mattress was against the wall behind the headboard. An observation conducted, on 1/9/24 at 1:10 p.m., of Resident L lying in bed. There was no body pillow or a mattress next to her bed. The mattress was against the wall behind the headboard. 3. The clinical record for Resident K was reviewed on 1/9/24 at 2:30 p.m. The diagnoses included but were not limited to Alzheimer's disease with late onset, dementia, major depressive disorder, diabetes mellitus, age-related physical debility, and muscle weakness. A care plan for fall risk, dated 10/28/21 and revised 10/16/23, indicated Resident K was at risk for falls due to history of one or more falls within the previous six months. The approaches included, but not limited to, bed in low position and fall mattress next to open side of bed. An observation conducted, on 1/9/24 at 1:15 p.m., of Resident K in bed with no mattress next to either side of her bed. The mattress was leaning up against the wall. An observation conducted, on 1/9/24 at 1:42 p.m., of Resident K in bed with no mattress next to either side of her bed. The mattress was still		assurance program will be put into place: POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year 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	

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	leaning up against the wall. This citation relates to Complaint IN00425026. 3.1-45(a)(1) 3.1-45(a)(2)			
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 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			

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	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 interview and record review, the facility failed to ensure residents with a urinary catheter had physician orders for such catheters; staff were monitoring and documenting the urinary outputs, and to timely notify the physician of decreased urinary output and urine leaking from a urinary catheter for 2 of 3 residents reviewed for urinary catheters (Residents' 75 and T). Findings include: 1. The clinical record for Resident T was reviewed on 1/4/23 at 9:49 a.m. The Resident's diagnosis included, but were not limited to, obstructive uropathy and diabetes. A care plan, last initiated 4/19/23, indicated he required a suprapubic catheter (catheter which is placed above the pubic area), changed to a foley on 05/17/23, related to obstructive uropathy. The goal was for him to have suprapubic catheter care managed appropriately. The interventions included, but were not limited to, staff to record urinary output in mL (Milliliter), initiated 4/19/23, avoid obstructions in the drainage, initiated 4/19/23, report complications/UTI such as: acute confusion, bladder spasms, low back/flank pain, malaise, nausea, emesis, chills, fever, foul odor, concentrated urine, blood in urine, obstruction, tissue trauma at site, dislodgment of catheter, initiated 4/19/23, and assess the drainage(frequency). Record the amount, type, color, odor. Observe for leakage, initiated 4/19/23. Resident T's clinical record contained a urology	F 0690	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident T urine output is being monitored per order. ·Resident 75 catheter orders were and urine output is being monitored per order. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents with foley catheters have the potential to be affected by the alleged deficient practice ·DNS/Designee will conduct an in-service with all nursing staff on Urinalysis Collection and documentation of urine outputs for residents with foley catheters on or before February 29, 2024 ·DNS/Designee ensured all other residents with catheters had catheter orders was monitored per physician order.	02/29/2024

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	after visit summary, dated 5/17/23, which read "...You had a successful exchange of your suprapubic catheter to a 16 fr[sic] Foley in the tract with a retention balloon with 10 ml[sic] water in the retention balloon. The previous suture was removed... Future tube exchanges can be done in an office or bedside without fluoro [x-ray] guidance..." A physician's order, dated 5/17/23, indicated to change foley catheter and urinary drainage bag as needed for dislodgement, leaking or occlusion. A physician's order, dated 5/17/23, indicated foley catheter care, catheter securement device in place and nurse to record output every shift. A physician's order, dated 5/17/23, indicated the foley catheter size was 16 French and 10 ml bulb. The November 2023 TAR (Treatment Administration Record) contained documentation of Resident T's urinary output on the following days and time: 11/1/23- day shift 500 ml, evening shift 600 ml, night shift 1500 ml, 11/2/23- day shift 500 ml, evening shift 500 ml, night shift 1000 ml, 11/3/23- day shift 800 ml, evening shift 600 ml, night shift 300 ml, 1/4/23- day shift 550 ml, evening shift medium with no ml entered, night shift 120 ml, 1/5/23- day shift intake not reported with comment of catheter leaking. Resident T's clinical record did not contain documentation or progress notes about urine color, consistency, or leaking of urine from 11/1/23 through 11/5/23. A progress note, dated, 11/05/2023 at 1:51 p.m., read ..."this writer was		What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? DNS/Designee will conduct an in-service with all nursing staff on Urinalysis Collection and documentation of urine outputs for residents with foley catheters on or before February 29, 2024. ·Urine output documentation for residents with foley catheters to be reviewed daily in clinical meeting How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year 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	

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	called to resident's room d/t [due to] resident suprapubic leaking and resident having pain this writer assessed resident and found that residents abdomen was distended resident has pain with palpation and urine is leaking through catheter insertion area and private area NP [nurse practitioner] called new orders send to ER [emergency room]. this writer called 911 send resident to ... ER..." Resident T's health record contained an acute care hospital history and physical, dated 11/5/23 at 10:42 p.m., which read "...Presented to the hospital brought in from his facility... for the concern of urine tract infection associated with his suprapubic catheter When I saw the patient he was alert oriented x 3...from information obtained he said he actually noticed leakage in the area of the suprapubic catheter and his depends and he told the nursing staff that he will need help and per patient he noticed the leakage about 3 days ago...He noticed some burning sensation and when I asked him if he noticed some urine from his penis he said his depends were wet..." On 11/10/23, Resident T returned to the facility from the acute care hospital. A Significant Change in Status MDS (Minimum Data Set) Assessment, completed 11/17/23, indicated Resident T was able to make himself understood and to understand what was said to him. He was cognitively intact and had an indwelling urinary catheter. The November 2023, December 2023, and January 2024 TAR's did not contain information on the amount of urine output, in milliliters, on the following days and shifts: 11/10/23- night shift recorded as small, 11/14/23- day shift recorded as			

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	medium, evening shift recorded as medium, night shift recorded as medium, 11/20/23- night shift not recorded, 11/21- day shift recorded as medium, 11/23/23- day shift recorded as medium, 11/24/23- day shift recorded as large, 11/26/23, evening shift recorded as large, 11/27/23- day shift recorded as large, 11/29/23- evening shift recorded as medium, 12/3/23- evening shift recorded as large and night shift recorded as medium, 12/4/23- day shift recorded as medium and evening shift recorded as medium, 12/6/23- night shift not recorded, 12/7/23- day shift and evening shift recorded as large, 12/13/23- evening shift and night shift recorded as large, 12/16/23- day shift and night shift recorded as large, 12/18/23- evening and night shift recorded as large, 12/19/23- day and evening shift recorded as large, 12/22/23- night shift not recorded, 12/23/23- evening shift recorded as large, 12/24/23- day shift recorded as medium, 12/26/23- day, evening, and night shift recorded as large, 12/27/23- evening shift recorded as large, 12/28/23- day and evening shifts recorded as medium and night shift recorded as large, 12/29/23- evening shift recorded as large, 12/30/23- day shift recorded as medium, 12/31/23- day shift recorded as large, 1/1/24-evening shift recorded as medium , 1/2/24- - day shift not recorded and evening and night shift recorded as medium, 1/3/24- day and evening shift recorded as large, 1/4/24- day shift recorded as medium and evening shift recorded as large, 1/5/23- day, evening, and night shifts recorded as large, and 1/6/23- day shift recorded as medium. During an interview on 1/4/24 at 9:49 a.m., Resident T indicated he had a problem with his catheter and was sent to the hospital. The hospital had fixed the problem. During an interview on 1/08/24 at 3:05 p.m.,			

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	Resident T indicated that prior to going to the hospital in November, he had experienced urine leaking around his catheter and through his penis for 3 or 4 days prior to being sent to the hospital. He had let the nursing staff know it was happening. 2. The clinical record for Resident 75 was reviewed on 1/3/24 at 3:31 p.m. The diagnoses for Resident 75 included, but were not limited to, chronic kidney disease, urinary tract infections and uropathy (an obstructive urinary flow). A care plan dated 11/24/23 indicated "Resident requires a suprapubic catheter r/t [related to] obstructive uropathy....Approach...Assess the drainage each shift. Record the amount, type, color, odor. Observe for leakage...staff to record urinary output in ml [milliliters]..." A physician order dated 11/22/23 indicated the resident was to receive once a week 60 milliliters of acetic acid. A physician order dated 11/22/23 indicated the resident was to receive 60 milliliters of acetic acid once a day as needed. An observation was made of Resident 75 on 1/3/24 at 3:31 p.m. The resident was observed in bed with a catheter that was in a dignity bag hanging on bed rail. The resident had indicated she has had the catheter for years. It does leak at times. That morning it had leaked a little. The December 2023 and January vitals report for Resident 75 indicated the following days, times the urinary outputs were not recorded as milliliters per plan of care: December 2023:			

