STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders and an assessment to self-administer their own medications for 1 of 1 residents reviewed for self-administration of medication. (Resident S) Finding includes: On 12/13/22 10 a.m., and 2:54 p.m., Resident S was observed in bed. At those times, there was an inhaler observed of Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder 100 -25 micrograms (mcg) on the over bed table. The resident indicated she used the inhaler 1 time every day. The record for the resident was reviewed on 12/15/22 at 11:25 a.m. Diagnoses included, but were not limited to, congestive heart failure, chronic respiratory failure, stroke, COPD, type 2 diabetes, sleep apnea, and bradycardia. The Annual Minimum Data Set (MDS) assessment, dated 10/12/22, indicated the resident was cognitively intact. There was no care plan to self-administer her medications. There was no self-administer of medications assessment completed for the resident. Physician's Orders, dated 9/22/22, indicated	F 0554	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Residents S was not harmed by the alleged deficient practice. The medication was immediately removed from bedside. 2. All residents have the potential to be affected by same alleged deficient practice. Each resident room was audited to ensure that there are no medications at bedside. 3. DON/Designee has educated all Licensed nurses and QMA's on the self-administration of medication policy and the Medication administration policy, with a focus on "do not leave the	01/13/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lenore Williams	RN	01/09/2023

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	Fluticasone Furoate-Vilanterol Inhalation Aerosol Powder Breath 100-25 mcg (Fluticasone Furoate-Vilanterol). Inhale 1 puff orally in the morning for COPD. Rinse and spit after every use. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated there was no self-administration of medication orders or an assessment for the resident. 3.1-11(a)		medication unattended" and "assessment for self-administration". 4. DON/Designee will audit 5 resident rooms 5 x wk x 4 wks, then 3 resident rooms 3 x wk x 4 wks, then 3 resident rooms 1 x wk x 4 wks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of			

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	such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on interview and record review, the facility failed to address resident council concerns in a timely manner for 1 of 1 resident council groups. This had the potential to affect all residents who attended or participated in the resident council group. Findings include: 1. The resident council minutes from the last 3 months were reviewed on 12/19/22 at 11:25 a.m. The 9/29/22 meeting minutes indicated there were no new concerns and they wanted their concerns from the August 2022 meeting addressed. The "Old Business" to be addressed were call lights, name tags, CNA rounds, food temperatures, and customer service concerns. The Administrator and the Director of Nursing were in attendance and informed the council there was no resolution for their concerns and they were "following up." 2. During the resident council meeting held on	F 0565	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. The residents participating in the Facility's Resident Council meetings were not harmed by the alleged deficient practice. An audit of all grievances was completed for the last 3 Resident Council meetings to ensure all unresolved	01/13/2023

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	12/19/22 at 1:30 p.m., there were 8 residents who attended. The residents expressed a concern that they still had not received resolution for grievances filed from the 8/2022 meeting. In October, they were "so angry they boycotted the meeting". The residents stated "[Name] Administrator keeps saying he is new. [Name] the Director of Nursing says she is new and there is no staff, but they will keep working on it." The Activity Director completed all of the grievances and handed them to the department of concern. They were all aware of how to file personal grievance with the Social Service Director. A resident council grievance, dated 6/30/22, indicated the food was not hot enough when it was served. A summary of the interview indicated the dining room was now open and they were taking temps of the food three times a week. The resolution was blank and if the resident was satisfied was also blank. The grievance was signed by the Dietary Manager and the Administrator with no date. The resident council grievances, dated 8/25/22, indicated the following: a. Call light response: Residents indicated it takes a long time for someone to answer call lights on both units daily. The grievance was signed by Administrator with no date. There was no resolution or resident satisfaction completed. b. Residents don't know staff names or titles when approached by staff on both units. The grievance was signed by Administrator with no date. There was no resolution or resident satisfaction completed. c. CNA rounds: Residents indicated they were not		grievances were resolved and appropriate follow-up was completed. 2. All residents participating in the Resident Council process have the potential to be affected by the same alleged deficient practice An audit of all grievances was completed for the last 3 Resident Council meetings to ensure all unresolved grievances were resolved and appropriate follow-up was completed. 3. Management staff including the Executive Director and the Director of Nursing have been in-serviced on the Resident Grievance Policy. The Social Services Director has been designated as the Grievance Official for the facility. The Social Service Director/designee is responsible for managing all facility grievances both individual grievances and resident council grievances. · All grievances created/received during monthly resident council meetings will be collected by Activity Director and given directly to Social Services Director. · Social Services Director will track and distribute grievances to designated department head to ensure delivery. · Social Services Director will ensure completion of grievances	

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	being checked on every 2 hours on both units daily. The grievance was signed by Administrator with no date. There was no resolution or resident satisfaction completed. d. Residents indicated they were hearing CNA and other staff cussing and saying rude insults in the hallways on both units. The residents indicated there was poor customer service in the hallways and at the nurses' station on both units. The grievance was signed by Administrator with no date. There was no resolution or resident satisfaction completed. e. Residents indicated the food was cold when they received it in their rooms for all meals on both units. The grievance was signed by Administrator with no date. There was no resolution or resident satisfaction completed. Interview with the Administrator on 12/20/22 at 9:00 a.m., indicated he was aware the grievances for the council were still a work in progress and documentation was lacking of the resolutions. The information was not being passed onto the residents. Interview with the Activity Director on 12/20/22 at 9:22 a.m., indicated during the council meetings she completed the grievance forms based on the residents' concerns and turned them into the Administrator if they were building concerns and the Director of Nursing if they were nursing concerns. At the meeting in 9/2022, the council wanted all of their past grievances from 8/2022 acted on. They boycotted the meeting for 10/2022 and just had one at the and of 11/2022. She expected the department heads to give their resolution to her by the next meeting within 30 days.		when returned, follow-up with resident personally to discuss satisfaction of solution, and present to Administrator to sign off once all steps are completed. 4. Social Service Director/Designee will audit resident council meeting minutes and grievances 1 x monthly x 3 months to ensure all concerns are identified and placed on the appropriate grievance form, with resolution, and appropriate follow-up. Social Services Director to complete and send monthly audits of unresolved grievances with due dates and reminders to all department heads. This is an ongoing practice. The Social Services Director / Designee will provide a report on a monthly basis at the QAPI Meeting to the interdisciplinary team for no less than 6 months.	

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	The current 6/19/18, "Resident Grievance" policy, provided by the Nurse Consultant on 12/20/22 at 9:30 a.m., indicated upon receipt of an oral, written, or anonymous grievance submitted by a resident the Grievance Official will take immediate action to prevent further potential violations of any resident right while the alleged violation was being investigated, if indicated. The grievance review will be completed in a reasonable time frame consistent with the type of grievance but not exceed 30 days. The Grievance Official will meet with the resident and inform the resident of the results of the investigation and how the resident's grievance was resolved or will be resolved. A copy of the grievance decision will be provided to the resident upon request. This Federal tag relates to Complaint IN00388811. 3.1-3(I)			
F 0585 SS=E Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may			

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	have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those			

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	grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less			

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	than 3 years from the issuance of the grievance decision. Based on record review, and interview, the facility failed to investigate and resolve resident grievances that were reported to staff for 4 of 4 residents reviewed for grievances. (Residents C, K, E, and H) Findings include: 1. During an interview with Resident C on 12/13/22 at 2:04 p.m., indicated she had filed many grievances in the last couple of months about missing her medications, the food, and staffing and there was no follow up or resolution. During an interview on 12/20/22 at 3:00 p.m., Resident C expressed how offended she was and humiliated in front of other residents when another resident cursed at her and told her to shut up and mind her own business. The resident indicated it happened in November of this year and she filed a grievance against the resident for being so rude. No one had ever spoken to her about the incident or even looked into the matter. The record for Resident C was reviewed on 12/20/22 at 12:15 p.m. Diagnoses included, but were not limited to, heart failure, renal dialysis, type 2 diabetes, high blood pressure and heart disease. The Quarterly Minimum Data Set (MDS) assessment, dated 11/15/22, indicated the resident was cognitively intact. A grievance, dated 8/24/22 at 11:20 p.m., indicated the resident reported not receiving her 8 p.m. medications through a text message to the Social Service Director (SSD) at 11:20 p.m. The SSD	F 0585	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Residents C, K, H, and E were not harmed by the alleged deficient practice. Resident C was re-interviewed for any grievances, concerns were discussed and resolution provided. Resident K was re-interviewed for any grievances, concerns were discussed and resolution provided. Resident H was re-interviewed for any grievances, concerns were discussed and resolution provided. Resident E was re-interviewed for any grievances, concerns were discussed and resolution provided. 2. All residents have the potential to be affected by the same alleged deficient practice An audit of all grievances was completed in the last 30 days to ensure resolution was identified and there was appropriate follow-up with the complainant.	01/13/2023

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	notified the Director of Nursing (DON). The resolution indicated the nurse was notified and ordered to give the meds. The medications were given and the nurse was disciplined. The resident notification of resolution/satisfaction was blank. The grievance was signed by the Assistant Director of Nursing and Administrator on 8/24/22. A grievance, dated 11/12/22 at 11:00 a.m., recorded by the Activity Director, indicated during an activity, a male resident (name) was playing dice with other residents. The resident was sitting next to Resident C and she asked what he rolled on the dice. The male resident said "mind your own f****** business." Resident C said, "you know I cannot see." He said, "we all know you cannot see." Resident C stated "do you have to say the F word?" The male resident stated, "last time I checked this is a free country." Resident C did not respond to him. The location of the incident was in the main dining room in front of 7 other residents. The entire investigation, resolution, and interviews were blank and not completed. The Administrator had signed the grievance with no date noted. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated there was no follow up for the resident's grievances. 2. Interview with Resident K on 12/14/22 at 10:00 a.m., indicated the food was terrible and meals were always late. The resident had missed meals before and she filed a grievance regarding the issue. She had also filed grievances for the food being cold and missing medications, however, "no one ever gets back to her" with the resolution. The record for Resident K was reviewed on 12/16/22 at 11:15 a.m. Diagnoses included, but		Any grievance identified as not having resolution and appropriate follow-up was addressed per the facility grievance process. 3. Management staff including the Executive Director and the Director of Nursing have been in-serviced on the Resident Grievance Policy. The Social Services Director has been designated as the Grievance Official for the facility. The Social Service Director/designee is responsible for managing all facility grievances both individual grievances and resident council grievances. · All grievances created/received during monthly resident council meetings will be collected by Activity Director and given directly to Social Services Director. · Social Services Director will track and distribute grievances to designated department head to ensure delivery. · Social Services Director will ensure completion of grievances when returned, follow-up with resident personally to discuss satisfaction of solution, and present to Administrator to sign off once all steps are completed. 4. Social Service Director/Designee will audit the grievances on the following schedule to ensure resolution and	

