STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15E683	A. BUILDING 00 B. WING	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MORGANTOWN HEALTH CARE	140 W WASHINGTON ST MORGANTOWN, IN 46160

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 6, 7, 8, 9, and 10, 2023 Facility number: 000399 Provider number: 15E683 AIM number: 100289100 Census Bed Type: SNF/NF: 32 Total: 32 Census Payor Type: Medicaid: 27 Other: 5 Total: 32 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 17, 2023.	F 0000	THIS PLAN OF CORRECTION IS PREPARED AND EXECUTED BECAUSE IT IS REQ;UIRED BY THE PROVISIONS OF THE STATE AND FEDERAL REGULATIONS AND CITATIONS LISTED ON THIS STAATEMENT OF DEFICIENCIES. THIS PLAN OF CORRECTION SHALL OPERATE AS MORGANTOWN'S WRITTEN CREDIGLE ALLEGATION OF COMPLIANCE. MORGANTOWN HEALTH CARE RESPECTFULLY REQUEST PAPER COMPLIANCE ON THE ATTACHED PLAN OF CORRECTION.	
F 0604 SS=E Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
DALE W. HARTMAN	HFA	09/01/2023

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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	abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from physical restraints for 4 of 5 residents reviewed for physical restraints. (Resident 28, Resident 3, Resident 15, Resident 23) Findings include: 1. On the following dates, times, and locations, Resident 28 was observed sitting in a Broda wheelchair (a chaired designed to provide supportive positioning, decrease postural deviations, and enhance patient safety while facilitating safe, frequent repositioning) with restraining straps secured across the resident's upper legs. The straps were unable to be removed by the resident: - On 8/6/23 at 11:00 a.m. and 2:00 p.m. in her room. - On 8/7/23 at 10:54 a.m. and 2:20 p.m. in her room. - On 8/8/23 at 10:10 a.m. and 11:30 a.m. in her room,	F 0604	1. ADON IMMEDIATELY STARTED TO REVIEW RESTRAINT ORDERS FOR EACH RESIDENT THAT WAS IN A RESTRAINT AT THIS TIME. 2. ALL RESIDENTS HAS THE POTENTIAL TO BE AFFECTED. 3. ALL ORDERS FOR RESTRAINTS WILL BE MORE SPECIFIC AND DETAILED TO RESIDENT REQUIREMENT OF USE OF RESTRAINTS TO MAINTAIN HIGHEST LEVEL OF INDEPENCE. A LOG WELL BE ESTABLISHED TO SHOW WHEN A RESIDENT IF PLACED ON RESTRAINTS, THE PHYSCIAN	09/03/2023

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	at 1:38 p.m. in the dining room, and at 2:45 p.m. in the hallway near the nurse's station. - On 8/9/23 at 9:17 a.m. in the dining room, at 10:28 a.m., 11:05 a.m., and 3:21 p.m. in her room. - On 8/10/23 at 9:45 a.m. in her room. There were no observations of the resident pacing during the survey time period. On 8/8/23 at 11:35 a.m., Resident 28's clinical record was reviewed. The diagnoses included, but were not limited to, anxiety disorder and dementia. Physician's orders with a start date of 4/1/23 through the current date indicated, "Broda chair with straps at meals to remain on task", "Broda chair with straps as needed related to pacing to the point of exhaustion". No documentation was identified that specified the length of time or frequency the resident was to be in the broda chair with straps. There was no documentation indicating if or when the resident was released from the restraints, and there was no documentation identifying any type of specific direct monitoring and supervision provided during the use of the restraint. During an interview on 8/9/23 at 11:45 a.m., the Assistant Director of Nursing indicated the resident leaned forward when she paced, and she paced quickly and to the point of physical exhaustion, therefore, the broda chair and restraint straps were for her safety. Staff removed the straps at times to walk with her. The physician order did not indicate a specific length of time or frequency the resident was to be in or out of the broda straps.2. On 8/8/23 at 10:46 a.m., Resident 3 was sitting in the hallway in the broda (for		ORDERS WITH DETAIL ORDERS MUST BE INCLUDED AS TO TIME OF PLACEMENT OF STRAPS AND TIMES TO BE RELEASED AND TIME IN BRODA CHAIR. CNA'S WILL CONTINUE WITH DOCUMTATION TO RECORD WHEN RESIDENT IS RELEASED PER ORDER. REVIEW AND UPDATE POLICY (RESTRAINT) AND WILL APPROVE AT NEXT QAPI MEETING. AN -IN-SERVICE OF ALL NURSING PERSONNEL SHALL BE DONE ON 08/31/23. 4. ADMIN, DON,ADPM WILL CHECK DAILEY THAT EACK RESIDENT IF FREE OF PHYSISICAL RESTRAINTS AS PRESCRIBED BY DOCTOR AND REPORT TO QAPA MONTHLY THEIR FINDINGS AND THE FACILITY WILL FOLLOW THEIR RECOMMENTATION FOR SIX MONTHS. 5. DATE TO BE COMPLTED 09/03/23.	