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	12/30/23 at 12:59 p.m., - medium amount of urine was documented, 12/31/23 at 6:30 a.m., - large amount of urine was documented, 12/31/23 at 1:06 p.m., - large amount of urine was documented, 12/31/23 at 4:48 p.m., - large amount of urine was documented, January 2024: 1/1/24 at 9:44 a.m., - large amount of urine was documented, 1/1/24 at 10:04 a.m., - medium amount of urine was documented, 1/1/24 at 4:48 p.m., - medium amount of urine was documented, 1/2/24 at 6:20 a.m., - large amount of urine was documented, 1/2/24 at 6:33 p.m., - large amount of urine was documented, 1/3/24 at 6:01 p.m., - large amount of urine was documented, 1/3/24 at 8:11 p.m., - large amount of urine was documented, 1/4/24 at 6:25 a.m., - large amount of urine was documented, 1/4/24 at 2:50 p.m., - large amount of urine was documented, 1/4/24 at 9:16 p.m., - medium amount of urine documented, 1/5/24 at 6:28 a.m., - large amount of urine was documented, 1/6/24 at 12:50 a.m., - large amount of urine was documented, 1/6/24 at 12:47 p.m., - medium amount of urine was documented, 1/6/24 at 8:20 p.m., - large amount of urine was documented, 1/7/24 at 1:14 a.m., - large amount of urine was documented,			

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	1/7/24 at 6:40 a.m., - large amount of urine was documented, 1/7/24 at 12:00 p.m., - medium amount of urine was documented, 1/8/24 at 5:54 a.m., 6:49 a.m., 8:59 a.m., - large amount of urine was documented, 1/9/24 at 6:00 a.m., - large amount of urine was documented, An interview was conducted with the Director of Nursing on 1/9/24 at 10:28 a.m. She indicated Resident 75 should have had catheter orders. It was missed on error. The emptying urinary drainage bag procedure was provided by the ED on 1/9/24 at 9:01 a.m. It indicated the procedure steps was "...9. measure and record amount of urine..." 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake			

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	to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to assure weights were obtained accurately for 1 of 4 residents reviewed for nutrition (Resident BB). Findings include: The clinical record for Resident BB was reviewed on 1/3/23 at 3:49 p.m. The Resident's diagnosis included, but were not limited to, dysphagia (difficulty swallowing) and abnormal weight loss. A physician's order, dated 6/12/23, indicated Resident BB was to be weighed weekly. A Significant Change of Status MDS (Minimum Data Set) Assessment, completed 11/10/23, indicated that he had significant cognitive impairment, needed maximal assistance with eating, and had experienced a significant, unplanned weight loss. During a confidential interview, they indicated the residents' weights were being documented incorrectly due to staff not wanting to document weight changes or concerns. During an interview on 1/3/23 at 3:49 p.m., Family Member 20 indicated Resident BB had lost a lot of weight in the past few months. His weight seemed to go up and down a lot. She wondered how accurate the weight were. She had been told by staff that the "Hoyer" lift was not giving them the right weights.	F 0692	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident BB is weighed per physician orders. Staff have been educated Weight Monitoring Policy. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ·All clinical staff re-educated on Resident Weight Monitoring Policy on or before February 29, 2024. ·All resident weights were obtained to ensure for accuracy, any weight concerns will be addressed ·A daily rounding tool reviewing weights to be utilized by DNS/designee. What measures will be put into	02/29/2024

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	A care plan, last updated 1/5/23, indicated Resident BB was at risk for altered nutrition related to aspiration risk. His g-tube (feeding tube) was found removed on 12/26/23 with no plans for replacement. His weight was down 20 pounds in 180 days. The goal was for him to maintain weight without significant changes. The interventions were to provide supplements as ordered. Honor known food/ fluid preferences, provide pureed diet with nectar thick liquids, monitor weight, and notify physician and family of significant weight changes. Resident BB's weight was recorded on 12/19/23 as 141 lbs. (pounds), 12/26/23 as 142 lbs., 1/2/24 as 143 lbs., and 1/9/23 as 144 lbs. On 1/09/24 at 1:56 p.m., Resident BB was observed being weighed with the mechanical lift by CNA (Certified Nursing Assistant) 42 and UM (Unit Manager) 23. UM 23 indicated his weight was 134.8 pounds. During an interview on 1/09/24 at 3:41p.m., the RD (Registered Dietician) indicated she had obtained the weight of 144 from the electronic medication administration record. Resident BB's weight had been recorded on the EMAR on 1/8/24 as 144 pounds. Since it was close to the weight from the last week she did not question if it was accurate. UM 23 informed the RD of Resident BB's weight had been obtained on 1/9/23 as 134.8 pounds. Due to the 9-pound difference in the weight obtained a re-weight would need to be done. During an interview on 1/9/24 at 3:41 p.m., UM 23 indicated she was unsure why there was such a difference between the 1/8/23 weight recorded on the EMAR and the weight obtained on 1/9/23.		place or what systemic changes make to ensure that the deficient practice does not recur? All clinical staff re-educated on Resident Weight Monitoring Policy on or before February 29, 2024. ·A daily rounding tool reviewing Resident weights will be utilized by DNS\Designee How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year 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	

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	She would reach out to the nurse who recorded the 1/8/23 to ask how the weight was obtained. During an interview on 1/10/24 at 8:45 a.m., UM23 indicated she had not heard back from the nurse who recorded the 1/8/23 weight of 144 lbs. On 1/10/24 at 1:56 p.m., Resident BB was observed being weighed with the mechanical lift by UM 23 and CNA 44. UM 23 indicated his weight was 136.8. On 1/20/24 at 9:37 a.m., the Director of Nursing provided the Resident Weight Monitoring Policy, last reviewed 12/2022, which read "...It is the policy of this facility that residents will be weighted no less than monthly or per physician's order... Ideally, weights will be obtained by a designated and consistent team or individual to ensure accuracy. This Federal tag relates to complaint IN00420608. 3.1-46(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to administer a resident's	F 0695	What corrective action(s) will be	02/29/2024

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	oxygen, as ordered, and ensure accuracy of his current oxygen orders in the clinical record for 1 of 4 residents reviewed for respiratory care. (Resident F) Findings include: The clinical record for Resident F was reviewed on 1/3/24 at 2:30 p.m. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease, dementia, and hypertension. The physician's orders indicated he was admitted to hospice services, starting 3/10/23, and for his oxygen to flow at 1.5 liters per nasal cannula, every shift, starting 4/4/23. The impaired gas exchange care plan, last reviewed/revised 10/26/23, indicated an intervention was to administer oxygen as ordered. An observation of Resident F and interview with Hospice Aide 17 was conducted on 1/3/24 at 2:32 p.m. Resident F was sitting in his Broda chair in his room. A home health aide from his hospice company, Hospice Aide 17, was present in the room with him. He was wearing oxygen per nasal cannula. His portable oxygen tank was attached to the back of his chair. It was set to 3 liters but the oxygen was not flowing. The needle on the tank was all the way to the left below the red. Hospice Aide 17 indicated she arrived at the facility 45 minutes ago. Resident F was hooked up to his oxygen concentrator when she arrived. She took him off to give him a bath. She shook the portable oxygen tank on the back of his chair and indicated it was empty. She was going to take him to activities, so she had to ask facility staff about having his portable oxygen tank filled. Hospice Aide 17 proceeded to assist Resident F out of the		accomplished for those residents found to have been affected by the deficient practice? Resident F's O2 order has been clarified with and reflected per orders. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ·All clinical staff re-educated on Oxygen Therapy and Devices policy on or before February 29, 2024. ·All residents receiving oxygen therapy were reviewed to ensure oxygen flow was provided per order ·A daily rounding tool reviewing Oxygen Therapy and Devices to be utilized by DNS\Designee. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? All clinical staff re-educated on	