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	were not limited to, bipolar disorder, vascular dementia, delusional disorder, high blood pressure, and schizoaffective disorder. The 12/2/22 Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. A grievance, dated 8/24/22, indicated the resident reported not receiving evening medications on the west unit. The resolution indicated the nurse was notified and ordered to give the meds. The medication were given and the nurse was disciplined. The resident notification of resolution/satisfaction was blank. The grievance was signed by the Assistant Director of Nursing and Administrator on 8/24/22. A grievance, dated 8/29/22, indicated there was no cold cereal on her tray and she did not get eating utensils. The resolution was will inservice staff to check trays. The resident notification of resolution/satisfaction was blank. The grievance was signed by the Registered Dietitian and Administrator on 8/30/22. A grievance, dated 10/11/22 at 6:15 p.m., indicated the resident was served dinner at 6:15 p.m. and received a chicken salad sandwich. The resident had concerns regarding the sandwich as she was once hospitalized in February of 2022 and requested something else and informed the CNA. The CNA came back to the resident's room and informed her the kitchen was closed and there was no food available or people to prepare anything for the resident. The resident documented that she reported the incident to the nurse on duty who went to the kitchen and was also informed the same thing, there was no food available. The CNA did come back later and brought a peanut		appropriate follow-up: 10 grievances weekly x 4 weeks, 5 grievances weekly x 4 weeks, then 3 grievances weekly x 4 weeks. Social Services Director to complete and send monthly audits of unresolved grievances with due dates and reminders to all department heads. This is an ongoing practice. The Social Services Director / Designee will provide a report on a monthly basis at the QAPI Meeting to the interdisciplinary team.	

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	butter and jelly sandwich for the resident, however, she had already ordered out for dinner because she was hungry. There were 3 pages of hand written concerns attached to the grievance form. The grievance was not investigated, resolved or signed by any facility staff. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the grievances were not resolved. 3. During an interview with Resident E on 12/13/22 11:00 a.m., indicated the food was terrible and she does not know what was on the menus. The record for Resident E was reviewed on 12/15/22 at 10:00 a.m. Diagnoses included, but were not limited to, COPD, bipolar disorder, anxiety, major depressive disorder, unspecified dementia with behavioral disturbances, schizophrenia, and dependence on oxygen. The Quarterly Minimum Data Set (MDS) assessment, dated 10/14/22, indicated the resident was cognitively intact. She was totally dependent on staff with 1 person physical assist for bathing. In the last 7 days the resident received an antipsychotic medication 7 times, anti-anxiety medication 7 times, and antidepressant medication 7 times. The resident did not use oxygen. A grievance, dated 9/21/22, indicated the resident did not know what was on the menu for breakfast, lunch and dinner. The summary of the interview indicated menus were being placed on units and will being doing updates. The resident notification of resolution/satisfaction was blank. The Dietary Manager and Administrator signed the grievance on 9/22/22.			

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	Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the grievance was not resolved or follow up completed. 4. Interview with Resident H on 12/13/22 at 10:25 a.m., indicated the resident ate all of his meals in his room. The food was cold all of the time. The food "sucks" and they did not follow his food likes and dislikes. The record for Resident H was reviewed on 12/16/22 at 10:00 a.m. Diagnoses included, but were not limited, depressive disorder, osteoarthritis, high blood pressure, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 12/3/22, indicated the resident was cognitively intact. He was an extensive assist with 2 person physical assist for bathing and extensive assist with 1 person physical assist for personal hygiene. The resident's vision was adequate. A grievance, filed on 8/2/22, indicated the resident reported the food was always cold on the west unit. The summary of the interview indicated the food was getting better, and the resident would like double portions. The resolution was not completed and the resident notification of resolution/satisfaction was blank. The grievance was signed by the Dietary Manager and the Administrator on 8/3/22. A grievance, filed on 11/2/22, indicated the food was poor quality and the portions were small. The food does not match the meal ticket and there was no hot plate. The summary of the interview indicated the resident stated "the roast beef is like chewing on the end of a belt." The resolution was to inservice staff on hot plates and checking meal			

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	tickets. The resident notification of resolution/satisfaction was not completed. The grievance was signed by the Administrator, Dietary Manager and the Registered Dietitian on 11/14/22. A grievance, dated 11/7/22, indicated the food was cold and he was not getting what was on the meal ticket. The summary of the interview indicated staff were inserviced on using hot plates and checking meal tickets. The resolution was not completed and the resident notification of resolution/satisfaction was blank. The grievance was signed by the Dietary Manager and the Administrator on 11/8/22. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the grievances were not resolved. The current 6/19/18, "Resident Grievance" policy, provided by the Nurse Consultant on 12/20/22 at 9:30 a.m., indicated upon receipt of an oral, written, or anonymous grievance submitted by a resident the Grievance Official will take immediate action to prevent further potential violations of any resident right while the alleged violation was being investigated, if indicated. The grievance review will be completed in a reasonable time frame consistent with the type of grievance but not exceed 30 days. The Grievance Official will meet with the resident and inform the resident of the results of the investigation and how the resident's grievance was resolved or will be resolved. A copy of the grievance decision will be provided to the resident upon request. This Federal tag relates to Complaints IN00387079 and IN00388811.			

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	3.1-7(a)(2)			
F 0623 SS=A 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			

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	section; (D) An immediate transfer or discharge is 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			

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	mental disorder established under the Protection and Advocacy for Mentally Ill 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 record review and interview, the facility failed to ensure a resident and/or their Responsible Party were notified in writing related to a transfer to the hospital for 1 of 6 residents reviewed for hospitalization. (Resident 5) Finding includes: Interview with Resident 5's Mother on 12/14/22 at 10:05 a.m., indicated the resident had been sent to the hospital several times within the last 120 days. She indicated staff always called her, but she did not recall receiving a written transfer notice. The record for Resident 5 was reviewed on 12/19/22 at 9:48 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary	F 0623	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Resident 5 was not harmed by the alleged deficient practice.	01/13/2023

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	disease (COPD), urinary tract infection, and schizoaffective disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/17/22, indicated the resident had short and long term memory problems and she was severely impaired for daily decision making. Nurses' Notes, dated 8/29/22 at 1:06 p.m., indicated the writer was called to the resident's room by the CNA to see changes which came over the resident during the morning. Originally she had clear lungs and was in zero distress, now her lungs sounded like rhonchi throughout and she had a wet heavy cough. The resident was transferred to the hospital via 911. She returned to the facility on 9/2/22. There was no documentation her Mother had been mailed and/or received a written notice of the transfer form. Nurses' Notes, dated 9/29/22 at 1:46 a.m., indicated the resident's peg tube (percutaneous endoscopic gastrostomy tube) was on the floor with the bulb intact. At 8:18 a.m., the notes indicated the resident had been admitted to the hospital for the dislodged peg tube. The resident returned to the facility on 10/3/22. There was no documentation indicating the resident's Mother had been mailed and/or received a written notice of the transfer form. Nurses' Notes, dated 10/7/22 at 10:35 p.m., indicated the resident's KUB (Kidney, Ureter, and Bladder X-ray) results were back. A modest colonic ileus (a temporary slowing of the digestive tract, which could lead to a blockage of the		The resident representative has since been given a written notice of transfer. 2. All residents have the potential to be affected by same alleged deficient practice. The DON/Designee has audited all discharges for last 14 days and each resident or responsible party, has received notice of discharge in writing. 3. DON/Designee have educated all staff on the "Admission, Discharge and Transfer" policy, with emphasis on "notice before transfer". The transfer form will be mailed to each responsible party of the cognitively impaired residents with each transfer/discharge. 4. DON/Designee will review each discharge 5x wk x 4 wks, then 3 x wk x 4 wks, then 1 x wk x 4 wk. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	intestine) was noted. 911 was called and the resident was transferred to the emergency room. She returned to the facility on 10/12/22. Again, there was no documentation her Mother had been sent or received the transfer notice. Nurses' Notes, dated 11/7/22 at 3:35 p.m., indicated the resident was observed sitting on the floor in her room at 1:30 p.m. She slid out of her bed onto the floor. A laceration was noted above her left upper eyelid. There was a small amount of bleeding and the area measured 3 centimeters (cm) by 2 cm. The Physician was notified and orders were received to send the resident to the emergency room for evaluation. She returned to the facility on 11/15/22. There was no documentation indicating her Mother had been sent and/or received a copy of the transfer form. Interview with the Director of Nursing on 12/19/22 at 1:30 p.m., indicated the resident's Mom should have been mailed notice of the transfer form. 3.1-12(a)(6)(A)(ii)			
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services			

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	staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to ensure residents or Responsible parties were invited to attend and participate in care planning conferences and care plans were updated to reflect the resident for 4 of 27 residents whose care plans were reviewed. (Residents 5, H, M, and F) Findings include: 1. Interview with Resident 5's Mother on 12/14/22 at 9:56 a.m., indicated she used to be invited to the resident's care conference but not recently. The record for Resident 5 was reviewed on 12/19/22 at 9:48 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), urinary tract infection, and schizoaffective disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/17/22, indicated the resident had short and long term memory problems and she was severely impaired for daily decision	F 0657	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Residents 5, H, M, and F were not harmed by the alleged deficient practice. Resident 5, H and F have been scheduled a care conference. Resident M psychotropic care plan has been updated. 2. All residents have the	01/13/2023

