STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155211	A. BUILDING 00 B. WING	07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF LEBANON, THE	1585 PERRY WORTH RD LEBANON, IN 46052

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00410168 and IN00412867. Complaint IN00410168 - No deficiencies related to the allegations are cited. Complain IN00412867 - Federal/State deficiencies related to the allegations are cited at F921. Survey dates: July 10, 11, 12, 13 and 14, 2023. Facility number: 000118 Provider number: 155211 AIM number: 100290470 Census Bed Type: SNF/NF: 43 Total: 43 Census Payor Type: Medicare: 2 Medicaid: 30 Other: 11 Total: 43 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 27, 2023.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance **is August, 22, 2023.** This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of credible Allegation of Compliance and **requests a desk review in lieu of a revisit.**	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric Emerson	Administrator	08/13/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.			

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	Based on interview and record review, the facility failed to ensure a resident's choice of code status was documented consistently in the medical record and the physician and staff were aware of the resident's choice for 1 of 2 residents reviewed for code status (Resident 196). Findings include: During a record review for Resident 196, on 7/11/23 at 11:16 a.m., the resident record lacked documentation for code status preferences available in a publicly accessible area. Resident 196's record was reviewed on 7/11/23 at 1:18 p.m. Resident 196 was admitted on 7/1/23 with diagnoses to include, but were not limited to, pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), and clostridium difficile [c-diff] (inflammation of the colon caused by bacteria that disrupt normal bacteria in the colon, often from antibiotic use, highly contagious, can cause severe damage to the colon, and even be fatal). Discharge Instructions from a local hospital, dated 7/1/23, indicated no documentation of the resident's code status orders. Review of Resident 196's record indicated there was no Indiana Physician Orders for Scope of Treatment (POST) form present for designation of the resident's preferences of attempt cardiopulmonary resuscitation (CPR) or full code, or do not attempt resuscitation/DNR indicating no code. A face sheet for Resident 196 lacked documentation of code status.	F 0578	F578 t is the intent of this facility to ensure residents choice of code status. 1.IWhat corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #196's code status was updated at the time of survey. Resident no longer resides in the facility. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents have the potential to be affected; therefore, this plan of correction applies to residents currently residing in the facility. A facility-wide audit was conducted to validate presence of code status documentation with any necessary corrections made at the time of the audit Facility wide audit conducted on 7/18/23 by DON. 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?	08/22/2023

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	Physician's orders, dated 7/1/23 - 7/11/23, lacked documentation of physician's orders for code status preferences. Interdisciplinary progress notes, dated 7/1/23 - 7/11/23, lacked documentation a discussion was had with the resident or resident representative regarding code status preferences. A care plan for Resident 196, dated 7/4/23, the SSD documented the resident was a full code. The goal was the resident's wishes related to her advanced directives to be honored. The intervention was to follow full code protocol. During an interview on 7/11/23 at 3:20 p.m., Licensed Practical Nurse (LPN) 16 indicated resident information regarding code status was supposed to be documented in the electronic medical record (EMR), staff no longer had access to hard charts containing resident information on the unit. Review of Resident 196's EMR with LPN 16 to include scanned hospital discharge orders, an admission profile, current physician's orders, resident face sheet, indicated no documentation regarding a code status. There was also no POST form observed. LPN 16 indicated, if code status information was not available, she would treat the resident as a full code. During an interview on 7/11/23 at 3:26 p.m., the Social Service Director (SSD) indicated she had no record of the resident's code status, it was possibly in the medical records Qualified Medication Aide's (QMA's) 17 office ready to be scanned. Medical Record QMA 17 was not available in her office, and no code status paperwork was not found on her desk. SSD then went to the Director of Nursing's (DON's) office, where a POST form for Resident 196 was found		SSD was re-educated by the Director of Nursing on request/refuse/discontinue treatment/formulate advanced directives, including but not limited to, ensuring residents have specified a code status upon admission. Audit completed on 7/19/23 and SSD educated by facility DON. Additionally, any staff that fails to comply with the points of this in-service will be further educated/or disciplined as indicated. DON/Designee will conduct an audit of all new admissions at least 5 X a week times 4 weeks, then weekly X 4 weeks, then 2 X monthly X 4 months to ensure code status has been specified. Any identified concerns will be promptly addressed with the responsible individual(s). Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or disciplined as indicated. 1.How will the corrective action(s) will be monitored? DON/Designee will provide results of these audits to be reviewed in QAPI Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved	

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	under a stack of paperwork on her desk. The POST form indicated it was prepared on 7/1/23 and signed by the physician on 7/10/23, indicated attempt CPR, full code status. During an interview on 7/14/23 at 9:39 a.m., the DON indicated the resident's code status should have come with the resident's orders from the hospital. If not, as soon as possible the resident should have been asked or the resident representative contacted to get the preference on her code status. The facility process was to get information of resident code status from the POST form, have the physician and resident or representative sign and date, and it was then entered into the EMR. Usually, the nurse or SSD gathered code status information upon admission. When the code status was entered into the EMR as an order, it would appear on the face sheet for nursing staff to access. The POST form was to be scanned into the EMR and could be found under the documents tab. If no code status was available, the resident would automatically be considered a full code. The DON acknowledged this was not best practices as a resident could have CPR administered against their wishes. The DON indicated, Resident 196's code status care plan had been put into the EMR by the SSD on 7/4/23, not sure where she got her information to put in the care plan but would ask. On 7/14/23 at 12:30 p.m., the Regional Nurse Consultant (RNC) provided the Advance Directives Policy and Procedure, dated 1/1/17, and indicated the policy was the one currently being used by the facility. The policy indicated, " ...The facility provides to all residents the right to accept or refuse medical and surgical treatment, and at the resident's option, formulate an advance directive ...Determine upon admission whether the		x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 1.Completion date: August 22, 2023	

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	resident/legal representative has an advanced directive and if not, determine whether the resident/legal representative wishes to formulate an advanced directive ...1. Upon admission, the facility will provide written information to the resident/legal representative concerning the resident's rights to make decisions regarding medical care including the right to accept/refuse medical treatment and the right to formulate advanced directives. 2. Upon admission, the facility must determine if the resident executed an advanced directive or has given other instructions to indicated what care is desired in case of subsequent incapacity ...3. If the resident/resident legal representative has executed one or more advance directives [or executed one upon admission], copies will be obtained and incorporated in the resident medical record...." 3.1-4(f)(5)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other			

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	officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview, and record review, the facility failed to ensure an unusual occurrence that directly affected the wellbeing and health of a resident (Resident 32) was reported to the State Department of Health. This deficient practice had the potential to effect 1 of 3 residents reviewed for accident. Findings include: On 7/10/23 at 11:24 a.m., Resident 32 was observed in her room. She was seated in a regular wheelchair (WC). She had poor posture and was hunched forward, unable to lift her head all the way. She indicated, on 5/5/23, she was in the main dining room when she all of the sudden didn't "feel right" and she started to choke. She did not remember anything else because she lost consciousness and was told later, staff had to perform cardiopulmonary resuscitation (CPR). During an interview on 7/14/23 at 9:22 a.m., Resident 32's husband indicated he had been notified of Resident 32's choking incident. Apparently, she had choked on a piece of chicken during lunch. No one was sure if her choking	F 0609	F609 It is the intent of this facility to report allegations of abuse, neglect, exploitation, or mistreatment. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The incident with Resident #32 has been reported to ISDH via the Gateway. Incident reported on 8/13/23 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents have the potential to be affected by not reporting unusual occurrences; therefore, this plan of correction applies to	08/22/2023

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	caused her cardiac arrest, or if a cardiac arrest caused her to choke. Either way, she became unresponsive, and the staff had to perform CPR. On 7/13/23 at 1:45 p.m., Resident 32's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, spinal stenosis (A narrowing of the spinal canal), idiopathic peripheral autonomic neuropathy (occurs when there is damage to the nerves that control automatic body functions) and weakness. A nursing progress note dated 5/5/23 at 1:30 p.m., indicated, Resident 32 indicated, "I'm not ok and need air." She became unresponsive and CPR was initiated. 911 was contacted. The resident's husband was notified. CPR was continued until emergency medical staff (EMS) arrived and took over the scene. EMS transported the resident to the hospital. During an interview on 7/14/23 at 9:44 a.m., the Activity Director (AD) indicated, she was seated at the table with Resident 32 when she noticed, she "looked kind of funny." The AC asked if she was O.K., and at first Resident 32 said, "yes," but then said, "no, I'm not O.K, I need air." The AC immediately signaled to the Director of Nursing (a previous nurse who was no longer at the facility) to come and assist. The AD indicated it looked like Resident 32 choked, but the nurses moved her immediately to take care of her. The AD indicated Resident 32 "didn't look so good on her way out, she was a shade of purple I had never seen." During an interview on 7/14/23 at 10:00 a.m., the current facility Director of Nursing (DON) indicated, she was not sure if the incident had been reported, but she would check.		all residents. All incidents that have occurred within the last 60 days have been reviewed by administrator and DON on 7/20/23. All incidents meeting guidelines for incident reporting have been submitted via Gateway. 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ED was re-educated by the Regional Director of Operations (RDO) on Reporting of Alleged Violations, including but not limited to, reporting unusual occurrences that directly affect the wellbeing and health of a resident on 7/20/23. Additionally any staff that fails to comply with the points of this in-service will be further educated/or disciplined as indicated. The ED/Designee will review all occurrences with IDT, daily, on scheduled days of work, ongoing, to determine if considered an unusual occurrence and will submit reportable unusual occurrences via the Gateway, when necessary. The ED/Designee will perform an audit of incidents that occur in the	

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	During a follow up interview on 7/14/23 at 10:45 a.m., the DON indicated the incident had not been reported at the time. In review of the progress notes and investigation, the DON indicated it was an incident that should have been reported as a major accident. 3.1-28(c)		facility to ensure that incidents are reported to ISDH in accordance with facility policy and the Indiana Long-Term Care Abuse and Incident Reporting Policy. Audits will be performed weekly x 4 weeks, then bi-weekly x 4 weeks, then monthly x 4 months. 1.How will the corrective action(s) will be monitored? ED/Designee will provide results of these audits to be reviewed in QAPI Meeting x 6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 1.Completion date: August 22, 2023	
F 0644 SS=A Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II			

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	determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to acquire a new Level 1 Pre-admission Screening and Resident Review (PASARR) after a resident received a new diagnosis for 1 of 4 residents reviewed for Level II outcomes (Resident 12). Findings include: On 7/14/23 at 9:02 a.m., Resident 12's record was reviewed. She was admitted on 5/10/18. Her diagnoses included, but were not limited to: a. She was diagnosed with recurrent major depressive disorder on 6/21/18. b. She was diagnosed with psychotic disorder, schizoaffective and bipolar disorder, with delusion on 5/12/20. c. She was diagnosed with anxiety disorder on 7/13/21. A Notice of PASRR Level I Screen Outcome, dated 5/7/18, was provided by the Regional MDS, on 7/11/23 at 1:34 p.m. It indicated Resident 12 had no serious mental illness and no Level II was required. If changes occurred or new information refuted these findings, a new screen must be submitted. It indicated she had suspected depression.	F 0644	NA	08/22/2023