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	positioning) chair with lap strap restraints on. On 8/8/23 at 1:37 p.m., Resident 3 was sitting in his room in the broda chair with lap strap restraints on. On 8/8/23 at 2:09 p.m., Resident 3 was sitting in his room in the broda chair with lap strap restraints on. On 8/8/23 at 3:07 p.m., Resident 3 was sitting in his room in the broda chair with lap strap restraints on. On 8/9/23 at 10:42 a.m., Resident 3 was sitting in his room in the broda chair with lap strap restraints on. Resident 3's clinical record was reviewed on 8/9/23 at 11:00 a.m. The diagnoses included, but were not limited to, dementia with behavioral disturbance and seizures. Resident 3's Quarterly Minimum Data Set (MDS) assessment, dated 5/16/23, indicated the resident used a chair that prevents rising which is considered to be a restraint. Current physician orders, dated 8/1/23 through 8/31/23, indicated Resident 3's orders included, but were not limited to: - Broda straps to maintain trunk control. The order lacked documentation for the length of time Resident 3 should be in the broda chair, how often, the type of monitoring and ongoing evaluation while resident was sitting in the broda chair. During an interview on 8/9/23 at 11:45 a.m., the			

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	Assistant Director of Nursing indicated the physician order did not indicate a specific length of time or frequency the resident was to be in or out of the broda straps. 3. On 8/7/23 at 10:33 a.m., Resident 15 was sitting in the hallway in the broda chair with lap strap restraints on. On 8/8/23 at 10:47 a.m., Resident 15 was sitting in her room in the broda chair with lap strap restraints on. On 8/8/23 at 1:37 p.m., Resident 15 was sitting in her room in the broda chair with lap strap restraints on. On 8/8/23 at 3:08 p.m., Resident 15 was sitting in her room in the broda chair with lap strap restraints on. On 8/10/23 at 10:32 a.m., Resident 15 was sitting in her room in the broda chair with lap strap restraints on. Resident 15's clinical record was reviewed on 8/10/23 at 10:48 a.m. The diagnoses included, but were not limited to, ataxia (impaired balance or coordination) following unspecified cerebrovascular accident and supra nuclear palsy. Resident 15's Quarterly Minimum Data Set (MDS) assessment, dated 5/23/23, indicated the resident used a chair that prevents rising which is considered to be a restraint. Current physician orders, dated 8/1/23 through 8/31/23, indicated Resident 15's orders included, but were not limited to, may use broda chair in evenings to maintain support.			

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	An updated physician order, dated 8/7/23, indicated to update current broda chair order to, broda chair while up due to inability to maintain erect torso related to palsy. The order lacked documentation of having restraints or straps for Resident 15. During an interview on 8/10/23 at 11:00 a.m., the Assistant Director of Nursing indicated there was no order for Resident 15 which indicated the resident should be in restraints or straps while in the broda chair. 4. On 8/6/23 at 11:04 a.m., Resident 23 was observed to be lying in his bed with his bed positioned against the wall on his right side and with a half side rail positioned in the middle of his left side of the bed. On 8/7/23 at 10:59 a.m., Resident 23 was observed to be lying in his bed with his bed positioned against the wall on his right side and with a half side rail positioned in the middle of his left side of the bed. On 8/7/23 at 11:49 a.m., Resident 23 was observed to be sitting at the foot of his bed with his bed positioned against the wall on his right side and with a half side rail positioned in the middle of his bed left side of his bed. On 8/8/23 at 11:27 a.m., Resident 23 was observed to be ambulating in his room. On 8/9/23 at 11:48 a.m., Resident 23's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease, dementia with behaviors, agitation, and muscle weakness. A Quarterly Minimum Data Set (MDS) assessment, dated 7/15/23, indicated Resident 23			