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	making. The Care Plan conference summary, dated 12/30/21 at 4:05 p.m., indicated a Care Plan meeting was held with the Interdisciplinary Team (IDT) and the resident's Mother was updated via a phone call. The resident's Care Plan was reviewed on 1/30, 3/17, 6/17, 9/17, and 12/17/22. There was no documentation the resident's Mother had been invited and/or attended the care conference. Interview with the Director of Nursing on 12/19/22 at 4:00 p.m., indicated the resident's Mother should have been invited to the Care Plan meetings. 2. During an interview on 12/13/22 at 10:24 a.m., Resident H indicated he has had no recent care conference. The record for Resident H was reviewed on 12/16/22 at 10:00 a.m. Diagnoses included, but were not limited, depressive disorder, osteoarthritis, high blood pressure, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 12/3/22, indicated the resident was cognitively intact. A care conference was held with the resident and daughter on 7/14/22. There were no other care conferences completed for the resident. Interview with the Director of Nursing (DON) on 12/20/22 at 4:00 p.m., indicated the old Social Service Director left in November and his care conference was missed.		potential to be affected by same alleged deficient practice. All residents have been audited to ensure completion of a care conference in the last 90 days, any resident identified as not have a care conference has one scheduled following the MDS completion schedule. All psychotropic care plans have been audited and updated as needed to reflect an accurate plan of care. 3. RDCO has educated the DON and Social Service regarding the care plan conference schedule and updating psychotropic medication care plans per the Plan of Care overview policy, with a focus on “review care plans quarterly and/or with a significant change” and “hold meetings at a time when resident is functioning at his/her best”. 4. Social Service/Designee will audit care plan conference schedule 3 x week x 4 weeks then 1 x wk x 8 weeks to ensure all residents receive a care plan conference. DON/Designee will audit psychotropic medication care plans 2 x wk x 4 wks, then 1 x wk x 8 wks to ensure updated care plans are in place. The DON will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6	

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	3. The record for Resident M was reviewed on 12/19/22 at 10:15 a.m. The resident was admitted to the facility on 3/28/22. Diagnoses included but were not limited to, respiratory failure, tracheostomy, psychotic disorder, schizoaffective disorder, sleep apnea, high blood pressure, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 10/4/22, indicated the resident was cognitively intact. In the last 7 days the resident had received an antipsychotic medication 7 times. A Care Plan, revised on 4/8/22, indicated the resident received an antipsychotic medication related to depression and sleeplessness. Physician's Orders, dated 7/19/22, indicated Quetiapine Fumarate (an antipsychotic medication) tablet 25 milligrams (mg) daily. The medication was discontinued on 10/25/22. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the Care Plan was outdated.4. During an interview with Resident F on 12/14/22 at 9:57 a.m., the resident indicated he was never involved in a care plan meeting. Resident F's record was reviewed on 12/16/22 at 12:08 p.m. Diagnoses included, but were not limited to, syncope and collapse, heart failure, stroke, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 11/26/22, indicated the resident was moderately cognitively impaired. The last documented care conference was 6/16/22.		months with 100% compliance achieved.	

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	Interview with the Director of Nursing on 12/19/22 at 3:43 p.m., indicated she had no further information to provide. 3.1-35(d)(2)(B)			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to provide ADL (activities of daily living) assistance to dependant residents related to completing scheduled showers, nail care, hair washed, and shaving male residents for 6 of 10 residents reviewed for ADL care. (Residents N, E, H, M, P, and O) Findings include: 1. On 12/14/22 at 9:30 a.m., Resident N was observed in bed with his eyes open. The resident was unshaven and his fingernails were long and dirty. On 12/15/22 at 9:40 a.m., 11:30 a.m., and 1:08 p.m., the resident was observed in bed. At those times, the resident was unshaven and his fingernails were long and dirty. On 12/16/22 at 5:30 a.m., and 10:00 a.m., the resident was observed in bed. At those times, the resident was unshaven and his fingernails were long and dirty. The record for the resident was reviewed on 12/16/22 at 6:50 a.m. Diagnoses included, but were	F 0677	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Residents N, E, H, M, P and O were not harmed by the alleged deficient practice. Resident N has been provided a shower, nail care and a shaven face. The resident's nails remain clean and trimmed. Resident E received a shower and hair was washed. Resident H received a shower and his hair was washed. Resident M has provided updated bathing preferences, care plan	01/13/2023

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	not limited to, stroke, type 2 diabetes, chronic kidney disease, heart failure, depressive disorder, atrial fibrillation, altered mental status, and high blood pressure. The Quarterly 10/23/22 Minimum Data Set (MDS) assessment indicated the resident was not alert and oriented and was severely impaired for decision making. The resident was an extensive assist with a 1 person assist for personal hygiene and totally dependent on staff for bathing. The Care Plan, revised on 4/6/22, indicated the resident had an ADL self care deficit and required assistance. The shower sheets indicated the resident received a bed bath on 12/7, however, being shaved was not checked as being done. The resident refused a shower on 12/10/22. A shower was given on 12/14/22 and shaved was not checked as being completed. No shower or bath was completed on 12/3 and 12/17/22. Interview with the Nurse consultant on 12/20/22 at 3:18 p.m., indicated the resident should have been shaved and his nails trimmed and cleaned. 2. During an interview with Resident E on 12/13/22 11:00 a.m., she indicated she did not get 2 bed baths twice a week and only gets her hair washed when a certain CNA was there. She had not had her hair washed in weeks. The record for Resident E was reviewed on 12/15/22 at 10:00 a.m. Diagnoses included, but were not limited to, COPD, bipolar disorder, anxiety, major depressive disorder, unspecified dementia with behavioral disturbances, schizophrenia, and dependence on oxygen.		updated, and has been set up for a shower at bedtime per his request. Resident O has been provided a shower, face shaven, nails have been trimmed and cleaned. Resident P has been provided a shower and hair washed. 2. All residents have the potential to be affected by same alleged deficient practice. The shower schedule for each resident has been updated according to resident preferences. Nail care has been assessed and provided in accordance with resident specified shower schedule. The ADL care plans have been reviewed and updated, for each resident, to reflect resident choice. New shower sheets have been initiated. 3. DON/Designee has educated all members of the nursing staff on the Nail and Hair Hygiene Policy with emphasis on “routine nail and hair hygiene as part of the bath or shower” with a focus on resident preference. 4. DON/Designee will observe that a shower/bath has been provided to the resident with nail care included. The observation will occur for 5 residents 3 x wk x 4 wks, then 3 residents 3 x wk x 4 wks, then 1 resident 1 x wk x 4 wk. DON/Designee will report on	

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	The Quarterly Minimum Data Set (MDS) assessment, dated 10/14/22, indicated the resident was cognitively intact. She was totally dependent on staff with 1 person physical assist for bathing. A Care Plan, revised on 2/1/22, indicated the resident had an ADL deficit related to weakness and incontinence. The resident was to receive bed baths on Tuesdays and Fridays. There was no documentation the resident received a bath on 11/22, 11/25, and 12/1/22. There was no documentation on the shower sheets if the resident's hair was washed. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the resident should receive at least 2 baths a week and have her hair washed. 3. During an interview on 12/13/22 10:18 a.m., Resident H indicated he did not get 2 showers a week and has not had his hair washed. The resident's hair was visibly greasy during the interview The record for Resident H was reviewed on 12/16/22 at 10:00 a.m. Diagnoses included, but were not limited, depressive disorder, osteoarthritis, high blood pressure, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 12/3/22, indicated the resident was cognitively intact. He was an extensive assist with 2 person physical assist for bathing and extensive assist with 1 person physical assist for personal hygiene. A Care Plan, revised on 9/14/22, indicated the		audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	resident had a ADL self care deficit and required assistance with all ADLs. The shower sheets indicated the resident was to receive a shower on Wednesdays and Fridays. The resident did not receive a shower on 11/19 and 12/4/22. There was no documentation the resident's hair was washed at the time of the showers. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the resident was to have at least 2 showers a week. 4. During an interview on 12/13/22 2:30 p.m., Resident M indicated he did not get showers 2 times a week. He preferred to have a shower at night time before he went to bed because he slept better. The record for Resident M was reviewed on 12/19/22 at 10:15 a.m. The resident was admitted to the facility on 3/28/22. Diagnoses included but were not limited to, respiratory failure, tracheostomy, psychotic disorder, schizoaffective disorder, sleep apnea, high blood pressure, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 10/4/22, indicated the resident was cognitively intact, was independent and only needed set up help for bathing. A Care Plan, revised on 3/28/22, indicated the resident had an ADL self care deficit related to weakness and a decline in functional status. Physician's Orders, dated 9/29/22, indicated the resident was to have staff set him up in the shower before bed nightly per his request.			

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The shower sheets indicated the resident received a shower on 11/3, 11/8, 11/17, 11/22, 11/24, 11/29, 12/6, 12/10, and 12/17/22. His showers were not completed 2 times a week or nightly per request.

Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the resident should have at least 2 showers a week.5. During an interview with Resident P on 12/13/22 at 2:22 p.m., the resident indicated she had not had her hair washed in a very long time and it felt greasy.

Resident P's record was reviewed on 12/16/22 at 10:25 a.m. Diagnoses included, but were not limited to, spondylosis of the lumbar region (degeneration of the spine), anxiety disorder, and depression.

The Admission Minimum Data Set assessment, dated 11/25/22, indicated the resident was cognitively intact for daily decision making. The resident required physical help with one person physical assist for bathing and limited assistance for personal hygiene.

The Shower/Bath Sheets indicated the resident received a complete bed bath on 11/21/22, 11/24/22, and 12/12/22. The type of shower or bath was not listed on 11/28/22, 11/30/22, 12/5/22, and 12/7/22. The Shower/Bath Sheets did not indicate the resident had her hair washed.

Interview with the Nurse Consultant on 12/20/22 at 3:41 p.m., indicated she had no further information to provide.

6. Interview with Resident O on 12/13/22 at 10:51 a.m., indicated the resident wanted to be clean shaven. His toe nails were also long.