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	On 7/14/23 at 9:37 a.m., Resident 12's MDS (Minimum Data Set) was reviewed. It was titled, Modification of Annual, dated 2/14/22. Section A indicated she was not considered by the state Level II PASRR (Pre-admission Screening and Resident Review) to have a serious mental illness. This MDS indicated her active diagnoses were psychiatric/mood disorder, anxiety disorder, and depression. It indicated she did not have schizoaffective and bipolar disorder. A care plan, dated 3/13/23, indicated Resident 12 was at risk for increased anxiousness related to a diagnosis of anxiety with need for an anxiolytic (anxiety medication). An intervention was to provide the anxiolytic medication and psychiatrist visits per the physician's order. A care plan, dated 3/13/23, indicated Resident 12 was at risk for decline in mood related to a diagnosis of depression with need for antidepressant medication (depressant medication). A care plan, dated 4/11/23, indicated Resident 12 had a diagnoses of schizoaffective disorder, bipolar type. An intervention was to provide medications as ordered. On 7/11/23 at 11:27 a.m., the Regional MDS indicated Resident 12 did not have a Level II. She should have had a new Level I after the diagnosis of psychotic disorder, schizoaffective disorder and bipolar on 5/12/20. On 7/14/23 at 12:16 p.m., the Social Services Director (SSD) indicated Resident 12's new diagnoses were probably missed because the SSD wasn't at the facility any longer. In her absence, the facility had used a social services designee,			

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	then a Social Service Director. During a review of CMS's (Centers of Medicare and Medicaid) RAI (Resident Assessment Instrument) Version 3.0 Manual, dated October 2019, indicated, " ...the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information ...."			
F 0645 SS=A Bldg. 00	483.20(k)(1)-(3) PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a			

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	nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30			

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	days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. Based on interview and record review, the facility failed to ensure a Level I was completed prior to admission for 1 of 4 residents reviewed for Level 1 submissions (Resident 19). Findings include: On 7/11/23 at 1:46 p.m., Resident 19's record was reviewed. He was initially admitted to the facility on 3/25/19. His diagnoses included, but were not limited to, major depressive disorder. He was diagnosed with it on his initial admission. His most recent physician orders, dated 11/7/22, was to provide a Sertraline (antidepressant) tablet 50 mg, by mouth once daily for depression. A care plan, dated 4/13/23, indicated he had a diagnoses of depression and to administer his medications as ordered and refer to psychiatric services as needed. An admission assessment, dated 11/11/22, indicated Resident 19 was not considered by the state Level II PASRR (Pre-admission Screening and Resident Review) process to have serious mental illness.	F 0645	NA	08/22/2023

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	On 7/11/23 at 2:16 p.m., the Regional MDS Consultant indicated Resident 19 had no information for PASRR. He should have had a Level 1 on admission. On 7/14/23 at 1:02 p.m., the Social Services Director (SSD) indicated she would not request a Level I today. During a review of CMS's (Centers of Medicare and Medicaid) RAI (Resident Assessment Instrument) Version 3.0 Manual, dated October 2019, indicated, " ...the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information...."			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan,			

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	and the residents' choices. A. Based on record review and interview, the facility failed to ensure a resident received a complete neurological assessment after an unwitnessed fall for 1of 3 residents reviewed for accidents (Resident 30). B. Based on record review and interview the facility failed to ensure a resident with a history of seizures had follow up assessments and physician notification after having seizure activity for 1 of 2 residents reviewed for quality care with catheter use (Resident 45). Findings include: A. On 7/14/23 at 11:14 a.m., Resident 30's medical record was reviewed. She had diagnoses which included, but were not limited to, unspecified psychosis (a mental disorder characterized by disconnection from reality), COPD (chronic obstructive pulmonary disease) (a group of lung disorders that block airflow and make it difficult to breathe), essential hypertension (high blood pressure), osteoarthritis (the breakdown of joint cartilage and the underlying bone), insomnia (inability to sleep), schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations), heart disease, and weakness. Resident 30 had unwitnessed falls on the following dates: 1/19/23, 3/3/23, 3/6/23, 3/15/23, and 3/29/23. The record lacked documentation that neurological assessments had been completed for the falls on 1/19/23, 3/6/23, 3/15/23 and 3/29/23. During an interview on 7/13/23 at 2:10 p.m.,	F 0684	It is the intent of this facility to complete neurological checks on residents after falls that are unwitnessed and to complete an assessment on residents after seizure activity and notify the physician. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? A. Resident #30 remains in the facility. Resident has had no further occurrences. B. Resident #45 no longer resides in the facility; therefore, no further corrective action could be taken for this resident. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? An audit of resident's charts, including progress notes for the last 30 days, has been completed in an effort to identify any residents who have incurred falls or have had a potential change in condition and to ensure vital signs, neurologic checks, and physician notification have been completed and documented. DON/designee completed on 7/24/23	08/22/2023

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	Director of Nursing (DON) indicated she was unable to locate neurological assessments for Resident 30. She indicated she was not employed by the facility at the time of the noted falls. A policy was provided by the DON on 7/14/23 at 12:23 p.m. It indicated, " ...In the case of a fall, the resident will have a head-to-toe assessment to include a pain assessment and assessment as to any change in their ROM (range of motion) ability/function. Further, residents who have an unwitnessed fall must have neuro checks started and continued per policy. Neuro check will be initiated even if the resident indicates they did not hit their head in an unwitnessed fall ...." B. On 7/11/23 at 2:16 p.m., Resident 45's closed medical record was reviewed. She admitted to the facility with diagnoses which included, but were not limited to, deficiencies of B-group vitamins, Vitamin D deficiency, epilepsy, and neoplasm (cancer) of the bladder. Resident 45 had a comprehensive care plan initiated 1/17/23 which indicated she was at risk for seizures due to her diagnoses of Epilepsy and convulsions. Interventions for the plan of care included but were not limited to; notify MD and family with each seizure. A nursing progress note dated 1/26/23 at 5:33 p.m., indicated Resident 45 was observed "acting strange" and noted to be very confused. She had a full body seizure that lasted approximately 30 seconds. Resident 45 was "now" awake but continued with confusion and garbled speech. The record lacked documentation that the MD was notified of the seizure. The record lacked documentation that a full set of vital signs or neurochecks had been obtained.		1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses have been re-educated by the DON/Designee relative to Quality of Care, including but not limited to, neurologic check completion, when to obtain vital signs, and physician notification. Education initiated on 7/12/23 and completed on 8/11/23 Additionally, any staff that fails to comply with the points of the this in-service will be further educated/or disciplined as indicated. DON/Designee will review, daily 5 x a week, x 4 weeks, then 3 x a 4 weeks, weekly x 4 months for during clinical meeting, the progress notes to ensure that neurologic checks have been completed and documented and to ensure physician notification has been done and documented for residents that have had fall or resident with any seizure like activity. Any identified concerns will promptly be addressed with the responsible individual(s). 1.How will the corrective action(s) will be monitored?	

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	A nursing progress note dated 1/26/23 at 8:11 p.m., (2 hours and 38 minutes later) indicated, Resident 45 was resting quietly in her bed with no further signs/symptoms of seizure. The note still lacked documentation of physician notification. On 1/27/23 at 1:37 a.m., a change of condition event was initiated. The event note was created months late on 6/9/23 at 2:15 p.m., made effective for the morning of 1/27/23. The event note indicated, resident has unwitnessed grand mal seizure and unwitnessed fall while in bathroom. resident observed for injury, and none found at this time, resident unresponsive. 911 was called and she was sent to the hospital. The event note indicated, the nurse attempted to call the MD on-call, but got no answer and no return call, so they left a message via text on diganotes (a communication software system for text messaging communication between providers and facilities). Further, a current set of vital sings was not obtained or documented at the time of her second seizure. Recorded vitals from 1/21/23 were attached to the event note. A nursing progress note dated 1/27/23 at 2:05 a.m., indicated, staff had been notified by Resident 45's roommate that she was having a seizure in the bathroom. Resident 45 was found on the floor lying next to the toilet with her head resting on the toilet side, she had convulsions and was unresponsive. She was moved to her side and a pillow was put under her head. 911 was called and EMS transported her to the ER. A Hospital Summary dated 1/27/23 indicated, " ...per staff at the Waters after having witnessed seizure twice today. Tonight around 1:00 a.m. she was sitting on toilet when she had one and hit her		DON/Designee will be responsible to provide audit results in QAPI Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 6 consecutive months the auditing will be stopped. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 1.Completion date: August 22, 2023	

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	head on the wall. She was postictal [altered state of consciousness after an epileptic seizure] for longer than usual thus was sent in for evaluation ...found to have multiple electrolyte abnormalities including hypomagnesemia, hypocalcemia, hypokalemia ... she is pleasantly confused but, according to The Waters she is more oriented than this at baseline ..." Along with the electrolyte imbalance, she was also diagnosed with acute onset of recurrent seizures. During an interview on 7/12/23 at 9:57 a.m., LPN 14 indicated Resident 45 had a diagnosis of seizures, and although she never witnessed one, it was important to monitor her for a change of condition. If she were to have witnessed a seizure, she would immediately call for help and ensure the resident was placed safely on the floor on her side. She would immediately call the DON and on-call to get orders and instructions. If she could not reach anyone she would call 911. It would also be important to get a set of vital sings as soon as possible to have ready to give report to EMS when they got there. During an interview on 7/12/23 at 3:47 p.m., Licensed Practical Nurse (LPN) 16 indicated, she was working the night of Resident 45's first seizure. She entered the resident's room to deliver her dinner tray and noticed she was standing strange and didn't look right. She set the food tray down as Resident 45 began to seize. LPN 16 guided her into her bed so that she did not fall and turned her to her side until the seizure passed. LPN 16 indicated she did take vital signs which should have been recorded in weights/vitals. LPN 16 indicated she had also contacted the on-call but did not get any new orders, only to continue to monitor her. When she went back to check on Resident 45 later that evening, she wasn't awake			

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	or asleep, but still in a post-seizure state. She gave report to the oncoming nurse when she left so he could continue to monitor her as well. During an interview on 7/13/23 at 3:22 p.m., NP 34 indicated she had checked her call logs and text message system and did not have a record of notification related to Resident 45's seizure on 1/26/23. Although Resident 45 had several complicated medical issues, the UTI may not have necessarily caused the seizures, it was more likely that her electrolyte imbalanced caused the seizure. However, the on-call MD should have been notified immediately, and if they were unable to get an answer it would be appropriate to send her out 911 immediately, especially if her postictal state lasted longer than usual. On 7/13/23 at 11:36 a.m., the DON provided a copy of current but undated facility policy titled, "Change in Resident's Condition or Status." The policy indicated, "It is the policy of the facility to ensure that the resident's attending physician and Representative are notified of changes in the resident's condition or status ... the nurse will notify the resident's attending physician when: ... there is a significant change in the resident's physical, mental, or psychological status ...." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent			

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	pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide necessary treatments and services to promote the healing of a pressure ulcer for 1 of 3 residents reviewed for pressure ulcers (Resident 196). Findings include: On 7/11/23 at 10:44 a.m., Resident 196 was observed to be lying flat on her back in bed with the covers up to her chin. The resident was alert, talkative, and indicated her plan was to discharge to home when she was steadier and could ambulate independently again. On 7/13/23 at 9:30 a.m., Resident 196 was observed lying flat on her back in bed with the covers up to her chin. The resident's bottom with Licensed Practical Nurse (LPN) 14, resident indicated she had a sore that staff treated every day. During an observation the resident's entire buttocks was pink, dry, and had flaky skin. The coccyx/sacral area and surrounding tissue was open to air, no medication was observed. Two open areas approximately 1 centimeter (cm) circular, pink in color with white slough (dead tissue usually cream or yellow in color), were observed. There was no eschar (dry, black, hard necrotic tissue). Resident 196's record was reviewed on 7/11/23 at	F 0686	It is the intent of this facility to provide necessary treatments and services to promote wound healing of pressure ulcers. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #196 no longer resides in the facility; therefore, no further corrective action could be taken for this resident. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? Residents with altered skin integrity, or those at high risk of altered skin integrity have the potential to be affected by this practice. The medical records of the identified residents have been reviewed to ensure treatment orders are present, physician and families have been notified, as necessary, and appropriate interventions for prevention of	08/22/2023