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AMERICAN VILLAGE	2026 EAST 54TH ST INDIANAPOLIS, IN 46220

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	room and down the hall. An observation of Resident F was made on 1/3/24 at 3:00 p.m. He was sitting in his Broda chair in the activity room. He was wearing his oxygen per nasal cannula. The portable oxygen tank on the back of his chair was set to 2 liters and was flowing. An observation of Resident F and interview with LPN (Licensed Practical Nurse) 15 was conducted on 1/3/24 at 3:05 p.m. LPN 15 indicated she usually worked a different hall but worked on this unit sometimes. She thought Resident F's oxygen was supposed to be set to 3 liters. LPN 15 checked Resident F's portable tank, saw it was set to 2 liters and changed it to 3 liters. LPN 15 then reviewed Resident Y's oxygen orders in his electronic clinical record, saw the order was for 1.5 liters, and changed the setting to 1.5 liters. Resident F's hospice plan of care, as of 12/12/23, located in his hospice binder at the nurse's desk was immediately reviewed after the above observation. The oxygen orders in the hospice plan of care were 2-6 liters as needed per nasal cannula, may titrate to patient comfort, starting 3/15/23. An interview was conducted with LPN 15 on 1/3/24 at 3:20 p.m. after reviewing the oxygen orders in his hospice plan of care. She indicated she was unsure and needed to call hospice for clarification of the order. An interview was conducted with LPN 15 on 1/4/23 at 10:26 a.m. She indicated they called hospice and received clarification Resident F's oxygen order was 2-6 liters. The order in the electronic clinical record for 1.5 liters was not		Oxygen Therapy and Devices policy on or before February 29, 2024. ·A daily rounding tool reviewing Oxygen Therapy and Devices to be utilized by the DNS\Designee. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year 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	

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	current and accurate. LPN 15 called hospice to have them send over the clarification. The 10/16/23 email between Hospice OT (Occupational Therapist) 14, Hospice RN (Registered Nurse) 13, and Family Member 12 indicated Hospice OT 14 had just finished seeing Resident F. "Staff had just laid him down in bed. No oxygen on him...Oxygen saturation was 74% on room air...." An interview was conducted with Hospice RN (Registered Nurse) 13 on 1/8/24 at 1:43 p.m. He indicated he began working with Resident F earlier last year, 2023. The issue with Resident F's oxygen was ongoing between the facility and the medical supply company, regarding his portable oxygen tank. There were times Resident F's oxygen was completely off, empty, and needed filled. There were times he was in bed and the concentrator wasn't on. In the 8-10 months he'd been caring for Resident F, this was the case "about 5 times." When Hospice OT 14 saw his oxygen was not on, she put it on him. As far as he knew, Hospice Aide 17 could leave his oxygen on as much as possible, as the tubing from the concentrator could reach the restroom. The 1/4/24 oxygen clarification order in the electronic clinical record indicated Oxygen at 2 liters per nasal cannula, may titrate to 6 liters to keep saturations above 90, every shift, starting 1/4/24. An observation of Resident F was made on 1/8/24 at 3:19 p.m. He was sitting in his Broda chair in the activity room. His eyes were closed. He was wearing his oxygen per nasal cannula. The portable oxygen tank was set to 2 liters. The needle on the tank was all the way to the left			

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	below the red. An observation of Resident F and interview with QMA (Qualified Medication Aide) 18 on 1/8/24 at 3:25 p.m. She indicated she was the QMA for the unit, as the nurse was located on the 100 hall. She looked at Resident F's portable oxygen tank and indicated it was empty, but she could fill it. She then pushed Resident F out of the activity room and down the hallway. The Oxygen Therapy and Devices policy was provided by the ED (Executive Director) on 1/9/24 at 9:01 a.m. It read, "Oxygen is a basic human need. Without it, we would not survive. The air that we breathe contains approximately 21% oxygen. For most people with healthy lungs, this is sufficient, but some people with certain health conditions whose lung function is impaired, the amount of oxygen that is obtained through normal breathing is not enough. Therefore, they require supplemental amounts to maintain normal body function....Initiation of Oxygen 1) Verify physician order...7) Apply device to the patient with appropriate liter flow." This citation relates to Complaint IN00425026. 3.1-47(a)(6)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident			

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	assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview, and record review, the facility failed to provide sufficient nursing staff with appropriate competencies or skill sets to ensure ADL (Activities of Daily Living) care was provided in accordance with the plan of care for 8 of 12 residents reviewed for ADL care (Residents B, H, J, K, M, R, S, and SS) and physician orders were effectively provided in accordance with the plan of care for 7 of 14 reviewed for medication administration and treatments (Residents' B, H, T, 40, 44, 83 and 118) Findings include: During this recertification and complaint survey, 1/3/24 to 1/10/24, two deficiencies were cited at a pattern level - F677 E and F684 E. 1. Activities of Daily Living (ADLs):	F 0725	p paraid="791877785" paraeid="{addee8fc-e1a8-464b-9632-190cb2dd0bf1}{7}" > ¿What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?¿¿ Facility wide staffing patterns reviewed by ED, DNS, RDCS, RVP.¿¿ How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?¿¿ ¿¿¿	02/29/2024

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	Eight residents out of 12 reviewed in total were not provided ADL care related to incontinence, eating, getting residents out of bed, and nail care. Cross reference F677. 2. Quality of Care: Seven residents did not have medications administered as ordered, follow physician orders for elevation of bilateral lower extremities, and apply pressure relief boots as ordered by the physician. Cross reference F684. An anonymous interview was conducted with a Family Member. They indicated there were issues in the facility due to understaffing. The workload was "unrealistic." They were in the facility on a routine basis. In the dining room, they witnessed how residents were and were not being fed. They didn't think the staff "understand the needs of the patients." The facility needed oversight, supervision, and communication. Staff set trays in front of residents and "they're just left there." The food wouldn't be cut up as needed, not considering the resident's needs. They saw a lot of untouched trays being returned to the kitchen. "In this place, poor dispositions are often. Staff are easily irritated." They were in halls when trays were cleared from rooms, and there were trays with no evidence of staff having attempted to feed the residents, residents who have no ability to say yes or no. They'd seen staff feed residents too much and too fast. Residents couldn't finish one bite before being served another, if the resident was fed at all. Staff were constantly on their phones, when they were supposed to be feeding		ul class="BulletListStyle1 SCXW177283934 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" Facility wide staffing patterns reviewed by ED, DNS, RDCS, RVP.¿ Internal and external agency usage to meet staffing needs as needed.¿¿ HR meeting scheduled weekly to discuss open positions needed and job postings.¿ Staff and manager dining room schedule updated All residents reviewed for acuity and needs. Staffed to ensure needs are met. CNA and Nurse assignment/ duties reviewed with accommodations made as needed All staff in-service on new staff and manager dining room schedule¿on or before February 29, 2024.¿ ¿	

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	residents. They rarely saw staff take the consideration to microwave a plate. They tried to assist other residents with eating, but the staff didn't want them to, but "it's hard for me to watch people not eat or drink." Some time ago, they were not in the facility for 3 consecutive days, and in that time frame, their family member, who was dependent on staff for changing their brief, had developed inflamed skin, "bloody even." They were upset that "I couldn't be gone for 3 days." There were times staff put 2 briefs on their family member. Staff refer to residents as feeds and "I don't appreciate that .... The aides run the show. I don't think they have sensitivity training." During an interview on 1/04/24 at 11:25 a.m., Resident 85 indicated that he watched residents with dementia sit in the activity area for hours in the same position. He had smelled very strong urine smells when he has stopped to talk with them and could tell they had been incontinent and not been changed. During an interview on 1/06/23 2:30 p.m., the DON (Director of Nursing) indicated that when there are 2 CNAs on the hall and a resident needs fed and another resident who is a mechanical lift needs changed, how should that be prioritized. On 1/9/24 at 12:53 p.m., the Administrator provided a list of 22 residents who required verbal cues, as needed, with eating. During an interview on 1/10/24 at 10:27 a.m., Unit Manager 23 indicated that there were 5 residents who resided on the 200 hallway that needed a mechanical lift for transfers. Two staff members were required to assist residents when the mechanical lift was used.		What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur?¿ Facility wide staffing patterns reviewed by ED, DNS, RDCS, RVP.¿ ·Staffing needs reviewed daily during Clinical Meeting¿ ·Internal and external agency usage to meet staffing needs as needed ·HR meeting scheduled weekly to discuss open positions needed and job postings.¿ ·Staff and manager dining room schedule updated ·All residents reviewed for acuity and needs. Staffed to ensure needs are met. ·CNA and Nurse assignment/ duties reviewed with accommodations made as needed ·All staff in-service on new staff	