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	On 12/15/22 at 11:34 a.m., Resident O indicated staff still had not shaved his face or cut his toenails. Resident O's record was reviewed on 12/15/22 at 11:39 a.m. Diagnoses included, but were not limited to, Parkinson's disease, chronic pain syndrome, and acute respiratory failure. The Discharge Minimum Data Set (MDS) assessment, dated 11/21/22, indicated the resident was cognitively intact for daily decision making. The resident required extensive assistance for personal hygiene, bed mobility, and dressing. A Care Plan, dated 8/12/22, indicated the resident had an activities of daily life (ADL) self care performance deficit and required assistance with ADLs. The Shower/Bath sheets indicated the resident received a bed bath on 11/17/22, 12/1/22, 12/6/22, 12/9/221, 12/13/22, and 12/15/22. The record lacked documentation the resident received nail care or assistance with shaving. Interview with the Nurse Consultant on 2/20/22 at 3:41 p.m., indicated she had no further information to provide. This Federal tag relates to Complaints IN00387079 and IN00390113. 3.1-38(a)(3)(B) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E) 3.1-38(b)(2)			

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview the facility failed to ensure a resident received timely treatment for a fractured shoulder, treatment was provided for a resident with complaints of constipation, and dry skin was assessed and treated for 1 of 1 residents reviewed for falls, 1 of 2 residents reviewed for constipation, and 1 of 1 residents reviewed for skin conditions non-pressure related. (Residents F, Q, and P) Findings include: 1. Resident F's record was reviewed on 12/14/22 at 9:53 a.m. Diagnoses included, but were not limited to, syncope and collapse, coronary artery disease, heart failure, and stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 11/26/22, indicated the resident was moderately impaired for daily decision making. Nurses' Notes, dated 8/14/22 at 7:40 a.m., indicated the resident was found on the floor sitting upright leaning back on the bed. The CNA who found the resident indicated the wheelchair was found in the hallway. The resident stated that his roommate	F 0684	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Residents F, Q and P were not harmed by the alleged deficient practice. Resident F has fully recovered from the fracture injury with no negative effects. Resident P received new orders from her primary care physician for as needed laxative medications to aide in control of the constipation. She was notified of the new orders and the need to request from the nurse when she experiences constipation. Resident Q received	01/13/2023

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	moved the wheelchair from behind him and that was why he fell. The resident began to complain of left shoulder pain. The physician was notified and orders were received to have a STAT x-ray of the left shoulder and Tylenol for pain. Nurses' Notes, dated 8/14/22 at 5:13 p.m., indicated the writer called regarding the x-ray results. The results were not ready. Nurses' Notes, dated 8/14/2022 at 10:00 p.m., indicated the x-ray results were received of left shoulder with acute fracture noted, the physician was notified and a new order was received to send the resident to the hospital. Transportation was notified and stated the estimated time of arrival would be approximately 60 minutes. Nurses' Notes, dated 8/14/2022 at 11:24 p.m., indicated transportation arrived to take resident to the hospital. The x-ray examination was completed on 8/14/22 at 11:59 a.m. The x-ray results were reported on 8/14/22 at 5:11 p.m. Interview with the Nurse Consultant on 12/21/22 at 10:55 a.m., indicated she had no further information to provide. 2. During an interview with Resident P on 12/13/22 at 2:29 p.m., the resident indicated she had an ongoing problem with constipation since she arrived to the facility on 11/18/22. Resident P's record was reviewed on 12/16/22 at 10:25 a.m. Diagnoses included, but were not limited to, spondylosis of the lumbar region (degeneration of the spine), anxiety disorder, and depression.		new orders to apply moisturizing lotion to bilateral lower extremities, including the left toes, daily. The care plans for each resident has been reviewed and updated to reflect current physician orders. 2. All residents have the potential to be affected by same alleged deficient practice. Each resident has been assessed for constipation and dry skin. Any resident concerns have been addressed with new physician orders and care plan updates. 3. DON/Designee has educated all licensed nurses on the Physician Order Policy with emphasis on “Execution of order” and the Notification for Changes in Condition policy with a focus on “the nurse will use good clinical judgement to call the MD or supervisor if uncertain in a change in condition”. 4. DON/Designee will audit physician orders in daily clinical meeting, Monday thru Friday, for any orders received to transfer a resident to the hospital to verify timely transfer to the hospital for evaluation. DON/Designee will audit POC documentation to verify resident BM every 3 days in daily clinical meeting, Monday thru Friday. This will be an on-going	

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	The Admission Minimum Data Set assessment, dated 11/25/22, indicated the resident was cognitively intact for daily decision making. A Care Plan, dated 11/21/22, indicated the resident received an antidepressant medication. Interventions included, but were not limited to, observe for side effects of the medications such as constipation, weight change, headache, or urinary retention. A Care Plan, dated 11/21/22, indicated the resident received an antipsychotic medication. Interventions included, but were not limited to, observe for side effects of the medication such as constipation, dry mouth, and abnormal movements. A Care Plan, dated 11/21/22, indicated the resident received an anti-anxiety medication. Interventions included, but were not limited to, observe for side effects of the medication such as constipation, dry mouth, and urinary retention. The Bowel Movement task indicated the resident did not have any bowel movements on the following dates: 11/20/22, 11/21/22, 11/28/22, 11/30/22, 12/1/22, 12/2/22, 12/7/22, 12/8/22, 12/10/22, 12/12/22, 12/15/22, 12/17/22, and 12/19/22. The record lacked an order for a treatment for constipation. Interview with the Nurse Consultant on 12/20/22 at 3:41 p.m., indicated she would get an order for a laxative for the resident. 3. Interview with Resident Q on 12/14/22 at 10:19		practice. DON/designee will audit 3 weekly skin assessments daily x 4 wks, then 3 weekly skin assessments x 4 wks then 1 weekly skin assessment per week x 4 wks for any concerns of dry skin. DON/Designee will report on audits monthly to the interdisciplinary team for 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	a.m., indicated she had very dry toes on her left foot and the bottom of her right foot felt dry too. On 12/15/22 at 10:40 a.m., Resident Q indicated her toes were still very dry on her left foot. Resident Q's record was reviewed on 12/15/22 at 1:03 p.m. Diagnoses included, but were not limited to, high blood pressure and diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 11/28/22, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 12/1/22 at 2:00 p.m., indicated to monitor digits to the left upper extremity cast and left lower extremity cast for circulation, motor, and sensory changes. Notify the physician with changes in color, temperature, and appearance every shift. Interview with RN 1 on 12/16/22 at 11:12 a.m., indicated the resident did have very dry and scaly toes on the left foot and they should have been putting lotion on the resident after bathing. Interview with the Nurse Consultant on 12/20/22 at 3:41 p.m., indicated she had no further information to provide. This Federal tag relates to Complaint IN00390793. 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must,			

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	if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on observation, record review, and interview, the facility failed to ensure residents with impaired vision and hearing received the necessary services related to following up with referrals for hearing aids and eye glasses for 2 of 3 residents reviewed for vision and hearing. (Residents 48 and H) Findings include: 1. During an interview on 12/13/22 at 11:18 a.m., Resident 48 indicated he had seen both the ear and eye doctor months ago, and was still waiting on his hearing aids and eye glasses. The resident indicated, "They even took molds of my ears for the hearing aids." The record for resident 48 was reviewed on 12/15/22 at 2:05 p.m. Diagnoses included, but were not limited to, type 2 diabetes, heart disease, and colon cancer. The Quarterly Minimum Data Set (MDS) assessment, dated 11/22/22, indicated the resident was cognitively intact. The resident's hearing was adequate and he had no hearing aides. The resident had clear speech and his vision was adequate and he had no corrective lenses. A Care Plan, revised on 7/13/22, indicated the	F 0685	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Resident 48 and H was not harmed by the alleged deficient practice. Resident 48 has follow up appointments scheduled for an exam with the eye doctor and a hearing exam. Resident H has a follow up appointment for an exam with the eye doctor. 2. All residents have the potential to be affected by same alleged deficient practice. The DON/Designee has audited each resident ancillary services visits for	01/13/2023

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	resident had impaired visual function related to blurred vision and does not have glasses. The approaches were to arrange for consultation with eye care practitioner as required and follow up with ophthalmology/optometrist as needed. There was no Care Plan for hearing loss. The resident was seen by the Audiologist on 7/5/22. Clinical findings indicated the resident had a degree of hearing loss to both ears. Hearing aids were recommended and impressions were taken. A medical consult was recommended to obtain medical clearance for the hearing aids. The resident was seen by the eye doctor on 6/22/22. A recommendation for new glasses and bifocals was made upon approval. A glasses prescription was written at the time of visit. The Audiologist was in the facility on 7/5, 7/6, 7/20 and 10/26/22. The eye doctor was in the facility on 6/22, 6/23, 6/24, 7/1, 7/29, 9/9, 9/30, 10/6, and 11/2322. The resident was not seen by the Audiologist or the eye doctor for follow up after the initial recommendations. Interview with the Director of Nursing on 12/20/22 at 8:30 a.m., indicated the resident had not seen the eye doctor or the Audiologist since they both had made the recommendations for a new hearing aids and new glasses. 2. During an interview with Resident H on 12/13/22 at 10:30 a.m., he indicated he was supposed to see the eye doctor and staff were supposed to get him up, but they could not find a		follow up appointments needed and all needed appointments addressed. 3. DON/Designee has educated Social Service regarding providing ancillary services with the “Social Services” policy, with emphasis on “referrals for eye care, dental care”. 4. DON/Designee will review 5 resident’s receiving eye and hearing services for completion of appointments and follow up needs 3 x wk x 4 wks, then 1 x wk x 8 wks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	hoyer pad so he was not seen. He had not seen the eye doctor or been told another appointment had been made for him. The record for Resident H was reviewed on 12/16/22 at 10:00 a.m. Diagnoses included, but were not limited, depressive disorder, osteoarthritis, high blood pressure, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 12/3/22, indicated the resident was cognitively intact. The resident's vision was adequate. There was no Care Plan for impaired vision. An eye doctor visit report on 7/29/22 indicated the resident was not treated due to refusal. The eye doctor was in the facility on 6/22, 6/23, 6/24, 7/1, 7/29, 9/9, 9/30, 10/6, and 11/2322. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the resident was not on the list each time the eye doctor had been in the facility since 7/29/22. 3.1-39(a)(1)			
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 pressure ulcers and does not develop pressure ulcers unless the individual's clinical			