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	1:18 p.m. Resident 196 was admitted on 7/1/23 with diagnoses to include, but were not limited to, pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), and clostridium difficile [c-diff] (inflammation of the colon caused by bacteria that disrupt normal bacteria in the colon, often from antibiotic use, highly contagious, can cause severe damage to the colon, and even be fatal), type 2 diabetes mellitus (chronic condition that affects the way the body processes blood sugar [glucose] either by not producing enough insulin, or by resisting insulin, atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and severe kidney failure (long lasting disease of the kidneys leading to renal failure and a build-up of excess waste and fluid from the blood). An admission Minimum Data Set (MDS) assessment, dated 7/6/23, assessed the resident as having the ability to make herself understood and to understand others. Brief Interview for Mental Status (BIMS) indicated the resident was cognitively intact. The resident required limited assistance of 1 person physical assist for bed mobility, walking in room, dressing, toilet use, and personal hygiene. Resident 196 was at risk for acquiring pressure ulcers, admitted with one stage II (partial thickness loss of skin presenting as a shallow open ulcer with a red, pink wound bed and no slough) pressure ulcer, not present upon entry. No skin tears were listed on MDS. Hospital Discharge Instructions, dated 7/1/23, indicated wound care consult for open stage II wound to coccyx (tail bone), peeling friction areas to gluteal cleft (buttocks crack) bilaterally. Skin tears times 2 on forearm, skin candidiasis (yeast infection) bilaterally upper medical thighs and perineal area.		alteration in skin integrity are documented. DON/Designee completed audit of all residents with current pressure wounds and treatments in place on 7/17/23. 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing staff have been re-educated by the DON/Designee relative to Treatment/Services to Prevent/Heal Pressure Ulcer, including but not limited to, ensuring residents with pressure ulcers receive the necessary treatment and services to promote healing, treatment orders are present, physician and families have been notified, as necessary, and appropriate interventions for prevention of alteration in skin integrity are documented. Staff in-service initiated on 8/9/23 and completed 8/11/23, Additionally, any staff that fails to comply with the points of this in-service will be further educated/of disciplined as indicated. DON/designee will conduct a random audit of at least 5 residents per week, for 4 weeks, with alterations in skin integrity to validate that treatments have been administered according to	

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	An admission/readmission assessment, dated 7/1/23, indicated wounds to include a pressure area on the coccyx measuring 1.0 centimeter (cm) by (x) 1.0 cm x 0.2 cm, 4 areas of bruising on right antecubital (arm in front of the elbow) and bilateral hands, and 2 skin tears on back of the left hand. A care plan, dated 7/1/23, indicated the resident had has actual impairment to skin integrity of the coccyx/gluteal cleft related to fragile skin and friction. The goal was for the resident's skin injury of the gluteal/coccyx to be healed by the next review. Interventions included but not limited to monitor/document location, size and treatment of skin injury, apply weekly treatment and documentation was to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Physician assessment, dated 7/3/23, indicated resident admitted post hospitalization. Diagnoses of cellulitis of right lower limb, skin normal turgor, warm and dry, no lesions or rashes, no redness or warmth bilateral lower extremities. A care plan, dated 7/3/23 indicated the resident had skin tears to left upper extremities upon admission. The goal was to resolve without complications. Interventions included but were not limited to notify the physician and family, observe for signs or symptoms of infection, and apply treatment as ordered. A care plan, dated 7/3/23, indicated the resident had a wound present to the coccyx upon admission. The goal was for the wound to decrease in size through the next review. Interventions included diet as ordered, pressure reducing mattress/cushion in chair, skin checks weekly and as needed, and treatment as ordered.		physician order, that physician and family notifications have been made and documented, and that appropriate interventions for prevention of alteration in skin integrity are documented. Thereafter, a random audit of at least 3 residents per week, for 4 weeks will be conducted to ensure continued compliance, and then random audits of at least 2 residents per week for 4 months. Any identified concerns will be promptly addressed with the responsible individual(s). 1.How will the corrective action(s) will be monitored? DON/Designee will be responsible to provide audit results in QAPI Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 6 consecutive months the auditing will be stopped. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 1.Completion date: August 22, 2023	

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A Nurse Practitioner (NP) 31 assessment, dated 7/5/23, indicated denies new rashes, bruising, or skin breakdown. Skin warm, dry, intact, with fair turgor, no new bruising or breakdown.

A Wound NP 35 visit note, dated 7/6/23, indicated a wound on the sacrum present upon admit. The plan was to apply triad paste to wound twice daily (BID) and as needed. Off load with pillows when supine (on the back face up). Original cause of wound was pressure injury. The date acquired 7/6/23. The wound was currently classified as an unstageable/unclassified wound (full thickness tissue loss in which the base of the ulcer is covered by slough and/ or eschar in the wound bed so the true depth cannot be determined). The wound measured 0.7 cm length x 0.5 cm width x 0.1 cm depth. There was a small amount of serous drainage noted. There was a large (67% - 100%) amount of necrotic tissue within the wound bed including adherent slough. The peri wound had tenderness on palpation.
A physician's order, dated 7/6/23, Hydrophilic External Ointment (a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations) clean coccyx wound with normal saline and apply skin prep around peri wound, apply hydrophilic ointment to coccyx wound bed topically every day shift for wound and leave open to air. Change Daily and as needed if becomes soiled, discontinue when healed.

A Wound NP 35 visit note, dated 7/12/23, was not provided during the survey.

On 7/14/23 at 11:54 a.m., the Director of Nursing (DON) provided an untitled document and indicated it was her wound tracking. The document indicated on 7/5/23 the sacral wound

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	measured 0.7 cm x 0.5 cm x 0.1 cm, and on 7/12/23 the sacral pressure wound measured 0.5 cm x 0.3 cm x 0.1 cm. There was no further description of the wound. Resident record lacked documentation the resident's sacral wound worsened from a described stage II wound (skin breaks open, appears as a scrape/abrasion, blister or a shallow crater in the skin) between admission on 7/1/23 to an unstageable wound on 7/6/23, or that the physician and resident or resident representative were made aware. During an interview on 7/11/23 at 10:23 a.m., the DON and LPN 14 indicated Resident 196 was in isolation related to a diagnoses of c-diff. The resident was alert and oriented, and able to answer questions. The resident was continent of bowel and bladder unless she could not make it to the bedside commode timely. She required standby assistance for activities of daily living (ADL's) and had no known skin breakdown. During an interview on 7/13/23 at 12:00 p.m., Wound NP 35 indicated it was brought to her attention on 7/6/23 the resident had a wound on her sacrum that was present upon admission from the hospital, and the wound was painful. NP 35 had observed the wound on 7/6/23 and documented it as unstageable related to the slough. She could not answer as to why the resident would go from shearing or a Stage II wound to an unstageable in that short amount of time as the resident was alert and mobile. The reason could have been due to her condition before admission, and the resident might have been experiencing diarrhea before admission due to c-diff and the skin could have been compromised. Upon assessing the resident on			

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	7/12/23, NP 35 indicated the wound on her sacrum/midline appeared to still be covered in slough and measured 0.5 cm x 0.3 cm x 0.1 cm and in her opinion improving. There was no black tissue, she considered a wound necrotic if it was covered in slough. The resident indicated the wound was still painful when laying on it but less painful than last week. During an interview on 7/14/23 at 9:46 a.m., the DON indicated the MDS Coordinator was responsible for the accuracy of information on the MDS. The original admission MDS did not indicated presence of a pressure ulcer, but when reviewed this date indicated the document had been altered last evening with correct information. DON indicated, the document had not been submitted yet, so the MDS coordinator had the option to correct until sent. During an interview on 7/14/23 at 9:51 a.m., Resident 196's record was reviewed with the DON. DON indicated, the admitting nurse assessed the resident and documented her wounds on the admission/readmission form. Wounds included bruises, skin tears, and an area on her coccyx which had measurements that was not staged but reflected a Stage II wound by description. On 7/1/23 the DON had put in care plans for the wounds with interventions. Observation of the resident record lacked documentation interventions were initiated. Wound NP documentation on 7/6/23 indicated the coccyx wound worsened to an unstageable wound with necrotic tissue and slough and gave new orders to change the treatment to twice daily. Physician's orders for wound care were not changed to twice daily and no documentation the orders were followed. Nurses were responsible for preventative wound care and making sure orders			

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	were writing and followed. On 7/14/23 at 12:30 p.m., the Regional Nurse Consultant provided a Preventative Skin Care policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "It is the intent of the facility that the facility provide preventative skin care ...Responsibility: charge nurse and nursing assistants monitored by the Director of Nursing ...Residents identified as being at high risk for potential breakdown shall be turned and repositioned frequently to prevent redness that does not fade or blanche ..." On 7/14/23 at 12:30 p.m., the Regional Nurse Consultant provided a S.W.A.T. [Skin and Weight Assessment Team] policy, undated, and indicated the policy was the one currently being used by the facility. "SWAT is designed to aggressively review and address those residents exhibiting significant weight loss or skin breakdown. Those residents will be monitored through this team effort on a weekly basis ..." Document on SWAT form: review date (date of SWAT meeting), onset date (date of which the open area appeared), current size (the measurement of the open area most recently recorded by nursing), current stage (the most recent stage determined by nursing or the physician), odor present (putrid smell of the open area on the skin), drainage present (presence of drainage of the open area on the skin), culture/results (within normal limits). Record on treatment sheet (open area treatments need to be recorded on treatment sheet. Notifications (physician, Registered Dietician, MDS, family, and care plan). Other (needs to be checked if the resident is on skin protocol program, hydration program, appetite enhancer, six small meals, etc. Lab values (record the most current albumin and			

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	or transferring levels within 30 days of review). 3.1-40(a)(2) 3.1-40(a)(3)			
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 ensure that a resident who is incontinent of bowel receives appropriate treatment and			

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	services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure, a resident (Resident 45) with a history of electrolyte imbalance, seizures and urinary tract infections (UTIs) received ordered labs in a timely manner for a urinalysis, reported and reviewed labs in a timely manner for 1 of 2 resident reviewed for catheter use. Findings include: On 7/11/23 at 2:16 p.m., Resident 45's closed medical record was reviewed. She admitted to the facility with diagnoses which included, but were not limited to, deficiencies of B-group vitamins, Vitamin D deficiency, epilepsy, and neoplasm (cancer) of the bladder. A Physician's note dated 11/7/22 at 1:58 p.m., indicated Resident 45 was being seen for a regularly scheduled, annual assessment as well as complaints for a possible UTI. "patient has concern for urinary urgency and possible getting UTI patient is getting frequent UTIs due to straight cath ... [straight catheter, also called an intermittent catheter, is a soft, thin tube inserted into the bladder through the urethra used to empty urine from the body] will check UA [urinalysis] and discuss regarding routine screening measures ...." The record lacked documentation of follow up for routine screening measures related to frequent UTIs due to Resident 45's preference to self-straight cath for urinary continence. Resident 45 had a comprehensive care plan initiated 1/17/23 which it was her preference to self-cath. However, there were no specified,	F 0690	It is the intent of this facility to obtain labs in a timely manner when ordered by the physician and provide education to residents that straight catheterize. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #45 no longer resides in the facility; therefore, no further corrective action could be taken for this resident. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? There are no residents currently residing in the facility that self-catheterize. All residents with ordered labs have the potential to be affected; therefore, this plan of correction applies to those residents. An audit was conducted to identify those residents with lab orders in place, and to ensure labs have been obtained timely, and reported and reviewed timely. DON completed audit on 8/11/23. 1.What measures will be put	08/22/2023

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	person-centered risks and/or revised interventions/approaches to address her preference besides, "reassess as needed...." A second comprehensive care plan initiated 3/28/23 indicated Resident 45 was at risk for complications related to her use and preference to self-straight cath and that she declined to allow staff to straight cath. Interventions included but were not limited to; nursing to provide education on peri care, observe In & Out cath, and ensure good peri care. The record lacked documentation of education provided to Resident 45 regarding self-straight cath risks and benefits. The record lacked documentation of nursing observations of Resident 45's ability to self-straight In & Out cath. The record lacked specification of education provided to Resident 45 regarding appropriate peri care. The record lacked documentation of initial and/or routine assessments of her ability to appropriately straight-cath herself. A nursing progress note dated 1/9/23 at 3:46 p.m., indicated, Resident 45 complained of a burning sensation while urinating and a new order was obtained for a UA & C&S (urinalysis with culture and sensitivity, a test to determine if there is the presence of a UTI and what bacteria could have caused it). A urine sample was not collected until 4 days later, on 1/13/23 at 11:47 p.m., which was provided by the resident via self-straight cath.		into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nursing staff have been re-educated by the DON/Designee relative to Bowel/Bladder Incontinence, Catheter, UTI, including but not limited to, ensuring ordered labs are obtained timely, and reported to and reviewed by the physician timely; and the need to educate, assess, and observe any resident that chooses to self-catheterize. In-service initiated 8/9/23 and completed on 8/11/23. Additionally, any staff that fails to comply with the points of this in-service will be further educated /or disciplined as indicated. DON/designee will conduct a random audit of at least 5 residents per week, for 4 weeks, with lab orders to ensure labs are obtained timely with results reported to the physician and reviewed by the physician timely. Thereafter, a random audit of at least 3 residents per week, for 4 weeks will be conducted to ensure continued compliance, and then random audits of at least 2 residents per week for 4 months. Any identified concerns will be promptly addressed with the responsible individual(s).	