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	During an interview on 1/10/24 at 10:33 a.m., CNA (Certified Nursing Assistant) 50 indicated there were 3 residents who resided on the 100 hallway that required assistance of a mechanical lift for transfers. During an interview on 1/1024 at 10:35 a.m., LPN (Licensed Practical Nurse) 51 indicated there were 9 residents residing on the 400 hallway that required assistance of a mechanical lift for transfers. The 400 hallway was normally staffed with 2 CNAs and a "split" assignment for a CNA, where the aide cared for residents on both the 200 and 400 hallways, on the day and evening shifts. During an interview on 1/10/23 at 1:18 p.m., the Staffing Coordinator indicated the number of licensed nurses and certified nursing assistants scheduled to provide direct care for the residents each day was determined by the facility census. The corporation decided the staffing ratio. He was unsure what type of information they used to decide how many staff should be scheduled, other than the census. Sometimes staff had complained that there were not enough staff to care for the residents on the weekends. A Resident Rights policy was provided by the ED on 1/9/24 at 9:01 a.m. It indicated "...Planning and implementing care...You have the right to be informed, and participate in, your treatment. This includes the right to...Receive the services and/or items included in the plan of care...The right to reside and receive services in the facility with reasonable accommodations of your needs and preferences except when to do so would endanger the health or safety of you or your residents..." 3.1-17(a)		and manager dining room schedule¿on or before February 29, 2024. ¿ How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?¿¿ POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year 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	

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F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to ensure medication labels were not altered (Resident 103); facility stock of clear needleless connectors and leur lock	F 0755	p role="heading" aria-level="1" paraid="1504270493" paraeid="{addee8fc-e1a8-464b-9632-190cb2dd0bf1}{192}" >What	02/29/2024

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	caps were not expired (Facility); the disposition medications for discharged and/or expired residents was completed timely (Residents 330 and 331); and a resident's home medications were stored appropriately (Resident 119). Findings include: A review of the facility's medication storage rooms and medication carts was conducted on 1/9/24. The following was observed: 1. On the Auguste's Cottage unit, in conjunction with LPN (Licensed Practical Nurse) 30 at 2:48 p.m. the medication cart contained a medication bottle had a handwritten label over where the resident's name should have been typed. The handwritten name label identified it as Resident 103's Zyprexa (an antipsychotic medication). LPN 30 peeled the handwritten label off the bottle which revealed a different person's name who never had resided at the facility. An interview with LPN 30 immediately following the discovery of an unknown person's name on the bottle indicated, Resident 103's family had brought that medication in from home. A review of Resident 103's current orders conducted on 1/10/24 at 9:28 a.m. indicated, Resident 103's Zyprexa order was discontinued on 11/28/23. 2. a. In the medication storage room for the 100/200/300/400 hallways, in conjunction with ADON (Assistant Director of Nursing) at 3:06 p.m. on the counter were storage units with multiple drawers. One drawer of that unit contained clear needleless connector devices. At least two of the connectors were found to have expiration dates of 8/12/22 and 1/11/23. Another drawer contained leur lock caps and at least one was found to have		corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 103's medication was removed from the medication cart and disposed of per policy. ·Expired needles connector devices removed from mediation room ·Resident 330 and 331's medications were returned to pharmacy ·Resident 119's home medications were returned to family p paraid="1339163165" paraeid="{addee8fc-e1a8-464b-9632-190cb2dd0bf1}{233}" >How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents receiving medications have the potential to be affected	

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	an expiration date of 4/23/21. An interview with ADON immediately following the observation of the expired medical supplies indicated, a more complete review of the remaining connector devices and leur lock caps needed to be reviewed to ensure they were not expired as well. b. On the counter near the medication fridge, were 4 bottles of medication labeled for Resident 330. All of the medication bottles contained medications labeled as Zofran (an anti-nausea medication), Eliquis (an anti-coagulant), amiodarone (used to treat heart rhythm issues), and Valsartan (used to treat hypertension). An interview with ADON immediately following this observation indicated, Resident 330 was no longer a resident at the facility. A clinical record review for Resident 330 conducted on 1/10/24 indicated, Resident 330 expired on 12/1/23. c. In a broken cabinet next to the medication fridge, a large, clear, plastic bag containing 15 bottles of medications and other medical supplies for Resident 119 was located. An interview with ADON was conducted immediately following the observation and indicated, she believed the bag of medication labeled for Resident 119 were her home medications that she had brought with her when admitted to the facility. When asked how home medications should be stored and accounted for, ADON indicated, the resident's medications should be logged and kept inside the medication cart until the resident's family/representative could pick them up. d. Inside the medication fridge, one Bydureon (an anti-diabetic medication) injection for Resident 331. An interview with ADON immediately		by the alleged deficient practice ·DNS/Designee will conduct an in-service for all nurses and QMAs on Inventory Control of Controlled substances policy on or before February 29, 2024 ·All medications were observed to ensure medication labels were not altered, stock of clear needleless connectors and lock caps were not expired and discharged resident medications were taken care of appropriately What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? DNS/Designee will conduct an in-service for all nurses and QMAs on Inventory Control of Controlled substances policy on or before February 29, 2024. ·DNS/designee to conduct audit of control medication carts and medication rooms weekly How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	

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	following the observation indicated, Resident 331 was no longer a resident at the facility. A clinical record review was conducted on 1/10/24 for Resident 331. Resident 331 was discharged from the facility on 09/17/2022. A Storage and Expiration Dating of Medications, Biologicals policy received on 1/9/24 at 4:05 p.m. from DON (Director of Nursing) indicated, "Procedure...3.7 Facility should ensure that test reagents, germicides, disinfectants, and other household substances are stored separately from medications...6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels or cautionary instructions...15. Facility should ensure that medications and biologicals for expired or discharged or hospitalized residents are stored separately, away from use, until destroyed or returned to the provider...17. Facility personnel should inspect nursing station storage area for proper storage compliance on a regularly scheduled basis..." 3.1-25(j) 3.1-25(o) 3.1-25(r)		POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year 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	
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;			

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	(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 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 observation, interview, and record	F 0758	p role="heading" aria-level="1"	02/29/2024

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	review, the facility failed to ensure an appropriate justification was in place for the continued utilization of an antipsychotic medication, follow up with the family in regards to side effects of antipsychotic medication, and follow up with an abnormal AIMS (abnormal involuntary movement scale) assessment for 1 of 5 residents reviewed for unnecessary medications. (Resident L) Findings include: The clinical record for Resident L was reviewed on 1/8/24 at 11:48 a.m. The diagnoses included, but were not limited to, dementia, major depressive disorder, muscle weakness, schizophrenia (diagnosis added in 2023), and cerebral ischemia. An observation conducted of Resident L, on 1/8/24 at 2:00 p.m., up in their wheelchair with excessive, repetitive movements to their arms and legs, including lip puckering, and sticking their tongue out. An observation conducted of Resident L, on 1/9/24 at 9:32 a.m., lying in bed with excessive, repetitive movements to their arms and legs. An observation conducted of Resident L, on 1/10/24 at 10:08 a.m., up in their wheelchair with excessive, repetitive movements to the arms and legs including lip puckering and sticking their tongue out. A physician order, dated 5/19/23, was noted for fluphenazine (antipsychotic medication)10 milligrams every 12 hours. A behavioral care plan, dated 6/17/21, indicated the following, "per daughter resident has multiple nervous breakdowns and PCP [primary care		paraid="1300727466" paraeid="{dea6d9dc-f660-45a1-96ca-4dffbc3d32e2}{56}" >What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident L behavioral care plans reviewed and updated. Behavior tracking initiated. ·Resident L medication has been reviewed by MD. ·AIMS assessment reviewed by MD and neurology follow up scheduled How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ·Audit completed of residents on anti-psychotic medications to ensure in compliance and aims completed. ·Audit completed on all AIMS assessments. MD made aware of	

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	physician] diagnosed her with Schizophrenia. A behavioral care plan, dated 11/10/23, indicated Resident L was at risk for delusions and hallucinations due to diagnosis of schizophrenia. Resident L utilized antipsychotic medication. A side effect care plan, dated 6/9/21, indicated Resident L was at risk for adverse side effects related to the use of psychotropic medication. The approach was to conduct an AIMS assessment twice a year, document side effects as observed and notify the physician, IDT (interdisciplinary team) to review routinely to attempt gradual dose reductions, observe for side effects: Antipsychotic meds: dizziness, dry mouth, indigestion, drowsiness, constipation, impaired balance, weight gain, tremors, abnormal involuntary movements. An AIMS Scale, dated 1/17/23, indicated facial and oral movements to be minimal, jaw movement to be minimal, tongue movement to be minimal, trunk movement to be minimal, the severity of abnormal movements to be minimal, and had no incapacitation due to the movements. A progress note, dated 4/12/23 at 3:02 p.m., indicated the following, "...Writer and UM [Unit Manager] noted resident having involuntary movements in legs, bulging eyes, dilated pupils and restlessness. Writer approached resident and asked if she was ok. Resident smiled at writer and shook head yes. All symptoms continued...Writer placed call to [name of outside psychiatry provider]. Psych NP [Nurse Practitioner] called writer back and writer explained resident's symptoms. Recent medication changes reviewed. New order to change fluphenazine to 5 mg [milligrams] BID [twice daily]. Psych NP will		any abnormalities. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? ED/Designee to attend Monthly GDR meeting and psychotropic management policy is being followed. ·Regional Social Service Support to in-service Social Service team on psychotropic management policy on or before February 29, 2024. ·DNS to review new AIMS assessments daily in clinical . How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ul class="BulletListStyle1 SCXW39308444 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible;	