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	had moderate impaired cognition and required limited assistance of one with bed mobility, and no restraint use. A Side Rail Assessment, dated 7/15/23, Resident 23 was ambulatory; demonstrated poor bed mobility; had history of falls; used the side rail for rising, positioning, or support; had cognitive impairment; one side rail was indicated to assist resident with positioning or turning. A Physical Restraint Elimination Evaluation, dated 7/15/23, indicated Resident 23 utilized a half side rail times one to enhance his ability to turn, reposition, and transfer. A care plan, dated 7/18/23 and current through target date 10/18/23, indicated Resident 23 utilized a half side rail to enhance his ability to turn and reposition. The interventions lacked documentation of where the side rail was to be placed on the side of the bed. During an interview on 8/9/23 at 11:10 a.m., Certified Nursing Assistant (CNA) 1 indicated Resident 23 had been utilizing a half side rail on his bed since his decline in activities of daily living. Once he was steady on his feet, he was able to ambulate in his room. During an interview on 8/10/23 at 1:20 p.m., the Director of Nursing (DON) indicated Resident 23 was able to ambulate in his room and utilized his half side rail for turning and repositioning in bed. With the DON in Resident 23's room, she observed his half side rail and indicated the side rail was not placed in the proper position. The half side rail needed to be placed higher up towards the head of the bed.			

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	During an interview on 8/9/23 at 2:27 p.m., the DON indicated Resident 23 could not get out of his bed freely and ambulate with the half side rail placed in the middle of the bed. On 8/10/23 at 1:15 p.m., the Director of Nursing provided the policy, "Use of Restraints," undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "... Policy ... 2. ... If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather that climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint ... 8. ... Treatment restraints shall be applied for no longer than the time required to complete the treatment ... 9. Restraints shall only be used upon the written order of a physician ... c. The type of restraint and period of time for the use of the restraint ... 12. b. The restraints that are used will be the least restrictive and applied for the least amount of time ... d. A resident placed in a restraint will be observed at least every thirty minutes by nursing personnel and an account of the resident's condition shall be recorded in the resident's medical record ... e. The opportunity for motion and exercise is provided for a period of not less than 10 minutes during each two hours in which restraints are employed ... f. Restrained residents must be repositioned at least every two hours on all shifts ... 19. Documentation regarding the use of restraints shall include: ... e. The length of effectiveness of the restraint time ... 3.1-26(b) 3.1-26(f) 3.1-26(g) 3.1-26(h)			

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F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is			

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	required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill			

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	Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on interview and record review, the facility failed to ensure that written notification required for facility-initiated transfers were given to the residents or resident representatives for 3 of 3 residents reviewed. (Resident 9, Resident 32, Resident 18) Findings include: 1. On 8/9/23 at 10:00 a.m., Resident 9's clinical record was reviewed. The diagnosis included, but was not limited to, schizophrenia. A review of his discharge Minimum Data Set Assessment, dated 7/25/23, indicated he was sent out to the psychiatric hospital. A 8/3/23 readmission progress note, indicated	F 0623	1. REVIEWED DISCHARGE POLICY AND TRANSFERED PACKET CREATED, NURSING TO DO LIST CREATED TO UTILIZE FOR DISCHAGE AND TRANSFER. IN-SERVICE SCHEDULED FOR 8/31/23. POLICY WAS REVIEWED BY DON,SSD,ADON, ADMIN. 2.ALL RESIDENTS HAS THE POTENTIAL TO BE AFFECTED. 3. ALL TRANSFER WILL BE AUDITED WITHIN 48 HOURS BY DON, ADON TO ENSURE THAT	09/03/2023