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	The original order for the UA was dated 1/13/23 and indicated, UA with Culture "if indicated." The results of the UA were reported on 1/16/23 at 4:22 p.m., and faxed to the facility on 1/17/23, with no specified time. Results of the UA indicated signs of a UTI as evidence by, the presence of blood, bacteria, protein, leukocytes and nitrates. The record lacked documentation of follow up on the lab results. During an interview 7/12/23 at 11:09 a.m., the DON provided a copy of a Laboratory Results Page. The report was blank. The DON indicated because different labs completely different tests for the facility, some have access to directly upload into the electronic charting system. However, other companies are unable to directly upload and can only upload via their own electronic medical record system, so a report is filed to trigger the MD/NP to log onto the particular lab for review. Highlight in the upper left corner of the blank report, was a timestamp that Nurse Practitioner (NP) 34 had not reviewed the results until 2/4/23 at 1:06 p.m. When asked about the results of the UA, the DON indicated there was some indication there could be a UTI, but it is often at the Lab's discretion if a culture should be completed, and since the original order indicated, "culture as indicated," the DON said a culture may not have been completed. The record lacked documentation of follow up to see if a second UA needed to be collected or a culture should be conducted on the first sample. Resident 45's nursing progress note, physician progress notes, Medication Administration		1.How will the corrective action(s) will be monitored? DON/Designee will be responsible to provide audit results in QAPI Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 6 consecutive months the auditing will be stopped. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 1.Completion date: August 22, 2023	

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	Record (MAR) and lab results all lacked documentation of follow up to the 1/20/23 UA test results. A Hospital Summary dated 1/27/23 indicated, " ...per staff at the Waters after having witnessed seizure twice today. Tonight around 1:00 a.m. she was sitting on toilet when she had one and hit her head on the wall. She was postictal [altered state of consciousness after an epileptic seizure] for longer than usual thus was sent in for evaluation ...found to have multiple electrolyte abnormalities including hypomagnesemia, hypocalcemia, hypokalemia ...likely in setting of UTI..." and suffered an acute kidney injury. A re-admission Social Service Note dated 1/31/23 at 9:46 a.m., indicated, a BIMS (brief interview for mental status test) was conducted for Resident 45 as she seemed to exhibit increased confusion. Prior to hospitalization, she consistently scored 15, which indicated intact cognition. On this date, she scored a 10 which can indicate moderately impaired cognition. During an interview on 7/12/23 at 9:57 a.m., LPN 14 indicated, she had worked with Resident 45 on an occasional basis. She remembered her as being alert, oriented, particular about certain things, but overall, pleasant and cooperative. One of the things she was particular about was her preference to self-cath. As far as LPN 14 remembered, staff did not conduct additional monitoring or assessment for her ability to self-cath because that's just how she was and what she preferred. If a UA was ordered, LPN 14 would want to have collected the sample herself to ensure a sterile technique was performed to reduce the risk of contaminating the sample, and if the Resident refused, she would make a nursing			

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	note about it. During an interview on 7/13/23 at 3:22 p.m., NP 34 indicated she had access to the 1/20/23 UA lab results, NP 34 logged on and indicated there were no UA results for review from January. She was not sure at that time where the results were. She could not remember the results at the time but indicated she would not always treat with an antibiotic right away without a culture and sensitivity so that she could prescribe the appropriate medication. On 7/13/23 at 11:36 a.m., the DON provided a copy of current but undated facility policy titled, "Lab Scheduling/Tracking." The policy indicated, "It is the policy of the facility to ensure that laboratory tests ordered by the physician are systemically scheduled and tracked so that ordered lab work is obtained and results are received and reported timely ... the Charge Nurse will monitor the scheduled labs daily to check to ensure that any collected lab results are received timely as well as to confirm that received results are reported to the physician as well as the resident's representative and that any orders received to the lab results are carried out ...." On 7/13/23 at 11:36 a.m., the DON provided a copy of current but undated facility policy titled, "Catheters." The policy indicated, "It is the policy of the facility to ensure that 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 ... the resident and their representative will be educated as to the use of a catheter to include: Not: this will be documented, risks and benefits ... timely and appropriate assessments will be performed related to the indication and use			

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	of the catheter ... Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and facility policy and procedure with adherence to infection prevention and control techniques ... the resident will have ongoing monitoring of the catheter related to the potential for UTIs and recognizing, reporting and addressing significant changes ...." 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 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 ensure a resident who was at risk for nutritional decline received thorough monitoring and interventions to prevent avoidable weight loss for 1 of 2 residents	F 0692	It is the intent of this facility to monitor residents who are at risk for nutritional decline and provide interventions to prevent weight loss.	08/22/2023

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	reviewed for nutrition (Resident 30). Findings include: During an observation and interview on 7/10/23 at 12:45 p.m., Resident 30 indicated she did not receive her weekly house shake that was ordered for Mondays. She indicated she would get it the next day. During an interview on 7/12/23 at 1:15 p.m., Resident 30 she indicated she received her house shake for the week. She indicated it had been added because she had weight loss. On 7/14/23 at 11:14 a.m., Resident 30's medical record was reviewed. She had diagnoses which included, but were not limited to, unspecified psychosis (a mental disorder characterized by disconnection from reality), COPD (chronic obstructive pulmonary disease) (a group of lung disorders that block airflow and make it difficult to breathe), essential hypertension (high blood pressure), osteoarthritis (the breakdown of joint cartilage and the underlying bone), insomnia (inability to sleep), schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations), heart disease, and weakness. On 7/20/22, Resident 30 weighed 133 pounds. On 1/2/23, Resident 30 was down to 114.0 pounds. On 7/3/23.. Resident 30 was weighed at 109.8 pounds. In total, Resident 30 last 14.29% of her weight between the above dates.		1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #30 has been assessed by the Registered Dietician to ensure appropriate interventions to prevent avoidable weight loss are in place with resident's care plan updated, as necessary. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? The facility completed an audit to identify any residents with significant weight changes. RD will review the identified and make recommendations, as needed. RD completed audit on 8/9/23. 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing staff was re-educated by the DON/Designee relative to Nutrition/Hydration Status Maintenance, including but not limited to, ensuring that residents at risk for nutritional decline are monitored and assessed with	

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	She had physician's orders, which included, but were not limited to, a general diet with regular texture and thin liquids. An order for other supplement with meals for weight loss at lunch and dinner may substitute sherbet, and an order to change two times daily house shakes to one house shake weekly due to refusals. The record lacked documentation that during the time of her weight loss RD (Registered Dietician) had assessed or followed up with her. Resident 30 was not added to SWAT (Skin and Weight Assessment Team) to review her weights as the policy recommended. There were no interventions added during the time of this weight loss. The weight loss was not recorded on the two MDS (Minimum Data Sets) completed during the weight loss time frame of 7/20/22 through 1/2/23. Resident 30 had a care plan dated 2/21/23 indicating she had experienced weight loss and was at risk for continued weight loss. Interventions included to make a referral to MD (Medical Doctor)/RD if there is a 5% weight loss over 30 days or a 10% weight loss over 180 days, dietary health supplements as ordered: Prostat liquid (a protein supplement) and weigh resident monthly. During an interview with the MDS coordinator on 7/14/23 at 12:10 p.m., she indicated she was not employed by the facility at the time of the weight loss occurrence. During an interview with the DON (Director of Nursing) on 7/14/23 at 1:45 p.m., she indicated she was not employed by the facility at the time of the weight loss occurrence.		recommended RD interventions implemented .Education initiated on 8/9/23 and completed on 8/11/23. Additionally, any staff that fails to comply with the points of this in-service will be further educated/or disciplined as indicated. DON, RD, or Designee will review weights and the documentation relative to weights at least 5 days a week X 4 weeks, then 3 days a week X 4 weeks, then weekly X 4 months to identify those residents who have experienced a change in nutritional status, and to ensure thorough monitoring and that interventions are implemented in timely manner. Any identified concerns will be promptly addressed with the responsible individual(s). 1.How will the corrective action(s) will be monitored? DON/Designee will be responsible to provide audit results in QAPI Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 6 consecutive months the auditing will be stopped. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	A policy titled, "S.W.A.T Program (Skin and Weight Assessment Team)" was provided by the Regional Nurse Consultant on 7/14/23 at 12:33 p.m., indicated " ...The team will appropriately determine clinical and dietary interventions to best address each resident's needs. Any dietary intervention and/or issues in need of review by the Dietician will be listed on the Dietician referral form and addressed at routine visit. Indicators determining implementation of S.W.A.T. monitoring were 10% or more weight change (undesirable) in 180 days. On-going weekly monitoring should continue on resident of S.W.A.T until one of the following conditions has been met: new admit at 4 weeks with no concerns, weight loss- eight weeks at stable weight unless medical condition dictates otherwise, or a history of fluctuating weight is present. When weight, food consumption, and/or lab values continue to decrease or approach critical levels, alternative interventions must be reviewed by the interdisciplinary team, open areas- when the areas have healed, change of condition until a stable status achieved and tube feeding will be on-going ...." 3.1-46		1.Completion date: August 22, 2023	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to provide pain relief and	F 0697	It is the intent of this facility to provide pain relief and to update	08/22/2023

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	failed to update his pain management care plan to include leg pain for 1 of 1 residents reviewed for pain management (Resident 8). Findings include: On 7/11/23 at 1:46 p.m., Resident 19's record was reviewed. He was initially admitted on 11/3/21. His diagnoses included, but were not limited to, chronic pain disorder, low back pain, peripheral vascular disease (PVD), and rhabdomyolysis (break down of muscle tissue resulting in kidney damage). A care plan, dated 6/13/23, indicated Resident 8 was taking anticonvulsants medication related to low back pain. The intervention indicated to carry out the medication management regimen as prescribed. A care plan, dated 6/25/23, indicated Resident 8 had pain related to a previous humerus (upper arm bone) fracture. An intervention indicated to give medication as ordered. A care plan, dated 6/26/23, indicated Resident 8 had compression hose for his left leg related to varicose veins. An intervention indicated to wearing them during the day and remove them at night. A care plan, dated 6/25/23, indicated Resident 8 would have not have adverse effects from opioid use. An intervention indicated to give the medication as ordered. A care plan, dated 6/26/23, indication Resident 8 had potential for complication, discomfort, related to a diagnoses of muscle wasting and atrophy due to a history of rhabdomyolysis.		the residents care plan for pain management. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? As stated on page 34 of the 2567, Resident #8 was provided with the correct size compression stockings at the time of survey. Resident #8's pain management care plan was updated to include leg pain. Resident care plan updated on 8/9/23 by RDCO. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents receiving pain medication have the potential to be affected by this cited practice. DON/Designee completed to identify those residents with ordered pain medication to ensure pain management care plans are up to date on 8/13/23 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?	