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	re-evaluate on Friday when in facility...." A progress note, dated 4/27/23 at 11:38 a.m., indicated the following, "...res. [resident] continues to tamper [sic] off of antipsychotic meds. res. is noted to have a restless leg movement since tampering meds [sic]. while up in w/c [wheelchair] staff reports that res. constantly moves while in bed this is new noted behavior for res." A progress note, dated 5/2/23 at 1:14 p.m., indicated the following, "...res. alert and oriented to self. staff anticipate all of res. needs. [sic] res. requires extensive assist with ald [sic][ADL - activities of daily living] care, transfers, toileting, bed mobility, dressing and bathing. res. able to feed self after staff setup. incontinent of bowel and bladder. res. legs continues to move non stop. staff reports that res moves constantly while she is in bed also. social services and [name of Nurse Practitioner] made aware...." A progress note, dated 5/4/23 at 3:28 p.m., indicated the following, "...'[name of Nurse Practitioner] here and seen res. noted that res. appears to be very restless with continuous leg movement. writer informed [name of Nurse Practitioner] that this behavior started when the fluphenazine started to be tamper [sic]. cna [certified nursing assistant] reports that when res. is laying in bed there is constant movement. res. appears very uncomfortable with continuous leg movement. [name of Nurse Practitioner] restarted fluphenazine 5mg bid [5 milligrams twice daily]...." A progress note, dated 5/18/23 at 11:04 a.m., indicated the following, "...res. alert and oriented to self and staff. staff anticipate res. needs. res. restarted on fluezphen [sic]. no increase sedation		cursor: text; font-family: verdana;" POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year 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.	

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	noted. res. leg movement starting to decrease. res. do not appear to be distress [sic]. up in w/c [wheelchair]. propel via staff...." A progress note, dated 5/18/23 at 2:30 p.m., indicated the following, "...writer was called to res. room and noted that res. was on the flr [floor]. laying on her back...res. has been noted to have some increase movement. res. started back on fluphenazine 5mg bid [5 milligrams twice daily]. increase movement has improved but continues to be more than before fluphenazine was stopped...." A nurse practitioner note, dated 5/18/23, indicated the following, "...Encounter Reason...schizophrenia - tardive dyskinesia [a disorder that results in involuntary repetitive body movements, which may include grimacing, sticking out the tongue or smacking the lips]...This is an 83 yr old [year old] female evaluated today for an acute visit due to schizophrenia and tardive dyskinesia...This patient has had a diagnosis of schizophrenia for years. She has been managed on fluphenazine 10 mg twice daily for quite some time. Per the daughter the patient does her best on this dose of fluphenazine. Psych has been recently decreasing the patient's fluphenazine dose. The patient has had a "wild look" in her eyes as well as increased tardive dyskinesia movements of her legs with dose decreases. The patient appears to be uncomfortable. She is nonverbal...The patient's family would prefer the patient be back on fluphenazine 10 mg twice daily and the dose not be altered for the patient's wellbeing...." A progress note, dated 6/9/23 at 10:21 a.m., indicated Resident L was noted with significant weight loss. A significant change MDS assessment was going to be conducted.			

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A significant change minimum data set (MDS) assessment, dated 6/16/23, noted severe cognitive impairment and no behaviors exhibited related to physical behavioral symptoms, verbal behavioral symptoms, other behavioral symptoms, rejection of care, and/or wandering.

A psychiatry progress note, dated 6/20/23, indicated the following, "...[Name of Resident L] admitted to [name of facility] on 6/8/21 following an acute hospitalization. PASSRR [preadmission screening and resident review] [sic] dated 6/16/21 endorses a history of schizo affective disorder along with dementia. However, per chart review by [name of collaborating physician] there is not enough evidence to support the diagnosis of schizophrenia in this patient...ANTIPSYCHOTIC USE...Start Date: 3/10/23...diagnosis for use: schizophrenia...Date of last GDR [gradual dose reduction]: NA [not applicable]...Resident is positive for dementia-related behaviors in past 12 months, is to receive individual therapy and psychiatric treatment services...."

An AIMS Scale, dated 7/3/23, indicated facial and oral movements to be minimal, lips and perioral area to be minimal, jaw movement to be minimal, tongue movement to be minimal, upper extremity movements to be minimal, lower extremity movements to be moderate (marked at a 3), trunk movement to be minimal, and overall severity of abnormal movements to be moderate (marked at a 3). The document indicated the following, "...Interpretation of the AIMS score...A score of 3 or 4 in only one body area warrants referring the resident for a complete neurological examination...."

There was no indication in Resident L's electronic

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	medical record that she was referred for a neurological examination. A pharmacy recommendation, dated 7/7/23, noted a gradual dose reduction (GDR) of the antipsychotic fluphenazine due to the recent AIMS assessment and risk for involuntary movements. The GDR request was declined with the Medical Director commenting "will disrupt well being". A psychiatry progress note, dated 7/25/23, indicated Resident L was not displaying changes in mood or worsening depression. A quarterly MDS assessment, dated 8/2/23, noted severe cognitive impairment and no behaviors exhibited. A psychiatry progress note, dated 8/22/23, indicated the following, "...Plan...Psychotic disorder with delusions due to known physiological condition...DISCONTINUE fluphenazine 10 mg p.o. [by mouth] twice daily...STARTED fluphenazine 7.5mg po q AM [by mouth every morning] and 10mg po q HS [by mouth at hours of sleep]...medication previously decreased per GDR - however medical team increased medication to previous dosing...Abnormal involuntary movements...Ingrezza 40 mg [medication used for involuntary movements] po q day [by mouth daily] started by medical team - this is not a [name of outside psychiatry provider] approved medication - previous GDR of offending agent (fluphenazine) increased by medical team...." A psychiatry progress note, dated 9/12/23, indicated the following, "...Plan...Abnormal involuntary movements...previous GDR of			

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	offending agent (fluphenazine) increased by medical team...." A psychiatry progress note, dated 10/17/23, indicated Resident L had not exhibited any changes in mood or worsening depression. Staff denied any new/significant changes in psych status. Resident L takes an antipsychotic medication and "Family not receptive to medication being decreased". A significant change MDS assessment, dated 10/19/23, noted severe cognitive impairment and no behaviors exhibited. A psychiatry progress note, dated 10/31/23, indicated the following, "...Continues to have rhythmic movements of BLE [bilateral lower extremities]. Clinician has attempted to reduce antipsychotic medications during past GDR/behavior meetings - however family has declined changes to antipsychotic medications. Family aware of clinicians desire to decrease medications to the lowest effective dosing - however continue to decline changes to antipsychotic medications...." A quarterly MDS assessment, dated 11/22/23, noted severe cognitive impairment and no behaviors exhibited. A psychiatry progress note, dated 11/28/23, indicated the following, "...Noted resident continues to display akathisia [a state of agitation, distress, and restlessness that is an occasional side-effect of antipsychotic and antidepressant drugs] - previous attempts to decrease this medication declined by family. Medications reviewed with no new orders at this time- plan to reach out to DTR/POA [daughter/power of			

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	attorney] again regarding decrease antipsychotic medication...." There was no documentation in the electronic medical record about a reapproach to the GDR of the antipsychotic medication for Resident L. An AIMS Scale, dated 1/9/24, indicated facial movements as moderate (scale of 3), lip movement as minimal, jaw movement as mild (scale of 2), tongue movement as minimal, upper and lower extremity movements as minimal, trunk movement as moderate, and severity of abnormal movements as minimal. An interview conducted with Certified Nursing Assistant (CNA) 34, on 1/10/24 at 10:10 a.m., indicated Resident L has these excessive, repetitive movements and they have occurred since she started working at the facility in August of 2023. Resident L can hold onto food items such as toast, but she was fed mostly by the facility staff. An interview conducted with the Regional Consultant for Social Services, on 1/10/24 at 1:28 p.m., indicated the facility staff reviewed information with the psychiatrist to see if we had the documentation to support the diagnosis of schizophrenia. The level 1 and level 2 were reviewed as well. It was determined that it was a history of schizophrenia and/or a primary dementia diagnosis. Resident L's schizophrenia diagnosis was not validated. Resident L's family spoke with the primary care provider and got the antipsychotic increased again. A GDR meeting was held and discussed with the family, but the family was insistent on keeping Resident L on that medication and the same dose.			