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GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
	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, record review, and interview, the facility failed to ensure pressure ulcers were covered as ordered for 1 of 2 residents reviewed for pressure ulcers. (Resident 8) Finding includes: On 12/16/22 at 3:44 a.m., Resident 8 was observed in her room in bed sleeping. A white gauze bandage was observed on the resident's left stump. At 9:14 a.m., the resident was in her room in bed. She was being assisted with breakfast and the bandage to the resident's left stump was not observed. At 10:31 a.m., the resident was seated in a broda chair across from the nurses' station. She was taken back to her room for a skin assessment by LPN 1. The LPN rolled up the resident's left pant leg and the bandage to the left stump was not visible. She proceeded to elevate the resident's upper leg and the gauze dressing was stuck together and dangling from the stump area. The resident's wound was not covered at that time. The LPN then unfolded the dressing and covered the pressure area. The record for Resident 8 was reviewed on 12/15/22 at 3:13 p.m. Diagnoses included, but were not limited to, acquired absence of the left leg below the knee, type 2 diabetes, and dementia without behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 11/16/22, indicated the resident	F 0686	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Resident 8 was not harmed by the alleged deficient practice. Resident 8 wound treatment was completed per physician order. 2. All residents have the potential to be affected by same alleged deficient practice. The DON/Designee has audited each resident with a wound dressing for verification of dressing in place. 3. DON/Designee has educated all licensed nurses regarding wound care with the "Wound Care Overview" policy, with emphasis on "review and select the appropriate treatment	01/13/2023

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	had short and long term memory problems and was severely impaired for daily decision making. She needed extensive assistance with bed mobility and was total assist for transfers. The resident had one Stage 3 pressure ulcer. A Care Plan, dated 10/12/22, indicated the resident was at risk for pressure ulcer development, impaired skin integrity, or at risk for altered skin integrity related to cognitive status, weakness, and incontinence. She had left knee trauma and a pressure ulcer to the left stump. Interventions included, but were not limited to, administer treatments as ordered by the medical provider. A Physician's Order, dated 11/2/22, indicated the left stump was to be cleansed every day shift with either normal saline or wound cleanser. Collagen was to be applied to the wound bed and the area covered with a dry dressing. The dressing could be changed as needed (prn) for soilage. Wound measurements, dated 12/12/22, indicated the area to the left stump was a Stage 3 and measured 1.18 centimeters (cm) x 1.28 cm with undermining of 0.4 cm at 5-10 o'clock . Interview with the Director of Nursing on 12/19/22 at 1:30 p.m., indicated the area to the resident's left stump should have been covered and a new dressing applied. 3.1-40(a)(2)		for the identified skin impairment". 4. DON/Designee will review 5 resident's requiring a wound care dressing for completion 5 x wk x 4 wks, then 3 x wk x 4 wks, then 1 x wk x 4 wks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	
F 0691 SS=D Bldg. 00	483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy			

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	services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on interview and record review, the facility failed to ensure a nephrostomy was monitored as ordered for 1 of 2 residents reviewed for catheters. (Resident O) Finding includes: The record for Resident O was reviewed on 12/15/22 at 11:39 a.m. Diagnoses included, but were not limited to, obstructive uropathy, Parkinson's disease, and acute respiratory failure. The Discharge Minimum Data Set (MDS) assessment, dated 11/21/22, indicated the resident was cognitively intact for daily decision making. The resident had an indwelling catheter and required extensive assistance for activities of daily living. A Care Plan, dated 9/1/22, indicated the resident had a right nephrostomy tube and foley catheter in place due to obstructive uropathy, renal calculus, and urine retention. A Physician's Order, dated 12/1/22, indicated to measure ostomy output every shift for nephrostomy care. The Treatment Administration Record for December 2022 lacked documentation of output from the nephrostomy on the following days and shifts: - 12/1/22: days and evenings - 12/3/22: days - 12/4/22: days and evenings - 12/5/22: days and evenings	F 0691	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Resident O was not harmed by the alleged deficient practice. The resident's nephrostomy output is being recorded and the physician and responsible have been notified of the output not being recorded. 2. All residents with a nephrostomy have the potential to be affected by same alleged deficient practice. All residents with a nephrostomy have been audited to ensure documentation of urinary output. 3. DON/designee has educated all licensed nursing staff regarding the Intake and Output measurement policy with an emphasis on "output to measure	01/13/2023

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	- 12/6/22: days and nights - 12/7/22: nights - 12/8/22: nights - 12/12/22: days - 12/13/22: days - 12/14/22: nights Interview with the Nurse Consultant on 12/20/22 at 3:41 p.m., indicated she had no further information to provide. 3.1-47(a)(3)		to include urine". 4. DON/Designee will audit the urinary output of each resident with a nephrostomy 3 x wk x 4 wks, then 1 x wk x 8 wks. The DON will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	
F 0692 SS=G 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, record review, and interview, the facility failed to ensure acceptable	F 0692	Preparation and execution of this plan of correction does not	01/13/2023

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	parameters of nutrition were maintained related to not following the Registered Dietitian's (RD) recommendations timely which resulted in a significant weight loss for a resident who was NPO and only receiving an enteral feeding. The facility also failed to ensure food consumption was documented for residents with a history of weight loss for 5 of 7 residents reviewed for nutrition. (Residents 89, 24, N, 5, and 8) Findings include: 1. On 12/12/22 at 9:37 a.m., Resident 89 was observed sitting in a wheelchair in her room. At that time, there was an enteral tube feeding of Jevity infusing at 45 cubic centimeters (cc) per hour. On 12/16/22 at 5:30 a.m., the resident was observed in bed. The tube feeding had been disconnected. At 8:03 a.m., LPN 1 was observed to hang a new bottle of the enteral feeding. The record for Resident 89 was reviewed on 12/15/22 at 3:00 p.m. Diagnoses, included but were not limited to, multiple sclerosis, dysphagia, dementia with behaviors, schizophrenia, peg tube, and depressive disorder. The Annual Minimum Data Set (MDS) assessment, dated 12/7/22, indicated the resident was moderately impaired for decision making. The resident weighed 105 pounds and had significant weight loss. She received greater than 51% of fluid intake and calories every day through the peg tube. The Care Plan, revised on 12/14/22, indicated the resident required a tube feeding.		constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Residents 89, 24, N, 5, and 8 were affected by the alleged deficient practice. Resident's 89, 24, N, 5 and 8 are being monitored with weekly weights, appropriate orders are in place, physician and responsible party notifications have been complete for each resident. The families and MD were notified of the omissions in the resident's meal consumption record. The care plan for each resident has been reviewed and updated. 2. All residents have the potential to be affected by same alleged deficient practice. Each resident has been weighed and any weight fluctuations have been calculated per facility policy. The physician and responsible parties have been notified with any significant weight losses noted. Supplements and diet changes have been implemented as ordered per the physician and	

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	The resident's weights were as follows: 7/7/22 - 129 pounds 8/16/22 - 129 pounds 9/2/22 - 108 pounds 10/2/22 - 112 pounds 10/17/22 - 112 pounds 11/13/22 - 105 pounds 12/19/22 - 101 pounds An RD Progress Note, dated 10/19/22 at 3:06 p.m. and 10/20/22 at 12:47 p.m., indicated the resident was NPO and received all nutrition via peg tube. The current tube feeding order of Jevity 1.2 at 35 cc per hour provided 42 grams of protein, 924 Kcal, and 1521 of water. RD recommended to discontinue current enteral nutrition order and current tube feed flush order. RD recommended Fibersource HN at 45 cc per hour times 22 hours. This would provide 990 milliliters (ml) of total volume, 1188 kcal, 53 grams of protein. RD recommended to flush with 125 ml of water every 4 hours. A RD Progress Note, dated 11/17/22 at 2:54 p.m., indicated the resident was NPO and received all nutrition via peg tube. The current tube feeding order of Jevity 1.2 at 35 cc per hour provided 42 grams of protein, 924 Kcal, and 1521 of water. The resident presented with a with a significant weight loss of 6.3% times 30 days. RD recommended Fibersource HN at 45 cc per hour times 22 hours. This would provide 990 milliliters (ml) of total volume, 1188 kcal, 53 grams of protein. RD recommended to flush with 125 ml of water every 4 hours. Physician's Orders, dated 3/25/22 and discontinued 10/8/22, indicated Enteral feed of Jevity 1.2 at 50 cc per hour times 22 hours.		consumption is being monitored. All appropriate care plans have been implemented, reviewed and updated per facility policy to reflect a resident centered plan of care. An audit was performed of all residents' meal consumptions for the last 7 days to ensure meal consumption was documented appropriately. Any resident identified as not having meal consumption recorded had their family and MD notified immediately 3. DON/Designee has educated all members of the Interdisciplinary Team and the Registered Dietician have been educated on the Resident Height and Weight Policy with an emphasis on "unstable residents will be weighed weekly", "weight loss concerns will be discussed in weekly clinical meeting". Nursing staff were educated on the policy, "Clinical Documentation Standards" with emphasis on meal consumption documentation. 4. DON/Designee will audit all resident weights that are clinically indicated for weekly weights 1 x wk x 12 wks in clinical meeting for stability of weights. Director of nursing/designee will audit 10 residents' weekly x 4 weeks, then 5 residents' weekly x 8 weeks to ensure accurate meal	

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	Physician's Orders, dated 10/9/22 and discontinued 11/17/22, indicated Enteral feed Jevity 1.2 at 35 cc per hour times 22 hours. Off at 6:00 a.m., and on at 8:00 a.m. Physician's Orders, dated 11/18/22 and discontinued 12/5/22, indicated Enteral feed Fibersource HN at 45 cc per hour times 22 hours. Off at 6 a.m., and on at 8 a.m. Physician's Orders, dated 10/20/22, indicated Fibersource HN - may substitute if Jevity 1.2 & Jevity 1.5 unavailable. Infuse at same rate per order. Physician's Orders, dated 12/6/22, indicated Enteral feed of Jevity 1.2 at 45 cc per hour times 22 hours. Off at 6:00 a.m., and on at 8:00 a.m. The Medication Administration Record (MAR) for the months of 10/2022 and 11/2022 indicated the Jevity 1.2 at 35 cc per hour was signed out as being administered 10/9-10/31/22 and 11/1-11/17/22. The tube feeding was flushed every 4 hours with 150 cc of water from 10/1-10/31/22 and 11/1-11/17/22. Jevity at 35 cc per hour was signed out as being substituted for the Fibersource HN on 10/20, 10/21, 10/24, 10/27-10/30/22 and on 11/2-11/4, 11/7, 11/10-11/13, and 11/16-11/17/22. Interview with the RD on 12/19/22 at 3:35 p.m., indicated she had made the recommendation for the tube feeding increase and for a different formula. The recommendation was not acted upon for 1 month. She documented her recommendations on a paper and it was up to the		consumption has occurred. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	nursing staff to follow through with the orders. Interview with the Nurse Consultant on 12/21/22 at 8:15 p.m., indicated there were no other weights obtained during the months of November or December 2022 and the RD's recommendation was not acted upon in a timely manner. 2. On 12/13/22 at 3:00 p.m., Resident 24 was observed in bed. At that time, the enteral feeding was turned off and not infusing. On 12/14/22 at 9:30 a.m., the resident was observed in bed and enteral feeding was infusing at 55 cubic centimeters (cc) per hour. On 12/16/22 at 5:30 a.m., the resident was observed in bed. The tube feeding had been disconnected. At 8:05 a.m., LPN 1 was observed to hang a new bottle of the enteral feeding. The record for Resident 24 was reviewed on 12/16/22 at 5:00 a.m. Diagnoses included but were not limited to, encephalopathy, quadriplegia, epilepsy, anxiety, and peg tube. The Modification of the Quarterly Minimum Data Set (MDS) assessment, dated 9/30/22, indicated the resident was not cognitively intact. The resident weighed 148 pounds and had a significant weight loss. A Care Plan, revised on 11/28/22, indicated the resident was NPO and required tube feeding. The approaches were to provide enteral feeding per physician diet orders and the RD will evaluate quarterly and as needed and make recommendations for changes to tube feeding as needed.			