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	On 7/13/23 at 2:42 p.m., Resident 8's physician orders, indicated to: a. Provide thigh high compression hose, dated 6/19/22, for left leg for symptomatic varicose veins (painfully, enlarged veins). On in AM (during the day) off at HS (bedtime). b. Provide oxycodone 50 mg, dated 5/6/23, every 6 hours for moderate to severe pain related to low back pain. c. Provide ibuprofen 600 mg, dated 11/8/22, every 8 hours as needed for pain. d. Provide Tylenol 325 mg, dated 6/26/23, every 6 hours as needed for breakthrough pain. On 7/12/23 at 1:50 p.m., Resident 8 was observed walking in the hall with his walker. Once he sat down in his room, he indicated his left leg hurt all the time. In a scale of 1 - 10, it hurts at level 7. He indicated he was still getting his narcotic pain killers. His indicated he preferred the compression stockings; they work well to relieve the leg pain. The facility provided compression stockings, but no one measured his legs to get the right size and the ones they provided did not work because they were too small and rolled down his thighs. He indicated his leg pain was horrible, it was enough to almost make him cry. He has told the nursing staff about this issue. On 7/13/23 at 2:35 p.m., Resident 8 indicated he took the oxycodone for his back and leg pain. Tylenol just did not do the trick. On 7/13/23 at 2:19 p.m., the Director of Nursing (DON) indicated the facility needed to provide different compression hose until he can get to his vascular appointment later this month. On 7/13/23 at 3:30 p.m., the DON indicated		Staff education was provided by the DON/Designee on Pain Management, including but not limited to, adequate provision of pain relief and ensuring pain management care plans are updated. In-service initiated on 8/9/23 and completed on 8/11/23. Additionally, any staff that fails to comply with the points of this in-service will be further educated/or disciplined as indicated. MDS nurse to be educated on updating care plans on, or before 8/22/23 DON/designee will review the eMARs of at least 5 residents per week receiving scheduled and/or PRN pain meds x 4 weeks, then at least 3 residents per week x 4 weeks, then 5 residents per month x 4 months to ensure medications adequate provision of pain relief. Those same residents will also be interviewed after review of the eMAR to verify pain medications are being administered as ordered, and effectiveness of pain medication and accuracy of pain assessments. Any identified concerns will be promptly addressed with responsible individual(s). MDS Coordinator/Designee will review the care plans of 5 random residents per week for 1 month to ensure pain management is addressed, as necessary.	

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	Resident 8's legs were measured and the facility already had the correct size compression stockings in their supplies. He was given the correct size stocking this afternoon. On 7/14/23 at 1:14 p.m., the DON indicated if a resident complained of pain regarding the fitting of compression stockings, the nursing staff should have followed up and let the physician know. Resident 8 had already told them he was having leg pain. A current policy, titled, "Management of Pain," with no date, was provided by the Regional Nursing Consultant (RNC), on 7/14/23 at 12:42 p.m. A review of the policy indicated, " ...Our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our resident the means to received necessary comfort, exercise greater independence, and enhance dignity and life involvement ...Using non-pharmacological and Complimentary and Alternative Medicine when appropriate ...Initiate an interdisciplinary plan of care based on the initial assessment and development of pain relieving strategies. Include both pharmacological and complimentary intervention in the care plan ...." 3.1-37(a)		Thereafter, the care plans of 5 random residents per month for 5 months will be reviewed to ensure continued compliance. Any identified concerns will be promptly addressed with the responsible individual(s). Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or disciplined as indicated. 1.How will the corrective action(s) will be monitored? DON/Designee and MDS Coordinator/Designee will be responsible to provide audit results in QAPI Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 6 consecutive months the auditing will be stopped. The QAPI Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 1.Completion date: August 22, 2023	
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			

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	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 record reviews and interviews the facility failed to properly reconcile and account for medications that were sent home with a resident who discharged from the facility for 1 of 2 residents reviewed for discharge (Resident 44). Findings include: A comprehensive record review was completed on 7/11/23 at 11:23 a.m. Resident 44 had the following	F 0755	It is the intent of this facility to reconcile and account for medications that are sent home with a resident when they discharge from the facility. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	08/22/2023

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	diagnoses, but not limited to ASHD (arteriosclerotic heart disease, a thickening and hardening of the walls of the coronary arteries), essential hypertension (high blood pressure), chronic pain syndrome, fibromyalgia (a chronic disorder characterized by widespread pain and other symptoms such as fatigue, muscle stiffness and insomnia), restless leg syndrome (uncomfortable sensations in the legs and the urge to move them in order to relieved the sensations, typically occurring in the evening or at night and often interfere with sleep), and diabetes mellitus, type 2 (elevated blood sugars). Resident 44 discharged from the facility on 5/20/23. A progress note, dated 5/20/23 at 12:50 a.m., indicated that Resident's daughter wanted to have her mother discharged home with family. The physician gave an order to discharge to home with medications including narcotics. Resident had orders for the following medications: a.) acetaminophen extra strength 500mg (a pain medication) b.) amlodipine besylate 10mg (for ASHD) c.) aspirin 81mg (a pain reliever used for blood thinning) d.) atorvastatin 40mg (used for elevated cholesterol) e.) buprenorphine buccal film 600mg (a narcotic medication used to treat pain) f.) clopidogrel bisulfate 75mg (used to prevent heart attacks and strokes) g.) docusate sodium 100mg (used to treat constipation) h.) duloxetine delayed release sprinkle 60mg (used to treat depression and peripheral neuropathy (nerve damage) i.) ferrous sulfate 325mg (used to treat anemia) j.) gabapentin 600mg (used to treat fibromyalgia) k.) isosorbide mononitrate 30mg (used to treat hypertension) l.) Jardiance 25mg (used to treat diabetes) m.) metformin 500mg (used to treat diabetes) n. metoprolol succinate 50mg		Resident #44 no longer resides at the facility; therefore, no corrective action could be taken for this resident. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents planning to discharge from the facility to home or to another facility have the potential to be affected; therefore, this plan of correction applies to those residents. 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses were re-educated by the DON/Designee relative to Pharmacy Srvcs/Procedures/Pharmacist/Records, including but not limited to properly reconciling and accounting for medications sent home with discharged residents. DON/Designee initiated education on 8/9/23 and completed on 8/11/23. Additionally, any staff that fails to comply with the points of this in-service will be further educated/or disciplined as	

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	(used to treat hypertension) o.) oxycodone 5mg (used to treat pain) p.) pantoprazole sodium 40mg (used to treat stomach conditions, such as ulcers) q.) sucralfate 1 gram (used to treat stomach conditions, such as ulcers), r.) tizanidine 4mg (used to treat neuropathy). On 7/13/23 at 2:15 p.m., the DON (Director of Nursing) provided a copy of a drug disposition for oxycodone. Resident 44 signed and acknowledged receipt of 22 tablets upon discharge. The DON indicated the facility did not have to reconcile and account for the number of non-controlled medications for residents at the time of discharge. A policy titled; "Controlled Substance Disposition" was provided by the DON on 7/13/23 at 10:05 a.m. The policy discussed disposition of controlled substances but not non-controlled medications. 3.1-25(a) 3.1-25(b)(l) 3.1-25(c)		indicated. DON/Designee will be responsible to audit the records of all residents being discharged to home or to another facility to ensure medications have been properly reconciled and accounted for, these audits will be conducted prior to resident discharges for 6 months. Any identified concerns will be promptly addressed with the responsible individual(s). 1.How will the corrective action(s) will be monitored? DON/Designee will be responsible to provide audit results in QAPI Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 6 consecutive months the auditing will be stopped. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 1.Completion date: August 22, 2023	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.			

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	Based on observation, interview, and record review, the facility failed to prevent a significant medication error related to administering a potassium extended release tablet dissolved in water with an indication of do not crush (Resident 16) for 1 of 29 residents observed for medication administration, and failed to hold a hypertensive medication Coreg per manufactures guidelines related to a low blood pressure reading (Resident 15) 1 of 29 residents observed for medication administration Findings include: 1. During a random observation of medication administration to Resident 16 on 7/13/23 at 7:30 a.m., Licensed Practical Nurse (LPN) 14 was observed to place a potassium chloride ER (extended release) tablet in a plastic medication cup with water and spend over 15 minutes smashing the tablet with a spoon until totally dissolved. The medication was then administered to the resident. LPN 14 indicated the resident received the medication twice daily and would not take it whole. She knew she was not supposed to crush the medication so she would dissolve it in water every day. The physician had not been notified of the resident refusal to take the medication whole. Resident 16's record was reviewed on 7/12/23 at 11:51 a.m. Diagnoses on Resident 16's profile included, but were not limited to, schizoaffective disorder (a combination of symptoms of schizophrenia and mood disorder such as depression or bipolar disease), bipolar disorder (episodes off mood swings ranging from depressive lows to manic highs), and hypo-osmolality and hyponatremia (serum is produced by retention of water, by loss of sodium	F 0760	It is the intent of this facility to administer mediations in a manner to prevent mediation errors. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1. LPN #14 was re-educated at the time of the survey. 2. Please note that the carvedilol order for Resident #16 did not include hold parameters for the evening dose, thus, the medication was given correctly according to the physician's order. The carvedilol order has been clarified with the physician to reflect physician's preference for holding/administering the medication. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? An audit was conducted to identify any residents that require their medications to be crushed, this plan of correction applies to those identified. The medications of these residents have been reviewed to ascertain if any medications that should not be crushed can be changed to those allowed to be crushed with adjustments made accordingly.	08/22/2023

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	or both). A physician's order for Resident 16, dated 5/19/23, indicated potassium chloride ER give 10 meq by mouth twice daily (BID) for hypokalemia (low blood potassium levels that can result in fatigue, muscle cramps, and abnormal heart rhythms). A medication administration record (MAR), dated July 2023, indicated the resident was documented as receiving her potassium chloride twice daily as ordered. A laboratory results document, date 5/23/23, indicated potassium level, dated 5/23/23, results 3.6 meq/L (normal 3.5-5.3). The resident record lacked current orders for future labs to include potassium. A care plan for Resident 16, dated 6/1/23, indicated she was at risk for development of low potassium levels related to daily use of non-potassium sparing diuretic. The goal was for the resident to be free from signs or symptoms of low potassium levels and maintain a normal potassium level through next review. The interventions included observe for signs or symptoms of low potassium levels such as nausea/vomiting, muscle cramps, or weakness. Weight as ordered and notify the physician of weight gains or losses. Labs to be drawn as ordered with all labs reported to the doctor and family. Receive meds as ordered. During an interview on 7/14/23 at 9:30 a.m., the Director of Nursing (DON) indicated potassium was not supposed to be crushed, LPN 14 should have asked for the medication to be ordered in a different form. Being newer to the facility, she was unsure of what continuing education the		An audit has been conducted to identify any residents having medication orders with specified parameters for withholding/administering the prescribed medication. This plan of correction applies to any residents identified in this audit. 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed Nurses and QMAs have been re-educated relative to Residents Free of Significant Med Errors, including but not limited to, medications that should not be crushed or altered from their original state, and ensuring that medications are either withheld or administered according to ordered parameters. DON/Designee initiated education on 8/9/23 and completed on 8/11/23. Additionally, any staff that fails to comply with the points of this in-service will be further educated/or disciplined as indicated. The DON/Designee will be responsible to conduct a medication administration observation audit on 5 residents a week for 4 weeks, then 2	