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	An interview with the Director of Nursing (DON), on 1/10/24 at 1:30 p.m., indicated she could not find anything in Resident L's clinical record regarding a neurological consultation. A policy titled "Psychotropic Management", revised 7/22, was provided by the DON on 1/10/24 at 11:08 a.m. The policy indicated the following, "...to ensure that a resident's psychotropic medication regimen helps promote the resident's highest practicable mental, physical and psychosocial well-being with person centered intervention and assessment. These medications are managed in collaboration with professional services and facility staff to include non pharmacological interventions, assessment and reduction as applicable...Procedure...1. Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition as diagnosed, and this is documented in the medical record. Each resident receiving psychotropic medication will have an adequate indication for use and supporting diagnosis for use which is documented in the clinical record...4. For antipsychotic medications, diagnoses alone do not necessarily warrant the use these medications. Antipsychotic medications may be indicated if...a. behavioral symptoms present a danger to the resident or others...b. expressions or indications of distress that are significant distress to the resident...c. Non-pharmacological approaches have been attempted, but did not relieve the symptoms which are presenting a danger or significant distress...d. GDR was attempted but symptoms returned...6. Psychotropic medications may be considered regularly for potential GDR including during monthly pharmacy reviews, during behavioral health services visits, and when the IDT is evaluating behavioral expressions. The frequency			

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	and schedule of GDRs will meet current standards of practice and be based on person centered risk factors and underlying conditions...." 3.1-48(a)(4) 3.1-48(a)(5) 3.1-48(a)(6) 3.1-48(b)(2)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure medications	F 0761	F761 (E) med storage What corrective action(s) will be	02/29/2024

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	stored in the facility's medication carts were not expired and/or had current orders for their use and/or were labeled with an opened date; a medication lock box was permanently affixed for narcotics in the medication fridge; and a medication cart remained locked during medication administration for 3 of 6 medication carts and 1 of 2 medication rooms reviewed within the facility. (Facility) Findings include: A review of the facility's medication storage rooms and medication carts was conducted on 1/9/24. The following was observed: 1. On the 100 hallway with LPN (Licensed Practical Nurse) 26 at 2:37 p.m., the medication cart contained an albuterol sulfate inhaler for Resident 19 with an expiration date of 4/28/23. 2. a. On the Auguste's Cottage hallway with LPN 30 at 2:48 p.m., the medication cart contained a bottle of Zyprexa (an anti-psychotic medication) labeled for Resident 103. The clinical record for Resident 103 was reviewed for current physician's orders on 1/10/24 at 9:28 a.m. Resident 103 did not have a current order for Zyprexa. Resident 103's physician's order for Zyprexa was discontinued on 11/28/23. b. An opened vial of haloperidol lactate (an anti-psychotic medication) labeled for Resident G did not have an opened date on the vial. The clinical record for Resident G was reviewed for current physician's orders on 1/10/24 at 9:38 a.m. Resident G did not have a current order for haloperidol lactate. Resident G's physician's order		accomplished for those residents found to have been affected by the deficient practice? Medication cart was immediately audited and corrected by unit manager ·100/200/300/400 medication room metal box is permanently affixed. ·All licensed nurses and QMAs educated on medication storage policy on or before February 29, 2024 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice ·DNS/Designee will conduct an in-service with all Licensed nurses and QMAs on medication storage policy ·All medication carts were inspected to ensure medications were stored appropriately and	

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	for haloperidol lactate was discontinued on 3/14/23. c. An opened bottle of Ofloxacin (an antibiotic) eye solution labeled for Resident 30 did not have an opened date on the bottle. The clinical record for Resident 30 was reviewed for current physician's orders on 1/10/24 at 9:38 a.m. Resident 30 did not have a current order for Ofloxacin. Resident 30's physician's order for Ofloxacin was discontinued on 12/20/23. c. An opened bottle of brimonidine tartrate (used to treat glaucoma or high pressure in eyes) eye drops did not have a resident label affixed nor did it contain an opened date. d. An opened bottle of dorzolamide-timolol (used to treat glaucoma or high pressure in eyes) eye drops labeled for Resident 24 did not have an opened date on the bottle. e. An opened bottle of valproic acid (an anti-convulsant) labeled for Resident 49 did not have an opened date on the bottle. 3. The 100/200/300/400 hallway medication room's fridge contained a metal lock box which was not permanently affixed. 4. On the 700 hallway with UM (Unit Manager) 27 at 3:42 p.m., the medication cart contained an opened bottle of Milk of Magnesia without an opened date. 5. During a medication administration observation conducted on 1/9/24 at 9:44 a.m., it was observed that LPN 31 when administering a medication to Resident 45 had left her medication cart unlocked		labeled appropriately. Medication fridges were inspected to ensure medication lock boxes were permanently affixed for narcotics. ·Medication carts were reviewed to ensure carts are locked when not in immediate use. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? DNS/Designee will conduct an in-service with all Licensed nurses and QMAs on medication storage policy on or before February 29, 2024.¿ ·A daily rounding tool including medication storage to be utilized by DNS/designee to ensure medications are appropriately labeled and medication carts locked when not in use. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	

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	and unsupervised. Resident 45 had stopped LPN 31 in the 400 hallway to request a prn (as needed) pain medication. As the resident went back to her room, LPN 31 wheeled the medication cart down the hallway and parked it across the hallway and slightly to over from Resident 45's room. LPN 31 prepped the medication, entered Resident 45's room and administered the medication but, LPN 31 had left her medication cart unlocked when she entered the resident's room. LPN 31 had her back to the resident's doorway and was out of sight of the medication cart. While she was in the resident's room, an unknown visitor was in the hallway. An interview with LPN 31 immediately following the observation indicated, she thought she had locked the cart. A Storage and Expiration Dating of Medications, Biologicals policy received on 1/9/24 at 4:05 p.m. from DON (Director of Nursing) indicated, "Procedure...General Storage Procedures...3.1.1 Store all drugs and biologicals in locked compartments, including the storage of Schedule II-V medications in separately locked, permanently affixed compartments permitting only authorized personnel to have access...4. Facility should ensure that medication and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier...5. Once any medication or biological package is opened...Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler) when the medication has a shortened expiration date once opened...If a		POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year 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	

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	multi-dose vial of an injectable medication has been opened or accessed...the vial should be dated and discarded within 28 days..." 3.1-25(n) 3.1-25(o)			
F 0814 SS=C Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure trash was contained in receptacles for 124 of 124 residents in the facility Findings include: An environmental tour of the facility was conducted with the Maintenance Supervisor and the Administrator on 1/9/24 at 2:00 p.m. During the tour, the outside dumpster area was observed. There were 2 large dumpsters with top lids, one rolling trash receptacle with no lid, and one round gray trash receptacle with no lid. One of the top lids to one of the dumpsters was open. The rolling trash bin had bags of trash inside, rainwater, leaves, and unbagged trash, easily visible, and uncontained as there was no lid, cover, door, or other method for containing the trash inside of the receptacle. The round gray trash receptacle was full of trash, rainwater, and leaves, easily visible, and uncontained as there was no lid or other method for containing the trash inside of the receptacle. There was a significant amount of trash on the ground outside of the dumpsters including a shoe, green latex gloves, and plastic cups.	F 0814	p paraid="524599411" paraeid="{4f3778f5-9686-445e-9c98-aa8aac37b3a1}{4}" >¿¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?¿¿ 2 round gray trash receptacles have been disposed of. ·lid of was immediately addressed and closed. ¿ p paraid="602744956" paraeid="{4f3778f5-9686-445e-9c98-aa8aac37b3a1}{31}" >How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?¿¿ All residents have the potential to be affected by the alleged	02/29/2024