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	Resident 9 was sent to the psychiatric inpatient hospital after an elopement and threatening to kill staff. There was no documentation the resident or resident's representative had been notified of his transfer in writing and provided the appeal rights information in writing and the contact information of the Office of the State LTC (Long-Term Care) Ombudsman after the resident was sent out to the hospital. During an interview on 8/10/23 at 9:25 a.m., the Assistant Director of Nursing (ADON) indicated the notice of transfer requirements had been likely been provided to the resident and resident representative when the resident was sent to the hospital. However, staff did not make a copy of the notice for the record. There was no other documentation or policy available for review. 2. On 8/9/23 at 10:12 a.m., Resident 18's clinical record was reviewed. The diagnoses included, but were not limited to, generalized anxiety disorder, alcohol use disorder, insomnia, and Lewy body dementia with severe behavioral and psychotic disturbance. A review of his discharge Minimum Data Set Assessment, dated 5/2/23, indicated he was sent out to the psychiatric hospital, and on 5/28/23, he was sent to an acute care hospital. On 4/25/23, Resident 18's psychiatric progress note, indicated the resident was being seen following an admission to psychiatric inpatient hospital. There was no documentation the resident or resident's representative had been notified of her transfer in writing and provided the appeal rights information in writing and the contact information of the Office of the State LTC (Long-Term Care) Ombudsman after the resident		ALL PAPER WORK IS COMPLETED ON DISCHARGES. A LOG WILL BE PREPARED FOR TRANSFERS. A COPY OF THESE WILL BE GIVEN TO THE RESIDENT AND A COPY WILL BE RETAINDED FOR THE RESIDENTS CHART AS WELL AS NOTIFICATION OF RESIDENTS REPRESENTATIVE IS NOTIFIED OF TRANSFER. POLICY WILL BE REVIEWED BY THE ADMIN,DON, ADON, SSD. IN-SERVICE SCHEDULED 8/31/23, 4. ADMIN, DON,ADON, SSD WILL MONITOIR DAILEY THAT A WRITTEN TRANSFER IS GIVEN TO RESIDENT OR REPRESENTATIVE WILL BE REPORTED TO THE QAPI COMMITTEE, THE FACILTIY WILL FOLLOW THE RECOMENDATION THE QAPI COMITTEE FOR SIX MONTHS. 5, DATE COMPLETED 09/03/23	

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MORGANTOWN HEALTH CARE	140 W WASHINGTON ST MORGANTOWN, IN 46160

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	was sent out to the hospital. During an interview on 8/10/23 at 9:25 a.m., the Assistant Director of Nursing (ADON) indicated the notice of transfer requirements had been likely been provided to the resident and resident representative when the resident was sent to the hospital. However, staff did not make a copy of the notice for the record. There was no other documentation or policy available for review. 3. On 8/9/23 at 10:32 a.m., Resident 32's clinical record was reviewed. The diagnoses included, but were not limited to, depression, anxiety, alcohol use disorder, insomnia, and dementia. A review of his discharge Minimum Data Set Assessment, dated 7/5/23, indicated he was discharged to another nursing home. During an interview on 8/10/23 at 9:25 a.m., the Assistant Director of Nursing (ADON) indicated the notice of transfer requirements had likely been provided to the resident and resident representative when the resident was discharged. However, staff did not make a copy of the notice for the record. There was no other documentation or policy available for review. 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic			

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	leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to ensure staff provided notifications of bed hold policy required for residents that transferred to the hospital for 2 of 2 residents reviewed for hospitalization. (Resident 9, Resident 18) Findings include: 1. On 8/9/23 at 10:00 a.m., Resident 9's clinical record was reviewed. The diagnosis included, but was not limited to, schizophrenia. A review of his discharge Minimum Data Set Assessment, dated 7/25/23, indicated he was sent out to the psychiatric hospital.	F 0625	1. REVIEWED TRANSFER AND HOLD POLICY AND IN-SERVICE TO BE 8/31/23. 2. ALL RESIDENTS HAVE THE POTENTIAL TO AFFECTED. 3. A LOG WILL BE PREPARE FOR TRANSFER AND BED HOLD POLICIES. A COPY OF THESE WILL BE GIVE TO THE RESIDENT AND A COPY WILL BE RETAINED IN THE RESIDENTS CHART.	09/03/2023

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	Review of the resident's clinical record revealed no documentation that a written notice that specified the facility's bed-hold policy permitting the resident to return and resume resident in the facility was provided to the resident or resident's representative. During an interview on 8/10/23 at 9:25 a.m., the Assistant Director of Nursing (ADON) indicated the bed-hold policy had been likely been provided to the resident and resident representative when the resident was sent to the hospital. However, staff did not make a copy for the clinical record. There was no other documentation or policy available for review. 2. On 8/9/23 at 10:12 a.m., Resident 18's clinical record was reviewed. The diagnoses included, but were not limited to, generalized anxiety disorder, alcohol use disorder, insomnia, and Lewy body dementia with severe behavioral and psychotic disturbance. A review of his discharge Minimum Data Set Assessment, dated 5/2/23, indicated he was sent out to the psychiatric hospital, and on 5/28/23, he was sent to an acute care hospital. Review of the resident's clinical record revealed no documentation that a written notice that specified the facility's bed-hold policy permitting the resident to return and resume resident in the facility was provided to the resident or resident's representative. During an interview on 8/10/23 at 9:25 a.m., the Assistant Director of Nursing (ADON) indicated the bed-hold policy had been likely been provided to the resident and resident representative when		DON AND ADON WILL REVIEW WEEKLY THE TRANSFER AND BED HOLDS WITHIN 48 HOURS TO ASSURE THE TRANSFER AND BED HOLDS ARE IN PLACE AND THAT GUARDIANS HAVE BEEN NOTIFIED OF TRANSFER AND BE HOLDS. IN-SERVICE SCHULED FOR 8/31/23. 4. ADMIN, DON,ADON WILL MONITOR WEEKY THAT EACH NOTIFICATION AND BED HOLD IS REPORTED TO QAPO AND THAT THE FACILITY WILL FOLLOW THE RECOMMENDATIONS OF THE QAPI COMMITTEE FOR SIX MONTHS. 5. DATE COMPLETED 09/03/23	