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	nurses and Qualified Medication Aides (QMA's) had received. There were do not crush lists provided inside the narcotic books on the medication carts for staff reference. Medication pharmacy labels may also state to not crush. DON indicated, ultimately it was her responsible for making sure the staff were educated and residents received their medications properly. On 7/13/23 at 3:00 p.m., the DON provided an Oral Dosage Forms That Should Not Be Crushed 2016 list, and indicated the list was the current on used by the staff. The form was available to the staff by being kept in the front of the narcotic binder on the medication carts. The do not crush list included, potassium slow release tablets. "FDA (2013): K-TAB (potassium chloride extended-release tablets) is a solid oral dosage form of potassium chloride containing 8 meq (milliequivalents), 10 meq and 20 meq of potassium chloride, USP, equivalent to 600 mg, 750 mg and 1500 mg of potassium, respectively, in a film-coated [not enteric-coated], wax matrix tablet. These formulations are intended to slow the release of potassium so that the likelihood of a high localized concentration of potassium chloride within the gastrointestinal tract is reduced. The expended inert, porous, wax/polymer matrix is not absorbed and may be excreted intact in the stool. ISMP (Institute for Safe Medication Practices): Enteric-coated potassium extended-release pills should not be dissolved to administer. Enteric-coated pills are designed to dissolve in the small intestine, not in the stomach. Dissolving them can destroy the drug's protective coating and cause the medication to be absorbed too quickly or too slowly, which can be harmful. In general, avoid crushing or dissolving		residents per week for 4 weeks, then 1 resident per week for 4 months to ensure that medications that should not be crushed or altered from their original state are administered correctly. The DON/designee will audit eMARs of at least 5 residents 5 times a week for 4 weeks, then 3 residents weekly for 4 weeks, then 2 residents weekly for 4 months to ensure that medication orders are followed relative to withholding/administering medications according to ordered parameters. Any identified concerns will be promptly addressed with the responsible individual(s). Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or disciplined as indicated. 1.How will the corrective action(s) will be monitored? DON/Designee will be responsible to provide audit results in QAPI Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 6 consecutive months the auditing will be stopped. The	

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	controlled-delivery, controlled-release, delayed-release, enteric-coated, and extended-release pills.2. A comprehensive record review was completed on 7/11/23 at 11:26 a.m. Resident 15 had the following diagnoses but not limited to osteoarthritis (degeneration of joint cartilage and the underlying bone), essential hypertension (high blood pressure), hyperlipidemia (high cholesterol), GERD (gastro-esophageal reflux disease (occurs when stomach acid repeatedly flows back into the tube connecting the mouth and stomach), presence of cardiac pacemaker, dysphagia (difficulty swallowing), type 2 diabetes mellitus (high blood sugar), sleep apnea, and chronic renal failure (kidney failure). Resident 15 had a medication order for carvedilol 12.5mg (a drug used to treat high blood pressure and certain heart problems) was ordered on 4/1/23 to administer one time daily on Tuesday, Thursday, Saturday, and Sunday for essential hypertension. The order had parameters to hold if SBP (systolic blood pressure (how much pressure the blood placed against the artery walls while the heart pumps)) less than 110 and to hold if the DBP (diastolic blood pressure (the pressure in the arteries when the heart rests between beats)) was less than 50. Do not give on dialysis (a procedure used for people that have renal failure). Resident 15 had an evening medication order for carvedilol 12.5mg, take 1 tablet daily for essential hypertension. The evening order for carvedilol lacked parameter instructions for administration. On 7/1/23 on dayshift, Resident 15's blood pressure was 108/77. His carvedilol was administered despite being below the administration parameter of 110 or less.		QAPI Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 1.Completion date: August 22, 2023	

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	A policy for medication errors was requested on 7/14/23 at 9:30 a.m. but was not provided at the time of exit on 7/14/23. 3.1-48(c)(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, and interview, the facility failed to ensure medications were stored properly in 2 of 2 medication carts, and 2 of 2 treatment	F 0761	It is the intent of this facility to store drugs and biologicals	08/22/2023

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	carts reviewed for medication storage (100 hallway, and 200 hallway). Findings include: During a random observation of the 100 hallway medication cart with Registered Nurse (RN) 9, on 7/10/23 at 10:09 a.m., the following was observed to be unbagged, not stored separately, or treatments in the medication cart among oral medications, a. Top right drawer was observed to be a catch-all of items to include, but were not limited to, a bottle of Johnson's baby shampoo without a resident label, 3 prefilled syringes of 0.9% sodium chloride injection with no resident label, an opened bottle of COVID -19 Ag reagent, 2 pill crushers soiled with unidentified white powder, AA batteries, Jergens hand lotion, and 2 cigarette lighters. b. Bottom drawer had an opened tube of Biofreeze (topical analgesic) belonging to Resident 40, a glucagon pen (emergency injection to treat sever low hypoglycemia) with Resident 15's name on the outside of the box, and an opened bottle of Povidone iodine 10% with Resident 43's name written on the bottle without a resident specific label for directions, all stored among vital sign equipment of stethoscopes and blood pressure cuffs. c. Top left drawer was observed to have the following medication stored randomly to include Resident 5's opened and undated bottle of Azelastine (antihistamine) nasal spray 0.1 %, Resident 31's bottle of Azelastine 0.05% eye drops (antihistamine) opened and undated, Resident 16 Systane nighttime eye ointment (lubricant) 3.5 grams (gm) opened and undated, and Resident 32 a Symbicort 160/4.5 (corticosteroid) micrograms (mcg) 10.2 gm inhaler opened and undated.		properly and within the accepted professional principles. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a., b., c., & d. The drawers of the 100 Hall medication cart have been cleaned with medications now stored properly. The medications that were opened and undated have been replaced with new prescriptions that have been dated appropriately. The 100-hallway medication room. a. The 100-hallway treatment cart has been cleaned with treatments now stored properly. The treatments that were opened and undated have been replaced with new prescriptions that have been dated appropriately. a., b., & c. The 200-hallway treatment cart has been cleaned with treatments now stored properly. The treatments that were opened and undated have been replaced with new prescriptions that have been dated appropriately. The 200-hallway medication refrigerator has been cleaned. a. The 200-hallway medication cart has been cleaned with	

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	d. Bottom drawer contained a can of value scents citrus air freshener deodorizer opened and stored among medications to include Resident 5 a tube of triamcinolone cream (topical corticosteroid used to treat swelling and itching) 0.1% opened and undated, and a bottle of Azelastine 0.1% nasal spray opened and undated, and Resident 19 a tube of Diclofenac sodium topical gel (antifungal) 1% opened and undated. The 100 hallway medication room was observed with RN 9, the sink, counter, and floor were observed to be heavily soiled with unidentified substances, dirt, paper debris, lime build up in the sink and around the faucet, and when turned on the water sprayed out of the faucet to the left side onto the counter. There was no paper towel. On 7/10/23 at 10:28 a.m., the 100 hallway treatment cart was observed with RN 9, the following treatments were observed to be stored randomly together and unbagged, among 6 containers of wound cleaner and a can of aerosol sunscreen, a. Top drawer Resident 5, 2 bottles of Nystatin powder opened and undated, Resident 36 a bottle of Nystatin powder opened and undated, Resident 43 a bottle of Povidone iodine 10% with no resident specific label opened and undated, Resident 146 a bottle of Nystatin powder opened and undated, Resident 39 a tube of Biofreeze opened and undated, Resident 40 a tube of Aquaphor cream (moisturizes dry, chapped, or irritated skin) with no resident specific label opened and undated, Resident 26 a bottle of Nystatin powder opened and undated, and Resident 15 a bottle of Nystatin powder opened and undated, a bottle of selenium anti-dandruff shampoo opened and undated, and a bottle of renew skin repair without a resident specific label, and Resident 16 a bottle of baby shampoo with no		medications now stored properly. The medications that were opened and undated have been replaced with new prescriptions that have been dated appropriately. LPN #14 has been re-educated relative to medication administration practice. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents of the facility have orders for either medications or treatments; therefore, this plan of correction applies to all residents currently residing in the facility. 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses and QMAs have been re-educated relative to Label/Store Drugs and Biologicals, including but not limited to, ensuring that medications and treatments are stored properly, and that medications are correctly labeled with resident identifying information, and dated when opened. Education was initiated on 8/9/23 and completed 8/11/23	

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	resident specific label, and a tube of hydrophilic wound dressing (absorbs excess fluids from wounds while maintaining a moist healing environment) opened, undated, and no resident specific label. On 7/11/23 at 9:51 a.m., the 200 hallway treatment cart was observed with Licensed Practical Nurse (LPN) 28, the following treatments were observed to be stored randomly together and unbagged, a. Second drawer Resident 18 a bottle of Nystatin powder opened and undated, Resident 5 a bottle Ketoconazole 2% shampoo (antifungal) opened unbagged with red liquid leaking out of the lid and dried on the side of the bottle, and a container of c-bactra-nyst-znox 1:1:1 ointment (combination ointment used to treat fungal infections) not bagged and undated, Resident 33 a tube of Ketoconazole cream 2% opened and undated, Resident 12 a tube of Aquaphor ointment opened and undated, Resident 13 a container of Proctofoam 1% (rectal foam that helps relieve swelling and itching in the anal region) opened and undated, Resident 29 a tube of Diclofenac sodium topical gel 1% opened undated, Resident 1 a tube of Biofreeze 4% gel opened undated, Resident 2 a bottle of Ketoconazole shampoo 2% opened undated, Resident 3 a bottle of ammonium lactate 12% (lubricant) opened and undated with the cap not closed, Resident 9 a bottle of Nystatin powder opened and undated stored among the containers wound cleaners, and Resident 23 had 2 containers of Eucerin cream opened and undated. There was a tube of Dermaphor ointment (moisturizer to treat or prevent dry, rough, scaly, itch skin, and minor skin irritation) and tube of Venelex wound dressing ointment (topical wound dressing for management of chronic and acute wounds and ulcers) both opened unbagged with no resident specific label or name.		by DON/designee. Additionally, any staff that fails to comply with the points of this in-service will be further educated/or disciplined as indicated. The DON/Designee will be responsible daily, to audit 1 medication cart and 1 treatment cart for daily 5 x a week for 4 weeks, then 1 medication cart and 1 treatment cart 2 times weekly for 4 weeks, then 1 medication cart and 1 treatment cart 1 time weekly for 4 months to ensure medications and treatments are stored properly, and medications are correctly labeled with resident identifying information, and dated when opened. Any identified concerns will be promptly addressed with the responsible individual(s). Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or disciplined as indicated. 1.How will the corrective action(s) will be monitored? DON/Designee will be responsible to provide audit results in QAPI Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 6 consecutive months the auditing will be stopped. The	

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	b. Third drawer Resident 2 a tube of Biofreeze opened and undated, and Resident 33 a tube of Lidocaine 4% cream opened and undated. c. Fourth drawer Resident 24 Aquaphor ointment butt cream opened and undated stored among 11 tubes of house stock calmoseptine, and an opened tube of medihoney with no resident specific label stored with wound dressings. The 200 hallway medication refrigerated top shelf was observed to have the majority of the shelf covered in a dark dried unidentified substance with resident medications laying on top of it. Observation of the 200 hallway medication cart with LPN 28, a. Resident 14 a bottle of Latanoprost solution 0.005% eye drops (used to treat glaucoma) opened and undated, Resident 2 a Symbicort inhaler opened undated, and Resident 197 a tube of aspercreme 10% (topical analgesic) opened undated and not bagged stored among the oral medications. On 7/11/23 at 10:18 a.m., a second observation of the 100 hallway medication cart indicated concerns from the prior day of opened and unbagged treatments being stored in the medication cart among oral medications, and undated opened medications continued. On 7/11/23 at 10:52 a.m., a second observation of 100 hallway medication room. Sink and counter observed to be heavily soiled with unidentified substances, lime build up in sink and around faucet, water sprays to the left side when turned on and still no paper towel. The floor was littered with paper debris, heavily soiled with unidentified dark and red dried substances. The DON indicated it was the nurse's responsibility to clean		QAPI Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 1.Completion date: August 22, 2023	