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	During the above observation, an interview was conducted with the Maintenance Supervisor. He indicated the rolling trash receptacle had broken wheels. Dietary staff kept throwing trash inside of the rolling receptacle, instead of opening the lid to one of the dumpsters and throwing the trash in there. The maintenance staff would then remove the trash from the rolling receptacle and throw it into one of the dumpsters. He hadn't been outside to empty the rolling receptacle for 2 weeks. He indicated it was the same situation with the round gray trash receptacle. He hadn't thought about throwing away the rolling trash receptacle and the round gray trash receptacle shouldn't be outside. The 2022 FDA (Food and Drug Administration) Food Code Guidelines regarding Areas, Enclosures, and Receptacles, Good Repair, Covering Receptacles, and Maintaining Refuse Areas and Enclosures was provided by the DON (Director of Nursing) on 1/10/24 at 2:55 p.m. It read, "Proper storage and disposal of garbage and refuse are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage or breeding place for insects and rodents...Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents." 3.1-21(i)(5)		deficiency¿ ·2 round gray trash receptacles have been disposed of and lid of dumpster was immediately addressed and closed. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur?¿ All staff will be educated on proper disposal of garbage and refuse along with notification of repairs needed to garbage receptacles on or before February 29, 2024.¿ ·POC Rounding Tool to be utilized daily by DNS/designee to include auditing dumpster area. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?¿¿ POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director¿	

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			·If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance¿	
F 0849 SS=D Bldg. 00	483.70(o)(1)-(4) Hospice Services §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for			

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	determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable			

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	medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the			

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	resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each			

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	patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. Based on observation, interview, and record review, the facility failed to timely notify hospice of a resident's falls for 1 of 1 resident reviewed for hospice. (Resident F) Findings include: The clinical record for Resident F was reviewed on 1/3/24 at 2:30 p.m. His diagnoses included, but were not limited to, dementia and hypertension. The physician's orders indicated he was admitted to hospice services, starting 3/10/23. An observation of Resident F was made on 1/3/24 at 2:32 p.m. He was sitting in his Broda chair in his room. A home health aide from his hospice company was present in the room with him. The hospice care plan, last revised 10/26/23, indicated an intervention was to notify hospice as needed.	F 0849	p role="heading" aria-level="1" paraid="2064458367" paraeid="{4f3778f5-9686-445e-9c98-aa8aac37b3a1}{123}" >F849 -Hospice What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident F's hospice provider has been notified of the falls. Clinical staff have been educated on timely notification. Care plan meeting with hospice provider on 1\26\24 to review Resident F's plan of care. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action	02/29/2024

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	The 9/9/23 fall event indicated he had an unwitnessed fall in the hallway in front of the dining area. He was found lying on his right side. The physician and resident representative were notified of the fall. It did not indicate hospice was notified of this fall. The 9/12/23 fall event indicated he had a witnessed fall trying to stand up in front of the nurse's station. The physician and resident representative were notified of the fall. It did not indicate hospice was notified of this fall. The 9/15/23 email between Hospice RN 13 and Family Member 12 indicated on 9/14/23, the previous social worker at the facility informed Hospice RN 13 during his 9/14/23 visit that Resident F had fallen twice, once on 9/9/23 and again on 9/12/23. Hospice RN 13 was surprised and informed the social worker that hospice had not been contacted for either fall. The social worker informed Hospice RN 13 that "we obviously should have, and was not sure who was working, but they had both happened in the evening, and regardless of time or staff, we should be notified every time." Hospice RN 13 would not have known about these falls had the social worker not told him, or if he hadn't noticed the large hematoma on the right side of Resident F's forehead. The social worker referenced in the 9/15/23 email no longer worked at the facility and was unavailable for interview. The 11/28/23 fall event indicated Resident F had a witnessed fall trying to stand up in front of the nurse's station. The physician and resident representative were notified of the fall. It did not indicate hospice was notified of this fall.		will be taken? ·All clinical staff re-educated on timely notification to hospice provider on or before February 29, 2024. ·A daily rounding tool reviewing timely notification to hospice provider to be utilized by DNS\Designee. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur? All clinical staff re-educated on timely notification to hospice providers on or before February 29, 2024. ul class="BulletListStyle1 SCXW237508125 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" A daily rounding tool reviewing hospice patients and timely notification to be utilized by DNS\Designee	

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	The 11/30/23 email between Hospice RN 13 and Family Member 12 indicated Hospice RN 13 was informed by staff during his visit on 11/30/23 that Resident F had a fall on 11/28/23 in front of the nurse's station and he did not recall being notified of this fall. An interview was conducted with Hospice RN (Registered Nurse) 13 on 1/8/24 at 1:43 p.m. He indicated he began working with Resident F earlier last year, 2023. Hospice was not notified of Resident F's 9/9/23, 9/12/23, and 11/28/23 falls. He'd discussed needing to be notified "a number of times" and it was brought up in a couple of his care plan meetings. The facility should notify hospice of each fall immediately, whether there was injury or not. An interview was conducted with the MCSS (Memory Care Support Specialist) on 1/10/24 at 10:39 a.m. She indicated for the most part, communication with hospice went through her. Nursing would be responsible for notifying hospice of any falls, because they could happen on any shift, when she's not there. Hospice should have been notified of his 9/9/23, 9/12/23, and 11/28/23 falls. She began working at the facility at the end of October, 2023 and hadn't yet had a care plan meeting with hospice, so any care plan discussions regarding his falls occurred prior to her working at the facility. The Hospice policy was provided by the DON (Director of Nursing) on 1/3/24 at 2:08 p.m. It read, "The Social Services Director or designee will act as the Hospice Coordinator which will be responsible for the following functions: a. Collaborating with hospice representatives and coordinating facility staff participation in the		How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year 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	

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	hospice care planning process for those residents receiving these services. b. Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family." This citation relates to Complaint IN00425026.			
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:			

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	(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. §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			

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	its IPCP and update their program, as necessary. Based on observation, interview and record review, the facility failed to maintain infection control by not ensuring gloves were changed and hand hygiene was completed appropriately during incontinent care, while assisting residents to eat, and while passing medications for 1 of 12 residents reviewed for ADL care, 3 of 5 residents randomly observed during medication pass, 3 residents randomly observed for 1 of 1 dinning observations. (Residents' 8, 10, 22, 80, 108, 111 and R). Findings include: 1. A dining observation of the rotunda dining room was conducted on 1/6/24 at 1:03 p.m. The following was observed: Resident 10 was seated at a table by herself with her lunch meal in front of her while Residents 111 and 8 were seating at another table together with their meal in front of them. All three residents required assistance with dining QMA (Qualified Medication Assistant) 2 was attempting to assist all three residents with their meals. She was standing while she would give a spoonful of food to Resident 8, then Resident 111 and then to Resident 10 without performing hand hygiene in between the residents. QMA 2 was observed touching the rims of Residents 8 and 111's cups when assisting them when drinking. When asked if Resident 111's drinks were of nectar thick consistency, she indicated, she was unsure because "they were from the 400 hall and she didn't know them". Resident 111's meal ticket was unable to be located at that time. Eventually, CNA (Certified Nursing Assistant) 7	F 0880	p paraid="1136315470" paraeid="{4f3778f5-9686-445e-9c98-aa8aac37b3a1}{242}" >¿ What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;¿¿ Residents 8,10,22,80,108, 111, and R showed no negative impact from the alleged deficient practice. ·An in-service will be completed on or before February 29, by IP/designee for all staff using Standard and Transmission Based Precautions and Hand Hygiene Policy¿ 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;¿ ¿¿¿ ·An in-service will be completed on or before February 29, by IP/designee for all staff using	02/29/2024

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	entered the dining area and sat down next to Resident 111 to assist him with eating his lunch. She did not perform hand hygiene prior to assisting him with his meal. While in the middle of assisting Resident 111 with his lunch, she was approached by another staff member, got up, and left Resident 111 at the table with QMA 2 and Resident 8. QMA 2 then went back to assisting both residents with eating without performing hand hygiene between residents. 2. a. An observation of LPN 32 administering medications was conducted on 1/9/24 at 9:07 a.m. LPN 32 had not performed hand hygiene prior to prepping a medication for Resident 108. When getting a plastic medication cup to place the medication into, she placed her long fingernail and finger inside of the medication cup and pinched the cup between her finger and thumb then proceeded to walk into Resident 108's room and hand the medication cup to the resident with her finger/fingernail still inside the cup. LPN 32 did not perform hand hygiene upon leaving Resident 108's room. b. An observation of LPN 32 prepping Resident 80's medications was conducted on 1/9/24 at 9:09 a.m. LPN 32 had not performed hand hygiene prior to prepping his medications. When getting a plastic medication cup to place the medication into, she placed her long fingernail and finger inside of the medication cup and pinched the cup between her finger and thumb. After administering the medications to Resident 80, she did not perform hand hygiene upon leaving Resident 80's room. c. An observation of LPN 31 prepping medications for Resident 22 was conducted on 1/9/24 at 9:26 a.m. LPN 31 had not performed hand		Standard and Transmission Based Precautions and Hand Hygiene Policy¿ ¿ 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 February 29, by IP/designee for all staff using Standard and Transmission Based Precautions and Hand Hygiene Policy¿ ·IP/designee will complete 30 observations per week of hand hygiene and PPE use using the PPE and Hand Hygiene 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	