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	the resident was sent to the hospital. However, staff did not make a copy for the clinical record. There was no other documentation or policy available for review. 3.1-12(a)(25) 3.1-12(a)(26)			
F 0727 SS=C Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS (Centers for Medicare and Medicaid Services) for Quarter 2 (January, February, March) of fiscal year 2023. Findings include: On 8/8/23 at 10:30 a.m., the facility's Payroll Based Journal (PBJ) Staffing Data Report was reviewed. The report indicated the facility had no RN hours	F 0727	1. REVIEWED CURRENT SCHEDULED TO ASSURE PROPER NURSING COVERAGE IN PLACE. 2, ALL RESIDENTS THE POTENTIAL TO BE AFFECTED. 3 WEEKLY REVIEW BY ADMIN., DON, ADON TO MAKE	09/03/2023

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	for 1/18/23, 1/26/23, 2/8/23, 2/9/23, 2/14/23, and 2/20/23. A review of the staffing sheets with the Business Office Manager (BOM) submitted indicated there was not RN coverage on 1/18/23, 2/14/23, and 2/20/23. The BOM did not know why there was no RN coverage for those days. 3.1-17(a)(3)		SURE PROPER SCHEDULING IS IN PLALCE FOR NURSING AND ACCORDING TO STATE REQUIREMENTS, IN-SERVICE SCHEDULED FOR 8/31/23. 4 ADMIN. DON, ADON WILL MONITOR DAILY AND REPORT TO QAPI, THE FACILITY SHALL FOLLOW THE RECOMMENDATIONS OF THE QAPI COMMITTEE FOR SIX MONTHS. 5. DATE COMPLETED 09/03/23	
F 0851 SS=D Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical			

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	environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. Based on interview and record review, the facility	F 0851	1. PBS REVIEWED ALONG	09/03/2023

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	failed to electronically submit to the Centers for Medicare and Medicaid Services (CMS) complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS for quarter 2 (January, February, March) of fiscal year 2023. Findings include: On 8/8/23 at 10:30 a.m., the facility's Payroll Based Journal (PBJ) Staffing Data Report was reviewed. The report indicated the facility had no RN hours for 1/18/23, 1/26/23, 2/8/23, 2/9/23, 2/14/23, and 2/20/23. The report further indicated the facility failed to have Licensed Nursing Coverage 24 hours/Day on 2/8/23 2/9/23, 2/17/23, and 2/10/23. Lastly, the facility received a 1 star staffing rating during the 2 quarter. A review of the staffing sheets the Business Office Manager submitted indicated there was not RN coverage on 1/18/23, 2/14/23, and 2/20/23, but the facility did have 24 hours of licensed nurse coverage. During an interview at that time, she indicated that the website to submit PBJ information was not user friendly and will often time out, erasing all of the information she had entered. She further indicated that she has been a month behind on submitting data.		WITH STATE REGULATIONS. 2. ALL RESIDENTS HAVE THE POTENTIAL TO BE AFFECTED. 3. PBJ TO REVIEWED WITH ADMIN. DON,ADON MONTHLY BEFORE TRANSMISSION AND THE PERSON WHO PREPARES THE INFORMATION BEFORE TRASMISSION TO CMS. AN IN-SERVICE IS SCHEDULED FOR 8/31/23. 4.ADMIN, DON. ADON WILL MONITOR WEEKLY, AND REPORT THEIR FINDINGS TO QAPI THEIR FINDINGS AND FACILITY SHALL FOLLOW THE RECOMMENTIONS OF QAPI, FOR SIX MOTHS. 5. DATE COMPLETED 09/03/23	