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	up the medication room, or to monitor housekeeping so they could clean. During a random observation on the 100 hallway medication cart on 7/13/23 at 9:25 a.m., sitting halfway down the hallway in front of room 110. On top of the medication cart was a cup of unidentified crushed medications, an inhaler, IV bag of clear medication, and a plastic water glass with pink liquid. The medication cart was unsupervised as LPN 14 was observed on another hallway taking a resident back to his room, and 2 unidentified resident were observed sitting near the cart conversing. At 9:36 a.m., LPN 14 was observed returning to the medication cart and administering the medications to Resident 32 at the end of the hallway. During an interview on 7/11/23 at 10:13 a.m., LPN 28 indicated, it was the responsibility of the nurse using the cart to maintain the carts in a neat and orderly manner, and date medications when opened. The contracted wound nurse used the treatment carts also, but it was still the nurses responsible for maintaining medication and treatment carts. During an interview on 7/14/23 at 9:25 a.m., the Director of Nursing (DON) indicated, being newer she was unsure of what continuing education the nurses and Qualified Medication Aides (QMA's) had received at the facility. There were do not crush lists provided inside the narcotic books on the medication carts for staff reference. Medication pharmacy labels may also state to not crush. DON indicated, ultimately it was her responsible for making sure the staff were educated and residents received their medications properly. The nurses were responsible for assuring the medication and treatment carts and			

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	medication rooms were clean, organized, and medications dated when opened, with management oversight. On 7/14/23 at 12:30 p.m., the Regional Nurse Consultant provided a Medication Storage in The Facility policy, dated May 2019, and indicated the policy was the one currently being used by the facility. The policy indicated, "Policy: Medications and biologicals are stored safely, securely, and properly following the manufacture or supplier recommendations ...3. Medication rooms, carts, and medication supplies are locked or attended by person with authorized access: a. License Nurses, b. Consultant Pharmacist, c. Pharmacist Technician, d. Individual lawfully authorized to administer drugs, e. Consultant Nurses. 4. Drugs for internal use are kept separate from externally used medications. 5. Eye drops, ointments, drops, and inhalers to be kept separately from floor stock medications. 6. Medications labeled for individual residents are stored separately from floor stock medications. 7. External medications including ointments for skin irritations and medication for application to wounds should be kept in a treatment cart, or in a separate drawer in the medication cart which is labeled as such. 8. Potentially harmful substances [e.g. urine test reagent tablets, household poisons, cleaning supplies, disinfectants] are stored in a locked area separately from medications...15. Mediation storage areas are kept clean, well lit, and free of clutter ...16. Medication and treatment carts are a property of the pharmacy; the facility is required to keep the carts clean and damage free ..." 3.1-25(j) 3.1-25(k) 3.1-25(m)			

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	3.1-25(o)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure all kitchen foods were covered, hand washing was correctly completed in the kitchen and dining room (Resident 7 and 10), and failed to clean to fryer in a timely manner for 2 of 2 days of observations. These deficient practices had the potential to effect 43 of 43 residents who received food from the kitchen. Findings include: 1. On 7/10/23 at 10:45 a.m., 2 large, pre-cooked	F 0812	1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were directly affected by the cited deficient practice. 1.How other residents having the potential to be affected by the same deficient practice will be	08/22/2023

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	turkey breasts were observed, uncovered, sitting on the stainless steel counter top. The Dietary Manager (DM) indicated the internal temperature of the turkey breasts were 83.4 degrees F. She indicated the danger zone for food sitting-out was 70 degrees F. The DM indicated she took them out of the refrigerator at 8:30 a.m. and set them on top of the oven. The oven was on and set at 350 degrees Fahrenheit (F). At 9:00 a.m., she set them on the kitchen counter and went to morning meeting. On 7/10/23 at 11:00 a.m., the DM indicated that was not how the kitchen usually handled food. She indicated it was after breakfast, and she was getting ready to prepare the turkey for lunch. She was going to grind it up and add barbeque sauce. Normally, she would have taken it out of the refrigerator, ground it up, added the barbeque sauce right away and placed it into the oven. But, she was cooking breakfast this morning. and just, "made a mistake." The turkey breasts were covered with foil while on top of the oven. When she put them on the counter, she took the foil off. She indicated she should have left the foil on the pan. 2a. On 7/10/23 at 11:26 a.m., Dietary Aide (DA) 8 was observed to wash her hands, she turned the water faucet off with her bare hands, then dried them on paper towels. She removed two steam table lids, drained them in the sink and placed them on top of the oven. On 7/10/23 at 11:27 a.m., Dietary Aide 8 was observed to wash her hands, she turned the water faucet off with her bare hands then dried them on paper towels. She acquired the temperature of the foods on the steam table and started serving food on plates for the residents.		identified and what corrective action(s) be taken? All residents have to potential to be affected; therefore, this plan of correction applies to residents currently residing in the facility. 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All dietary staff to be educated by facility executive director/designee on or before August 22, 2023 regarding safe-handling of food, appropriate temperatures for food, and proper sanitation for the kitchen, including, but not limited to hand hygiene. All sanitation concerns have been addressed and corrected on or before 8/11/2023. Dietary Director/Designee will conduct an audit of all safe-handling of food, appropriate temperatures for food, and proper sanitation for the kitchen, including, but not limited to hand hygiene at least 2 X a week times 4 weeks, then weekly X 4 weeks, then 2 X monthly X 4 months to ensure code status has been specified. Any identified concerns will be promptly addressed with the responsible individual(s).	

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	On 7/12/23 at 10:52 a.m., Cook 29 was observed preparing pureed foods. She washed her hands, turned the faucet off with her bare hands then dried them on paper towels. 2b. On 7/10/23 at 11:52 a.m., Certified Nursing Assistant (CNA) 4 sat down between Resident 7 and Resident 10. She pulled the chair up with her bare hands and did not use hand hygiene. She mixed a pat of butter into Resident 10's mashed potatoes, then mixed butter into Resident 7's mashed potatoes. She did not perform hand hygiene between residents. During a continuous observation, from 11:54 a.m., to 11:57 a.m., CNA 4 was observed going back and forth between the two residents providing several bites of food to each resident without using hand hygiene. On 7/10/23 at 11:57 a.m., CNA 4 provided a bite of mashed potatoes to Resident 10. Then, she reached down to her lap and pulled up a small blanket. She did not use hand hygiene before providing a bite of food to Resident 7. On 7/10/23 at 11:58 a.m., CNA 4 readjusted Resident 7's clothing protector and did not perform hand hygiene before proving Resident 10 a bite of food. During a continuous observation, from 11:58 a.m., to 12:02 p.m., CNA 4 was observed going back and forth between the two residents providing several bites of food to each resident without using hand hygiene. On 7/10/23 at 12:02 p.m., CNA 4 was observed rubbing her right shoulder with her left hand. She		Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or disciplined as indicated. 1.How will the corrective action(s) will be monitored? Dietary Director/Designee will provide results of these audits to be reviewed in QAPI Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 1.Completion date: August 22, 2023	

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	155211	A. BUILDING 00 B. WING	07/14/2023

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	did not use hand hygiene before providing Resident 7. On 7/10/23 at 12:03 p.m., CNA 4 was observed to lay both her hands flat on her thighs. She did not hand wash before providing food to Resident 10. On 7/10/23 at 12:04 p.m., CNA 4 was observed to lay both her hands flat on her thighs. She did not hand wash before providing food to Resident 7. On 7/10/23 at 12:07 p.m., CNA 4 touched her hair, did not use hand hygiene, and provided food for Resident 10. On 7/10/23 at 12:10 p.m., CNA 4 touched her hair, did not use hand hygiene, and provided a drink for Resident 10. During an interview, on 7/14/23 at 1:18 p.m., the DON indicated staff should use hand gel between touching themselves or other surfaces. For assisting residents with eating, the CNAs should only assist one resident at a time. The facility had enough staff for the resident's to received one on one care with eating. A current policy, titled, "Hand Hygiene," with no date, was provided by the DON, on 7/12/23 at 11:36 a.m. A review of the policy indicated, " ...wet hands ...apply generous amount of soap to hands and run hands together vigorously for at least 20 seconds dry thoroughly with a disposable towel ...rinse hands with warm water ...Use towel to turn off faucet and exit ad the area ...." A current policy, titled, "Stop Germs! Wash Your Hands," with no date, was provided by the DON, on 7/14/23 at 2:10 p.m. A review of the policy indicated, " ...Keeping hands clean is one of the			

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	most important things we can do to stop the spread of germs and stay healthy ...." 3. On 7/10/23 at 11:25 a.m., the front of the fryer was observed with oil streaks down the front of it, the inside had a thick ring of very brown crumbs at and above the oil line with a slightly burned odor. Dietary Aide (DA) 8 indicated the kitchen staff were unable to clean the fryer because the grease dumpster behind the kitchen was full. The last time it was cleaned was June 27th. On 7/12/23 at 10:51 a.m., the front of the fryer was observed with oil streaks down the front of it, the inside had a thick ring of very brown crumbs at and above the oil line with a slightly burned odor. On 7/12/23 at 11:18 a.m., the Dietary Manager (DM) indicated the grease dumpster outside was overflowing. We have new grease for the fryer once we can empty it. We called the Maintenance man (MM) twice. The MM calls the company to come out to empty the grease dumpster. We fry chicken tenders and french fries every day. as always available food. A current policy, titled, "Cleaning Instructions: Fryer," with no date, was provided by the DON, on 7/12/23 at 11:36 a.m. A review of the policy indicated, " ...fryer will be cleaned on a routine basis ...." 3.1-18(l) 3.1-21(i)(2) 3.1-21(i)(3)			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations			

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	§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;			

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	(iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on observation, interview and record review, the facility failed to ensure a resident, (Resident 32) received a pneumococcal vaccination upon her admission and written consent for 1 of 5 residents reviewed for vaccination status. Findings include: On 7/10/23 at 11:24 a.m., Resident 32 was observed in her room. She was seated in a regular wheelchair (WC). She had poor posture and was hunched forward, unable to lift her head all the way. She was alert, oriented and pleasant. When asked if she had any concerns, she indicated, she wanted to get off her all-liquid diet. When asked why she was on a full liquid diet, Resident 32 indicated, on 5/5/23 she was in the main dining room when she all of the sudden didn't feel right and she started to choke. She did not remember anything else because she lost consciousness and was told later, staff had to perform cardiopulmonary resuscitation (CPR). Resident 32 indicated she had a type of neuropathy that affected more than just her extremities and her esophagus was twisted and narrow which may	F 0883	It is the intent of this facility to offer the pneumococcal vaccine upon admission and administer if resident consented. 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #32 has received a pneumonia vaccine on 7/5/23. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? An audit was conducted to identify those residents who had consented to receive the pneumonia vaccine, however, had not yet received. Those residents identified have had the pneumonia vaccine administered. Audit was	08/22/2023