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	The resident's weights were as follows: 8/16/22 199 pounds 9/2/22 148 pounds 10/2/22 146 pounds 10/3/22 146 pounds 10/4/22 146 pounds 11/13/22 142 pounds 12/14/22 145 pounds A RD Quarterly Assessment, dated 11/28/22, indicated the resident presented with a significant weight loss of 28.5% times 90 days (8/16-11/13/22). The resident was NPO and had an open wound on the right second toe. Recommendations were to discontinue current tube feed order and start Fibersource HN at 65 cc times 22 hrs. Interview with the Registered Dietitian on 12/19/22 at 3:35 p.m., indicated she made the recommendation for the tube feeding increase and it had not been acted upon as of yet. She documented her recommendations on a paper and it was up to the nursing staff to follow through with the orders. Physician's Orders, dated 11/17/22, indicated Fibersource HN at 55 cc per hour times 22 hours. Off at 6:00 a.m., and on at 8:00 a.m. Water flush of 125 cc every 4 hours per peg tube. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the RD was going to reassess the resident's nutritional status. 3. The record for Resident N was reviewed on 12/16/22 at 6:50 a.m. Diagnoses included, but were not limited to, stroke, type 2 diabetes, chronic kidney disease, heart failure, depressive disorder, atrial fibrillation, altered mental status, and high			

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	blood pressure. The Quarterly, 10/23/22 Minimum Data Set (MDS) assessment, indicated the resident was not alert and oriented and was severely impaired for decision making. The resident was an extensive assist with a 1 person assist for personal hygiene and totally dependent on staff for bathing. The resident weighed a 126 pounds and had significant weight loss. A Care Plan, revised on 10/12/22, indicated the resident had a nutritional problem. The approaches were to monitor meal intake. The resident's weights were as follows: 8/1/22 178 pounds 9/4/22 177 pounds 10/10/22 126 pounds 10/18/22 126 pounds 10/20/22 127 pounds 10/24/22 128 pounds 10/27/22 128 pounds 11/3/22 128 pounds 12/14/22 128 pounds An Admission RD Assessment, dated 10/12/22, indicated the resident presented with a significant weight loss of 28.8% x 30 days (10/10/22 vs 9/4/22). The resident received a regular diet. Recommendations to continue weekly weights. The meal consumption for the last 30 days indicated no meals were documented on 11/18-11/20, 11/23, 11/24, 11/26, 11/27, 11/30, 12/4, 12/6-12/10, 12/14, and 12/15/22. Breakfast was not documented on 11/17, 11/21, 11/22, 11/25, 12/5, and 12/11/22. Lunch was not documented on 11/17, 11/21, 11/22, 11/25, 12/5, and 12/11/22.			

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	Dinner was not documented on 12/3 and 12/12/22. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the meal consumption intakes were incomplete.4. The record for Resident 5 was reviewed on 12/19/22 at 9:48 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), urinary tract infection, and schizoaffective disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 9/17/22, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. She required extensive assistance with eating and received a mechanically altered diet. A Physician's Order, dated 12/8/22, indicated the resident was to receive a pureed diet with nectar thick liquids. A revision on 12/14/22, indicated the resident could have soft foods with supervision. Dietary Progress Notes, dated 12/1/22 at 4:44 p.m., indicated the resident was being followed in Nutrition at Risk (NAR) for readmission on 11/15/22. The resident was currently NPO (nothing by mouth) and was receiving a tube feed bolus. The resident presented with a significant weight loss of 38.9% times 60 days. Her current weight was stable with a gradual weight gain of 4.5% times 45 days. Continue with current nutritional plan. Dietary Progress Notes, dated 12/9/22 at 12:49 p.m., indicated the resident was being followed in Nutrition at Risk (NAR) for readmission on 11/15/22. Her current diet order was a regular diet with puree texture and continue with tube feed			

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	order of Jevity 1.5 bolus four times a day. The resident presented with a weight gain of 4.3% in 7 days. The weight gain was desired related to a history of weight loss. Continue to follow in NAR. The food consumption logs, dated 12/8-12/18/22, indicated there was no meal consumption documented on 12/13, 12/17, and 12/18/22. No breakfast was documented on 12/15/22 and no dinner was documented on 12/11 and 12/14/22. Interview with the Director of Nursing on 12/19/22 at 1:30 p.m., indicated the food consumption logs should have been completed based on the resident's history of weight loss. 5. The record for Resident 8 was reviewed on 12/15/22 at 3:13 p.m. Diagnoses included, but were not limited to, acquired absence of the left leg below the knee, type 2 diabetes, and dementia without behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 11/16/22, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. She required extensive assistance with eating and received a mechanically altered diet. A Care Plan, dated 10/12/22, indicated the resident was at nutritional risk related to a history of diabetes, hypertension, cognitive status, weight loss, and impaired skin integrity. Interventions included, but were not limited to, monitor daily intakes. The 12/2022 Physician's Order Summary (POS), indicated the resident was to receive a pureed diet.			

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	155218	A. BUILDING 00 B. WING	12/21/2022

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	The food consumption log, dated 11/16 - 12/16/22, indicated no meal consumption was documented on 11/25, 11/28, 12/3, 12/4, 12/5, 12/6, 12/8, and 12/9/22. No breakfast or lunch was documented on 11/24, 11/26, 12/11, and 12/12/22. No dinner was documented on 11/17, 11/19, 11/20, 11/21, 11/29, 12/1, and 12/15/22. Interview with the Director of Nursing on 12/19/22 at 1:30 p.m., indicated the food consumption logs should have been completed based on the resident's history of weight loss. 3.1-46(a)(1)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.			

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	Based on observation, record review, and interview, the facility failed to ensure a resident's tube feeding was infusing at the correct time for 1 of 1 residents reviewed for tube feeding. (Resident 85) Finding includes: On 12/13/22 at 11:00 a.m., Resident 85 was observed in his room in bed. His tube feeding pump was turned off. On 12/14/22 at 11:06 a.m., the resident was observed in his room in bed with the tube feeding pump turned off. On 12/15/22 at 9:47 a.m., the resident's tube feeding was infusing at 35 cubic centimeters (cc's) per hour. At 11:45 a.m. and 1:09 p.m., the resident was seated in his wheelchair in the main dining room. He was disconnected from his tube feeding. At 2:54 p.m., the resident was in his room watching television. The tube feeding remained disconnected and the pump was turned off. On 12/16/22 at 3:47 a.m., the resident was in his room in bed watching television. His tube feeding was infusing at 35 cc/hr. At 5:47 a.m., the feeding pump was turned off and the tube feeding bag had been removed from the pole. At 8:17 a.m. and 10:31 a.m., the resident's tube feeding was infusing at 35 cc/hr. On 12/17/22 at 9:17 a.m., the resident's tube feeding was infusing at 35 cc/hr. The record for Resident 85 was reviewed on 12/15/22 at 11:21 a.m. Diagnoses included, but were not limited to, stroke and dysphagia (difficulty swallowing).	F 0693	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Resident 85 was not harmed by the alleged deficient practice. The physician order has been clarified to include the start time with total volume of tube feeding to be administered to meet the resident's caloric needs. 2. All residents with enteral tube feeding have been audited to ensure all orders have an established start time with total volume of tube feeding to be administered to meet the residents' caloric needs. 3. DON/designee have educated all licensed nurses regarding the Physician Order policy with an emphasis on "execution of order". 4. DON/Designee will audit 5 residents, that receive enteral tube	01/13/2023

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	The Quarterly Minimum Data Set (MDS) assessment, dated 10/8/22, indicated the resident was moderately impaired for decision making and he needed extensive assistance with eating. He had a feeding tube and received a mechanically altered diet. The Care Plan, dated 9/19/22, indicated the resident was at nutritional risk related to needing a tube feeding to aid in meeting his nutrition needs. Interventions included, but were not limited to, provide tube feeding per medical provider orders. A Physician's Order, dated 10/1/22, indicated the resident was to receive Glucerna 1.2 at 35 cc/hr for 20 hrs via his feeding tube. There was no documentation indicating when the tube feeding was to be turned on and off. There was also no documentation on the 12/2022 Medication and Treatment Administration Records indicating what time the tube feeding was to be turned on and off. Interview with the Director of Nursing on 12/19/22 at 1:30 p.m., indicated a clarification order needed to be obtained. 3.1-44(a)(2)		feeding, 3 x wk x 4 wks, then 1 x wk x 8 wks for confirmation of established time parameters for administration. The DON will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with			