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	hygiene prior to prepping the medications. After placing the medications into a plastic medication cup, she placed her thumb inside the cup and pinched it between her thumb and index finger. Once in the resident's room, she donned a pair of gloves without performing hand hygiene prior and after doffing the gloves and leaving the resident's room, LPN 31 did not perform hand hygiene. A hand Hygiene policy received on 1/9/24 at 9:01 a.m. from ED (Executive Director) indicated, the facility "will follow the Centers for Disease and Prevention (CDC) guidelines for the standards of hand hygiene...Procedure: Healthcare personnel should use and alcohol -based hand rub or wash with soap and water for the following clinical indications: * Immediately before touching a resident... * After touching a resident or the resident's immediate environment * After contact with blood, body fluids, or contaminated surfaces (e. g. touching front of facemask, nose, mouth, hair, overbed table, call light) * Immediately after glove or PPE [sic, personal protection equipment] removal... Indication for Hand-rubbing but not limited to... * Before the starting a medication preparation... * After touching self or clothing during meal service."3. The clinical record for Resident R was reviewed on 1/4/23 at 2:30 p.m. The Resident's diagnosis included, but were not limited to, chronic kidney disease and heart failure. On 1/06/24 at 1:13 p.m., Resident R was observed receiving incontinent care from CNA (Certified Nursing Assistant) 24. CNA 24 opened 2 clear plastic bags and placed them on the floor. She obtained a basin with warm water and placed it on Resident R's bedside table and donned disposable		put into place; and by what date the systemic changes for each deficiency will be completed¿ ¿ ul class="BulletListStyle1 SCXW89048470 BCX0" role="list" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; font-family: verdana;" IP/designee will review hand hygiene and PPE observation tools.¿ The POC QAPI Tool will be utilized by ED/designee weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year 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	

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	gloves. CNA 24 removed Resident R's sweatpants and opened 2 incontinent briefs. She cleansed Resident R's peri area with body wash and a washcloth and dried the area with a towel. She then assisted him to turn on his side. She cleansed his buttocks, removing stool. CNA 24 then placed the soiled washcloth into one of the bags on the floor and obtained a new washcloth from a bag of linen in the room. She did change her gloves or perform hand hygiene prior to obtaining the new washcloth. She wiped Resident R's buttocks with the clean washcloth and dried the area with a towel, placing the washcloth and towel into the bag on the floor and removed both briefs, putting them into the 2nd bag on the floor. CNA 24 then placed a new incontinent brief on Resident R and pulled up his sweatpants. Resident R requested that his shirt be changed, and CNA 24 assisted him in removing his shirt and placing a new shirt on and then adjusted his bed with his bed remote. CNA 24 then emptied the basin of water and put it away, gathered the bags from the floor and left the room. CNA 24 continued to wear the disposable gloves she had donned prior to starting peri care for all care and tasks completed in the room and left the room wearing the disposable gloves. During an interview on 1/6/24 at 1:45 p.m. CNA 24 indicated she should have changed her gloves and done hand hygiene after cleansing Resident R's buttocks. This citation relates to complaint IN00422553 and IN00420608. 3.1-18(b)(1) 3.1-18(l)			

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaints IN00422553, IN00425026 and IN00420608. Survey dates: January 3, 4, 5, 6, 8, 9, 10, 2024 Facility number: 000189 Residential Census: 37 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 17, 2023	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure survey on January 10, 2024. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0155 Bldg. 00	410 IAC 16.2-5-1.5(l) Sanitation and Safety Standards - Deficiency (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation, interview, and record review, the facility failed to ensure trash was contained in receptacles for 37 of 37 residents in the facility.	R 0155	What corrective action(s) will be accomplished for those residents found to have been affected by the	02/29/2024

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	Findings include: An environmental tour of the facility was conducted with the Maintenance Supervisor and the Administrator on 1/9/24 at 2:00 p.m. During the tour, the outside dumpster area was observed. There were 2 large dumpsters with top lids, one rolling trash receptacle with no lid, and one round gray trash receptacle with no lid. One of the top lids to one of the dumpsters was open. The rolling trash bin had bags of trash, rainwater, leaves, and unbagged trash inside, easily visible, and uncontained as there was no lid, cover, door, or other method for containing the trash inside of the receptacle. The round gray trash receptacle was full of trash, rainwater, and leaves, easily visible, and uncontained as there was no lid or other method for containing the trash inside of this receptacle either. There was a significant amount of trash on the ground outside of the dumpsters including a shoe, green latex gloves, and plastic cups. During the above observation, an interview was conducted with the Maintenance Supervisor. He indicated the rolling trash receptacle had broken wheels. Dietary staff kept throwing trash inside of the rolling receptacle, instead of opening the lid to one of the dumpsters and throwing the trash in there. The maintenance staff would then remove the trash from the rolling receptacle and throw it into one of the dumpsters. He hadn't been outside to empty the rolling receptacle for 2 weeks. He indicated it was the same situation with the round gray trash receptacle. He hadn't thought about throwing away the rolling trash receptacle with broken wheels and the round gray trash receptacle shouldn't be outside.		deficient practice?¿¿ 2 round gray trash receptacles have been disposed of. ·lid of was immediately addressed and closed. ¿ How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?¿¿ All residents have the potential to be affected by the alleged deficiency¿ ·2 round gray trash receptacles have been disposed of and lid of dumpster was immediately addressed and closed. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur?¿ All staff will be educated on proper disposal of garbage and refuse along with notification of repairs needed to garbage receptacles.¿ ·POC Rounding Tool be utilized daily DNS/designee and will	

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	The 2022 FDA (Food and Drug Administration) Food Code Guidelines regarding Areas, Enclosures, and Receptacles, Good Repair, Covering Receptacles, and Maintaining Refuse Areas and Enclosures was provided by the DON (Director of Nursing) on 1/10/24 at 2:55 p.m. It read, "Proper storage and disposal of garbage and refuse are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage or breeding place for insects and rodents...Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents."		include auditing dumpster area. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?¿¿ POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year 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¿	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to properly store food in the refrigerator and ensure staff were knowledgeable about the function of the dishwasher for 37 of 37 residents in the facility. Findings include:	R 0273	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?¿¿ 2 containers of chicken base and	02/29/2024

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	A tour of the kitchen and interview was conducted with the DM (Dietary Manager) on 1/3/24 at 12:20 p.m. During the tour, an observation of the preparation refrigerator was made. There were containers of chicken base and beef base with food remnants on the outside of the containers. The DM indicated the containers should be wiped off prior to putting them back into the refrigerator. During the tour, an observation of the dishwasher was made. The DM ran a cycle for demonstration. A red warning light on the front of the dishwasher was flashing during the cycle, indicating there was no detergent or detergent was disabled. Upon observation of the pail of detergent, underneath and to the right of the dishwasher, there was no detergent flowing through the line from the pail of detergent feeding into the dishwasher. The DM removed and adjusted the line from the detergent. She ran another demonstration cycle afterwards. The red warning light was no longer flashing. An interview was conducted with Cook 19, the only dietary staff member present in the kitchen, during the above observation. She indicated she was the only one working in the kitchen today and used the dishwasher earlier this morning. She was unsure if the red warning light was flashing or whether there was detergent flowing through the line. The Food Storage policy was provided by the ED (Executive Director) on 1/10/24 at 3:55 p.m. It read, "Refrigeration: ...All foods should be covered or wrapped tightly, labeled and dated." The Cleaning Dishes and Dish Machine policy		beef base with food remnants on the outside were immediately wiped off. ·The dishwasher detergent feeding system was immediately adjusted and in working order. ¿ How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?¿¿ All residents have the potential to be affected by the alleged deficiency¿ ·2 food containers were immediately addressed and wiped off ·The dishwasher detergent feeding system was immediately adjusted and in working order. What measures will be put into place or what systemic changes make to ensure that the deficient practice does not recur?¿ All kitchen staff will be educated on dishwasher detergent system and ensuring there no remnants on food containers in	

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	was provided by the ED on 1/10/24 at 3:55 p.m. It read, "Make sure detergent and sanitizer dispensers are properly loaded....Some common problems can be solved easily by changing procedures or chemicals."		refrigerator.¿ ·POC Rounding Tool to be utilized by DNS/Designee daily and will include auditing dumpster area. How be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?¿¿ POC QAPI Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter for one year 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¿	