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	have caused her to choke. She indicated, she had also been treated for pneumonia and had still been a little weak from the infection. During an interview on 7/14/23 at 9:22 a.m., Resident 32's husband indicated he and Resident 32 had given permission and consent for her to receive the flu and pneumonia vaccinations. As far as he was aware, she had received them. When asked about cardiac arrest and choking incident on 5/5/23, he indicated, he had been on the way to visit her when the facility called and told him what happened. When he got the hospital, she was in bad shape. She was on a ventilator, and it was unclear if she would recover. He indicated, Resident 32 had previously been treated for pneumonia, but they thought it had been resolved. She had some residual shortness of breath and weakness. On 7/13/23 at 1:45 p.m., Resident 32's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, spinal stenosis (A narrowing of the spinal canal), idiopathic peripheral autonomic neuropathy (occurs when there is damage to the nerves that control automatic body functions) and weakness. Upon a readmission, Resident 32 signed a Vaccination Consent Form, dated 2/24/23, and requested the pneumonia vaccine. The record lacked documentation that the vaccine had been administered. Nursing progress notes were reviewed and revealed the following:		completed by DON/designee on 7/19/23. 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nursing staff, including IP, have been re-educated by the DON/Designee relative to Influenza and Pneumococcal Immunizations, including but not limited to, ensuring that a resident who has given consent receives the pneumonia vaccine in a timely manner. Education initiated 8/09/23 and completed 8/11/23. Additionally, any staff that fails to comply with the points of this in-service will be further educated/or disciplined as indicated. The IP/Designee will be responsible to audit the charts of 5 residents per week X 4 weeks, then 3 residents per week X 4 weeks, then 2 residents per month X 4 months to ensure any resident who has given consent for a vaccination receives the vaccination in a timely manner. Any identified concerns will be promptly addressed with the responsible individual(s	

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	On 3/28/23 at 10:44 a.m., Resident 32 received Doxycycline (an antibiotic medication) for congestion. On 3/28/23 at 5:19 p.m., Resident 32 complained of shortness of breath and wheezing. She was given breathing treatment and felt better. On 3/30/23 at 8:50 p.m., Resident 32 continued on antibiotic therapy for respiratory infection. On 4/3/23 at 12:33 p.m. a new order for a chest x-ray was placed and on 4/4/23 at 8:08 p.m., the x-ray results were reviewed and showed signs of pneumonia. The on call Medical Doctor (MD) was contacted and new ordered were received to schedule albuterol treatments every 6 hours and continue her antibiotic. During an interview on 7/14/23 at 12:38 p.m., the Director of nursing, (DON) indicated, she was not yet hired at the time of Resident 32's readmission, but standard nursing practice would indicate, if a resident signed consent to receive a vaccination, then it should be administered during the next round of vaccines. Since Resident 32's consent was signed upon her admission and in the middle of the flu season, she should have gotten the vaccine as soon as possible. On 7/14/23 at 12:30 p.m., the DON provided a copy of current, but undated facility policy titled, "Guidelines for Pneumococcal Vaccination." The policy indicated, "It is the intent of the facility to minimize the risk of residents acquiring, transmitting and/or experiencing complication s from Pneumococcal pneumonia. This policy will assure that each resident and/or their representative/(POA) is informed ... and that each resident has the opportunity to receive the		1.How will the corrective action(s) will be monitored? DON/Designee will be responsible to provide audit results in QAPI Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 6 consecutive months the auditing will be stopped. The QAPI Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 1.Completion date: August 22, 2023	

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	vaccine ...." 483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.			
F 0921 SS=F Bldg. 00	Based on interview and record review, the facility failed to ensure compliance with Indiana Department of Environmental Management's (IDEM) requirement to submit documentation of a fully certified Water Distribution Manager to comply with the Safe Drinking Water Act. Further, the facility failed to ensure a Plan of Correction was submitted after an onsite inspected which resulted in deficient practice on June 30, 2021. These deficient practices had the potential to effect 43 of 43 residents who resided in the facility. Findings include: During an interview on 7/14/23 at 12:14 p.m., the Section Chief for the IDEM Drinking Water Field Inspection, (SC), indicated, IDEM did not have documentation to satisfy the requirement of a designated water safety operator. Additionally, an onsite inspection had been conducted on 6/30/2021, and the facility failed to submit a formal Plan of Correction for the cited deficiencies at that time. On 7/13/2023, a second letter of noncompliance was submitted which requested these requirements to be addressed. The SC submitted a copy of the letter of noncompliance for review. A Noncompliance Letter on IDEM letterhead, dated 7/13/2023 indicated, "On July 13, 2023, representatives of IDEM, Office of Water Quality,	F 0921	**F 921**– It is the intent of the facility to ensure to have a designated water safety operator to meet set standards. 1. **CORRECTIVE ACTIONS TAKEN**: a. Effective immediately, the Waters of Lebanon will have a designated water safety operator in the building to meet set standards. b. The Waters of Lebanon will notify the IDEM commissioner within 30 days if any changes to the current person serving as the operator. c. The Waters of Lebanon has corrected all of the seven deficiencies and sent the documentation with photos back to IDEM. d. The Waters of Lebanon has a site-specific water management program in place. 2. **ALL OTHERS WITH POTENTIAL TO BE AFFECTED**: e. All residents and all staff and visitors have the potential to be affected but none were. 3. **MEASURES TO PREVENT REOCCURRENCE**: f. On 07/18/2023 the	08/22/2023

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	conducted a second review of the Waters of Lebanon ...a summary of the review is provided below: ...according to our records ... The Waters of Lebanon is without a certified operator in responsible charge ... it also states that a written notice is to be submitted to the Commissioner no later than 30 days after the occurrence of a change in the person serving as the certified operator in responsible charge ... On 7/17/23 at 1:55 p.m., the SC provided a copy of the first noncompliance letter dated 6/6/23, which stated the same information as above. Further, the SC submitted a summary of prior Sanitary Survey results, where were reviewed on 7/14/23 at 12:30 p.m. A Sanitation Survey was conducted on 7/3/18 which resulted in a System Management & Operation Deficiency, "DSS FSO certification for [Maintenance Director] expired on 6/30/14 ... [MD] needs to become DSS certified or have another person become certified as the Facility Specific Operator ..." During an interview on 7/14/23 at 1:30 p.m., the Maintenance Director indicated he believed he was DSS certified and provided a copy of his certificate. A copy of the Maintenance Director's DSS certificate was reviewed, although it was undated, an accompanying letter dated 10/22/25 indicated instruction for the DSS examination. A review of the Indiana State License and Certification website on 7/14/23 at 1:35 p.m., revealed the Maintenance Director's DSS certification was "Inactive." A review of the IDEM		Administrator inserviced the Maintenance Supervisor/designee on the requirement to ensure to have a designated water safety operator with an active certification, will notify IDEM within 30 days of any changes to the water safety operator, any deficiencies will be corrected immediately and sent back to IDEM and must have a site specific water management program in place to meet set standards. g. Maintenance Supervisor/designee will ensure to have a designated water safety operator with an active certification, will notify IDEM within 30 days of any changes to the water safety operator, any deficiencies will be corrected immediately and sent back to IDEM and must have a site specific water management program in as a part of the facility's monthly Preventive Water Management Program/ Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately. The Maintenance Supervisor/designee will review with the Administrator the inspection results. h. The Administrator will monitor adherence to the Preventative Maintenance schedule and validate the	

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	website for Operator Requirement and Qualifications indicated, "Once certified, an operator must get their required continuing education hours and renew their license(s) triennially (every three years)." Secondly, the Sanitary Survey report submitted by the SC indicated, a Sanitation Survey was conducted on 6/30/2021 and cited 7 deficiencies, with no resolved dates. During an interview on 7/14/23 at 1:37 p.m., the Maintenance Director indicated he was not responsible for writing or submitted plan or correction reports. That was his Regional Supervisor's responsibility. During an interview on 7/14/23 at 1:45 p.m., The Maintenance Director Regional Supervisor (RMD) indicated, he could not remember when or who he submitted a plan of correction to, but that he was sure it had been completed. On 4/14/23 at 2:00 p.m., the Maintenance Director provided a copy of his "notes" on the corrections that were made for the 6/30/21 sanitation survey. The report was 11 pages long and contained pictures of deficient equipment/areas. The MD indicated, next to the pictures were his handwritten notes of the corrections that had been completed. The report lacked documentation of who completed the repairs, and/or how the deficiency would be monitored/maintained as to not repeat the deficiency. The Maintenance Director and the RMD were unable to provide a copy of a formal plan of correction. On 7/14/23 at 2:30 p.m., the Maintenance Director		Preventative Maintenance documentation is in place. 4. **MONITORING CORRECTIVE ACTION**: i. The inspection results will be presented by the Maintenance Supervisor/designee to the Administrator monthly and the Administrator will present the inspection results at the monthly Quality Assurance/Performance Improvement (QA/PI) meeting. Inspection results and system components will be reviewed by the QA/PI Committee with subsequent plans of correction developed and implemented as deemed necessary to ensure compliance is maintained.	

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	provided a copy of current, but undated facility policy titled, "Water Systems- Legionella Risk Prevention." The policy indicated, "It is the policy of the facility to ensure that microbial growth is inhibited in the water system. The facility will provide a safe, sanitary and comfortable environment to include practices in place to help prevent the development and transmission of communicable disease and infection ... If you qualify for a Water Management Program, make a building specific list (for the building for which the Water Management Program is being devised) taken from the Mater Lust as to areas/equipment that need to be monitored ... program review needs to take place at least annually ...." This federal/state tag relates to Complaint IN00412867. 3.1-19(b)			
F 9999 Bldg. 00	3.1-13 ADMINISTRATION AND MANAGEMENT (w) The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to:	F 9999	1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1., 2., 4., 5., & 6. Employee #s 7, 19, 20, 22, & 23 will receive the required dementia training on or before August 22,2023. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken?	08/22/2023

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	(1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. (x) The director of the Alzheimer's and dementia special care unit shall do the following: (1) Oversee the operation of the unit. (2) Ensure that: (A) personnel assigned to the unit receive required in-service training; and (B) care provided to Alzheimer's and dementia care unit residents is consistent with: (i) in-service training; (ii) current Alzheimer's and dementia care practices; and This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure the state required dementia training was provided upon hire and annually for staff working at the facility for 5 of 7 staff members reviewed for dementia training (Employees 7, 19, 20, 22, and 23). Findings include: 1. Employee 7 was hired on 8/25/17. Her file lacked documentation of the required annual 3 hours of dementia training. 2. Employee 19 was hired on 11/17/22. During an interview with her on 7/14/23 at 12:12 p.m., she indicated she did not receive the required 6 hours of dementia training. 4. Employee 20 was hired on 3/3/23. During an interview with her on 7/14/23 at 12:15 p.m., she indicated she did not receive the required 6 hours		All staff have the potential to be affected by the cited practice; therefore, this plan of correction applies to all residents currently residing in the facility. 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All facility staff will be re-educated relative to Administration and Management, including but not limited to annual in-service training requirements on or before 8/22/23. HR Director/Designee will conduct an audit of at least 5 employee files weekly for 2 months, and then 5 employee files bi-monthly for 4 months to ensure all required in-service education is completed. Any identified concerns will be promptly addressed with the responsible individual(s). Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or disciplined as indicated. 4. How will the corrective action(s) will be monitored? DON/Designee will be responsible	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155211	A. BUILDING 00 B. WING	07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	of dementia training. 5. Employee 22 was hired on 11/17/19. Her file lacked documentation of the required annual 3 hours of dementia training. 6. Employee 23 was hired on 8/21/18. Her file lacked documentation of the required annual 3 hours of dementia training. During an interview with HR (Human Resources) on 7/14/23 at 1:00 p.m., she indicated they used "Hand over Hand" to train all employees. She indicated she was new to the position and had a plan to address the dementia training for the facilities employees. A policy was requested for dementia training on 7/14/23 at 1:00 p.m. A copy of the instructor's certification was provided on 7/14/23 at 2:01 p.m. A policy was not provided at the time of exit on 7/14/23.		to provide audit results in QAPI Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 6 consecutive months the auditing will be stopped. The QAPI Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Completion date: August 22, 2023	