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	professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure signs and symptoms of upper respiratory infections were monitored after medication was initiated, orders were obtained for oxygen and it was set at the correct flow rate, and tracheostomy care was monitored for 5 of 7 residents reviewed for respiratory services. (Residents 64, 85, S, E, and M) Findings include: 1. Interview with Resident 64 on 12/13/22 at 11:06 a.m., indicated she had a cough and was recently started on nebulizer treatments. The record for Resident 64 was reviewed on 12/16/22 at 8:27 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 11/16/22, indicated the resident was cognitively intact. A Physician's Order, dated 12/13/22, indicated the resident was to receive Albuterol Sulfate Inhalation Nebulization Solution 2.5 milligrams/3 milliliters 0.083%, 1 vial inhale orally every 6 hours as needed for shortness of breath, wheezing, and coughing. Nurses' Notes, dated 11/21/22 at 11:08 a.m., indicated the resident was complaining of nasal congestion and a nonproductive cough was noted. A new order was obtained to start	F 0695	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Residents 64, 85, S, E, and M were not affected by the alleged deficient practice. Residents 64 and 85 acute condition change has resolved and both remain in stable condition. Resident S continuous O2 dose was corrected to 3 lpm, per the physician order, and the O2 tubing was changed and dated. Resident E was removed from the Oxygen. Resident M has had a self-administration assessment completed and has had a follow up appointment with the ENT. All notifications to doctor and families have been completed. The care plan for each resident has been reviewed and updated. 2. All residents with a	01/13/2023

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	Fluticasone Propionate Nasal Suspension 50 micrograms daily. The next entry in the Nurses' Notes was on 11/27/22. Nurses' Notes, dated 11/27/22 at 11:28 a.m., indicated the resident was complaining of shortness of breath, wheezing, and a nonproductive cough. As needed Albuterol and guaifenesin (a medication for chest congestion) were given as ordered. Oxygen was applied at 2 liters per nasal cannula. Nurses' Notes, dated 11/28/22 at 1:50 p.m., indicated the resident was complaining of coughing and chest congestion. The Physician was in the facility and a new order was received for Prednisone (a steroid) 20 mg daily for 5 days. The next entry in the Nurses' Notes was on 12/13/22. Nurses' Notes, dated 12/13/22 at 2:58 p.m., indicated the resident continued to smoke outside with a harsh cough, new orders were received to start as needed (prn) nebulizer treatments. Interview with the Director of Nursing on 12/19/22 at 1:30 p.m., indicated follow up documentation should have been completed. 2. The record for Resident 85 was reviewed on 12/15/22 at 11:21 a.m. Diagnoses included, but were not limited to, stroke and chronic obstructive pulmonary disease (COPD). The Quarterly Minimum Data Set (MDS) assessment, dated 10/8/22, indicated the resident was moderately impaired for daily decision making. Physician's Orders, dated 12/2/22, indicated the		tracheostomy and require the use of Oxygen have the potential to be affected by same alleged deficient practice. Each resident with a tracheostomy has been audited and assessed for self-administration of tracheostomy care and has physician orders in place for routine tracheostomy care. All in use Oxygen tubing has been audited, replaced, dated and a routine change/date schedule has been established. Each resident with Oxygen in use has been audited and verified for current orders and the ordered flow rate. Each resident that has a respiratory acute condition change in the last 7 days has been audited and addressed with follow up documentation. All appropriate care plans have been implemented, reviewed and updated per facility policy to reflect a resident centered plan of care 3. DON/Designee has educated all licensed nurses regarding the Tracheostomy Care Policy, The Oxygen Medical Gas Use policy and the Clinical Documentation Standards policy with an emphasis on “clinical care and treatment records as evidence of care”. 4. DON/Designee will audit 5 residents with a tracheostomy for tracheostomy care completion 3 x	

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	resident was to receive Diabetic Tussin EX Syrup (cough syrup), give 10 milliliters (ml) every 4 hours as needed (prn) for cough and Azithromycin (an antibiotic) tablet 250 milligrams (mg), give 2 tablets by mouth one time only for infection/cough then 250 mg, 1 tablet for 4 days. Nurses' Notes, dated 12/2/22 at 1:20 p.m., indicated the resident was complaining of pain and discomfort when he coughed. No active cold symptoms were noted at the time. The Physician was updated and new orders were received for a Zpac (Azithromycin) and prn cough syrup. The next entry in the Nurses' Notes was on 12/9/22 related to Nutrition at Risk. There was no additional documentation in the Nurses' Notes or skilled documentation notes since the antibiotic was initiated. Interview with the Director of Nursing on 12/19/22 at 1:30 p.m., indicated follow up documentation should have been completed. 3. On 12/13/22 at 10:00 a.m. and 2:54 p.m., and on 12/14/22 at 9:25 a.m. and at 11:50 a.m., Resident S was observed in bed. At those times, the resident was wearing oxygen per nasal cannula. The flow rate was greater than 3.5 liters but not above 4 liters. The tubing was dated 12/2/22 as well as the nebulizer face mask on the night stand. The record for the resident was reviewed on 12/15/22 at 11:25 a.m. Diagnoses included, but were not limited to, congestive heart failure, chronic respiratory failure, stroke, COPD, type 2 diabetes, sleep apnea, and bradycardia. The Annual Minimum Data Set (MDS) assessment, dated 10/12/22, indicated the resident was cognitively intact and used oxygen.		wk x 4 wks, then 1 x wk x 8 wks. Don/Designee will audit 10 Oxygen tubing's for current date placement 1 x wk x 12 wks. Don/Designee will audit 5 residents receiving Oxygen therapy for a current order and flow rate 3 x wk x4 wks then 1 x wk x 8 wks. Don/Designee will verify completion of follow up documentation on residents with an acute respiratory condition in change 3 x wk x 8 wks then 1 x wk x 4 wks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	The Care Plan, revised on 10/18/22, indicated the resident had Chronic Obstructive Pulmonary Disease (COPD) with shortness of breath while lying flat. The approaches were to provide oxygen therapy as ordered and change tubing per facility policy. Physician's Orders, dated 9/22/22, indicated oxygen at 3 liters via nasal cannula continuously every shift for shortness of breath. Physician's Orders, dated 11/3/22, indicated change oxygen tubing and humidifier bottle every week and as needed one time a day every Thursday. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the oxygen was to be at 3 liters per nasal cannula and the tubing was to be changed weekly. 4. On 12/13/22 at 11:00 a.m., on 12/14 at 10:54 a.m., on 12/15 at 9:41 a.m., 11:30 a.m., 1:10 p.m., and 3:00 p.m., and on 12/16 at 6:40 a.m. and 10:00 a.m., Resident E was observed in bed. At those times she was wearing oxygen per nasal cannula at 5 liters per minute. There was no date on the oxygen tubing. On 12/19/22 at 9:10 a.m., the resident was observed in bed wearing oxygen per nasal cannula at 2.5 liters per minute. There was no date on the tubing. The record for Resident E was reviewed on 12/15/22 at 10:00 a.m. Diagnoses included, but were not limited to, COPD, bipolar disorder, anxiety, major depressive disorder, unspecified dementia with behavioral disturbances, schizophrenia, and dependence on oxygen.			

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	The Quarterly Minimum Data Set (MDS) assessment, dated 10/14/22, indicated the resident was cognitively intact. She was totally dependent on staff with 1 person physical assist for bathing and did not use oxygen. A Care Plan, revised on 2/1/22, indicated the resident had Chronic Obstructive Pulmonary Disease (COPD) with shortness of breath while lying flat. The approaches were to provide oxygen therapy as ordered and change tubing per facility policy. There were no Physician's Orders for the oxygen Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated there were no orders for oxygen for the resident. 5. During an interview with Resident M on 12/13/22 at 2:40 p.m., he indicated he was able to do his own tracheostomy care. He changed the inner cannula when it needed to be done. It was not done every day. He cleaned the actual trach and changed it out every month. He soaked the old trach in a bleach and water mixture until he was ready to change it. He walked to the bathroom and pointed to a clear cylinder with a lid over it and inside was a white plastic tracheostomy piece floating in the water. The resident indicated nursing staff do nothing with his tracheostomy as he took care of it himself. The record for Resident M was reviewed on 12/19/22 at 10:15 a.m. The resident was admitted to the facility on 3/28/22. Diagnoses included but were not limited to, respiratory failure, tracheostomy, psychotic disorder, schizoaffective disorder, sleep apnea, high blood pressure, and			

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	major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 10/4/22 indicated the resident was cognitively intact and had a tracheostomy. A Care Plan, revised on 4/8/22, indicated the resident had a tracheostomy in place due to respiratory failure. The approaches were to provide trach care as ordered. Physician's Orders, dated 4/12/22, indicated change trach ties one time a week and prn. Trach care every shift. The 11/2022 and 12/2022 Treatment Administration Records indicated all the trach care was signed out by nursing staff as being completed. Interview with LPN 1 on 12/19/22 at 11:00 a.m., indicated the resident does his own trach care. He transferred from the east unit, so she was unsure how long that had been going on. She had never seen him do his trach care nor had she done his trach care. She had not assessed the trach or the stoma on a daily basis when she worked. There was no self assessment for the resident to do his own trach care. Interview with the Director of Nursing on 12/20/22 at 8:30 a.m., indicated the resident did not have a self assessment to perform his own trach care. The nursing staff were supposed to be assessing the trach and making sure the care was completed. Interview with the Nurse Consultant on 12/20/22 at 8:30 a.m., indicated the resident's trach had been discontinued as well as the inner cannula.			

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	The resident refused for staff to put a new trach in. The facility was going to set up another appointment with the ENT Doctor and have him replace the trach. 3.1-47(a)(4) 3.1-47(a)(6)			
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 interview and record review, the facility failed to ensure pain was effectively monitored for a resident with complaints of pain and a resident receiving pain medications for 2 of 2 residents reviewed for pain. (Residents F and P) Findings include: 1. During an interview with Resident F on 12/14/22 at 9:59 a.m., the resident had complaints of pain to his hand that were not being addressed. During an interview on 12/16/22 at 1:15 p.m., Resident F complained of pain to his hand and rated his pain a 9 out of 10 on the pain scale and requested to have his nurse bring him something for pain. Resident F's record was reviewed on 12/16/22 at 12:08 p.m. Diagnoses included, but were not limited to syncope and collapse, heart failure, diabetes mellitus, and respiratory failure.	F 0697	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Residents F and P were not harmed by the alleged deficient practice. Residents F and P were both assessed for pain with the use of a numeric pain scale. Physician and responsible parties have been notified of resident concerns of pain. Care plans have	01/13/2023

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	The Quarterly Minimum Data Set (MDS) assessment, dated 11/26/22, indicated the resident was moderately impaired for daily decision making. A Physician's Order, dated 6/7/22, indicated to monitor for pain every shift. The December 2022 Medication and Treatment Administration Record (MAR/TAR) indicated the resident did not have pain accurately assessed each shift. Interview with RN 1 on 12/16/22 at 1:18 p.m. indicated the order for the pain scale must have been entered incorrectly because there should have been a numeric pain scale to complete on the MAR/TAR. Interview with the Nurse Consultant on 12/20/22 at 3:41 p.m., indicated she would be changing the way they enter the pain scales on the MAR/TAR so it reflects a numeric pain scale. 2. Interview with Resident P on 12/13/22 at 2:19 p.m., indicated the resident received pain medications but she was still in pain. Resident P's record was reviewed on 12/16/22 at 10:25 a.m. Diagnoses included, but were not limited to, spondylosis of the lumbar region (degeneration of the spine), anxiety disorder, and depression. The Admission Minimum Data Set assessment, dated 11/25/22, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 11/18/22 at 4:30 p.m., indicated Acetaminophen 325 milligrams (mg) two		been updated accordingly to reflect a resident centered plan of care. 2. All residents have the potential to be affected by same alleged deficient practice. All residents have been audited to ensure pain monitoring every shift is in place, that includes a numeric pain scale. 3. DON/designee has educated all licensed nursing staff regarding the Pain Management and assessment policy with an emphasis on “pain scale and pain monitoring”. 4. DON/Designee will audit 5 residents for completion of pain monitoring that includes a numeric pain scale 3 x wk x 4 wks, then 1 x wk x 8 wks. The DON will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	tablets every six hours as needed for pain or fever. A Physician's Order, dated 11/18/22 at 9:00 p.m., indicated Gabapentin 300 mg one capsule by mouth two times a day for nerve pain. A Physician's Order, dated 11/18/22 at 5:00 p.m., indicated Hydrocodone-acetaminophen 5-325 mg, 1 tablet by mouth every 6 hours as needed for pain. A Physician's Order, dated 11/18/22 at 10:00 p.m., indicated to monitor for pain every shift. The December 2022 Medication and Treatment Administration Record (MAR/TAR) indicated the resident did not have an accurate pain evaluation completed each shift. Interview with the Nurse Consultant on 12/20/22 at 3:41 p.m., indicated she would be changing the way they enter the pain scales on the MAR/TAR so it reflects a numeric pain scale. 3.1-37(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a dialysis access site was assessed for 1 of 2 residents reviewed for dialysis. (Resident B)	F 0698	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set	01/13/2023

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	Finding includes: The record for Resident B was reviewed on 12/19/22 at 9:39 a.m. Diagnoses included, but were not limited to, end stage renal disease, stroke, and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 11/11/22, indicated the resident was moderately impaired for daily decision making and he received dialysis while a resident of the facility. A Care Plan, reviewed on 11/8/22, indicated the resident had direct access to his circulatory system related to having a right subclavian permacath (dialysis access site). Interventions included, but were not limited to, evaluate for signs and symptoms of infection: redness, tenderness, swelling, pain, and drainage. Report abnormal findings to the medical provider, resident, and resident's representative. A Physician's Order, dated 11/10/22, indicated to check the dialysis site (right chest) for signs and symptoms of infection every shift. The order had not been transcribed onto the 11/2022 and 12/2022 Medication and Treatment Administration Records (MAR's and TAR's) and there was no other documentation in the resident's record. Interview with the Director of Nursing on 12/19/22 at 2:00 p.m., indicated the resident had a perma cath and it was assessed in dialysis. She indicated the order should have been carried over onto either the MAR or TAR and the perma cath assessed every shift as ordered.		forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Resident B was not harmed by the alleged deficient practice. Resident B was assessed and a physician order was obtained for the assessment of the dialysis access site per facility protocol. 2. All residents with a dialysis access site have the potential to be affected by the same alleged deficient practice. An audit of all residents with a dialysis access site has occurred to ensure each residents' access site is being assessed per facility protocol, anyone identified not having the appropriate orders for assessment had their physician notified and orders obtained. All physicians and responsible parties have been notified as needed and all applicable care plans have been updated. 3. DON/Designee has educated all licensed members of the nursing staff on the Hemodialysis Care and Monitoring policy with an emphasis on "assessment of dialysis access	

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	3.1-37(a)		site". 4. DON/Designee will audit 5 residents with a dialysis access site to ensure an order for assessment is present and documented 3 x wk x 4 wks, then 1 x wk x 8 wks. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	
F 0757 SS=E Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or			

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	§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to manage medications appropriately related to ensuring blood pressure and heart rate parameters were monitored prior to giving blood pressure medication, administering medications as ordered, and holding insulin with no Physician's Order for 4 of 5 residents reviewed for unnecessary medications. (Residents B, S, C, and Q) Findings include: 1. The record for Resident B was reviewed on 12/19/22 at 9:39 a.m. Diagnoses included, but were not limited to, end stage renal disease, stroke, and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 11/11/22, indicated the resident was moderately impaired for daily decision making and he received dialysis while a resident of the facility. A Physician's Order, dated 12/12/22, indicated the resident was to receive Metoprolol Tartrate (a cardiac medication) Oral Tablet 25 milligrams (MG) by mouth twice a day for blood pressure. Hold the medication if the systolic blood pressure (top number) was less than 100 or heart rate less than 60. The 12/2022 Medication Administration Record (MAR) indicated there was no documentation that the resident's blood pressure or heart rate had been checked prior to giving the medication from 12/12 to current.	F 0757	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Residents B, S, C and Q were not harmed by the alleged deficient practice. Resident B's physician and family has been notified of omissions of medications and medications not being held per physician orders. Resident S's physician and family has been notified of omissions of medications and medications not being held per physician orders, insulin has been administered as ordered. Resident C and Q's physician and family have been notified of omissions of medications and medications not being administered timely per physician orders. The care plan for each resident has been reviewed and updated as needed. 2. All residents have the	01/13/2023

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	Interview with the Director of Nursing on 12/19/22 at 1:30 p.m., indicated the resident's blood pressure and heart rate should have been documented on the MAR. 2. The record for Resident S was reviewed on 12/15/22 at 11:25 a.m. Diagnoses included, but were not limited to, congestive heart failure, chronic respiratory failure, stroke, COPD, type 2 diabetes, sleep apnea, and bradycardia. The Annual Minimum Data Set (MDS) assessment, dated 10/12/22, indicated the resident was cognitively intact and used oxygen as a resident. Physician's Orders, dated 10/28/22, indicated Midodrine HCl tablet 10 milligrams (mg). Give 1 tablet by mouth every morning and at bedtime for low blood pressure and hold if SBP (Systolic Blood Pressure - top number) is greater than 120. Metoprolol Tartrate tablet 25 mg. - give 12.5 mg by mouth every morning and at bedtime for high blood pressure. Hold if SBP is less than 100 or DBP (Diastolic Blood Pressure - bottom number) is less than 60. Physician's Orders, dated 9/22/22, indicated Insulin Glargine 100 units/milliliter. Inject 30 units subcutaneously at bedtime. The Medication Administration Record (MAR) for the month of 11/2022 indicated the Insulin 30 units was not signed out as being administered on 11/12, 11/19, 11/26, and 11/29/22 The Metoprolol and Midodrine was not signed out as being administered on 11/12, 11/19 and 11/29/22 for the 9:00 p.m. dose. The Midodrine was administered on 11/10 at 8:00		potential to be affected by same alleged deficient practice. Each resident with medications ordered that require parameters has been audited for having parameters in place and being followed. All residents receiving insulin and oral medications have been audited for the last 7 days to ensure that all medications are being signed out as administered. The physician and responsible parties have been notified with any medications that have not been signed out as administered and all relevant care plans have been updated as needed. 3. DON/Designee has educated all licensed nurses and QMA's regarding the medication administration policy with a focus on "Documentation of medication will be current for medication administration" and "execution of orders as it relates to medication parameters." 4. DON/Designee will audit 5 residents 3 x wk x 8 wks, then 5 residents 1 x wk x 4 wks to ensure that all medications are signed out as administered. DON/designee will audit 3 residents 3 x wk x 4 wks then 3 residents' weekly x 8 weeks to ensure parameters for medication administration have been followed. DON/Designee will report on audits monthly to the	

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	a.m., (blood pressure was 144/78), on 11/15 (blood pressure was 142/75), and on 11/20/22 (blood pressure was 130/80). The medication was signed out as being administered for the 9:00 p.m. dose on 11/9 (blood pressure was 121/75), on 11/10 (blood pressure was 125/74), 11/17 (blood pressure was 122/84), and 11/24/22 (blood pressure was 129/78). 12/2022 MAR indicated the Midodrine was signed out as being administered at 8:00 a.m., on 12/6 (blood pressure was 124/87) and on 12/9/22 (blood pressure was 126/70). The 9:00 p.m. dose was held on 12/2/22 and blood pressure was 120/68. The medication was administered on 12/11/22 at 9:00 p.m., and the blood pressure was 128/76. The Midodrine was not signed out as being administered on 12/8/22 at 9:00 p.m. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated the blood pressure medications were blank and/or given when they should have been held. 3. During an interview on 12/13/22 at 2:10 p.m., Resident C indicated she did not get her medications on time and sometimes she had missed her medications, including blood pressure medications and insulin. The record for Resident C was reviewed on 12/20/22 at 12:15 p.m. Diagnoses included, but were not limited to, heart failure, renal dialysis, type 2 diabetes, high blood pressure and heart disease. The Quarterly Minimum Data Set (MDS) assessment, dated 11/15/22, indicated the resident was cognitively intact.		interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	The 9/2022 Medication Administration Record (MAR) indicated the following medications were not signed out being administered at 8:00 p.m. on 9/6/22 - Glipizide 5 mg (milligrams) - Gabapentin 100 mg - Coreg 3.125 mg - Bumetanide 1 mg - Atorvastatin 40 mg The 11/2022 MAR indicated the following medications were not signed out as being administered on 11/12/22 at 8:00 p.m. - Atorvastatin 40 mg - Refresh Optive Advanced Ophthalmic 2 drop in both eyes - Bumetanide 1 mg 2 tabs - Coreg 3.125 mg - Gabapentin 100 mg - Glipizide 5 mg Interview with the Nurse Consultant on 12/21/22 at 8:15 a.m., indicated the medications were not signed out as being administered.4. Resident Q's record was reviewed on 12/15/22 at 1:03 p.m. Diagnoses included, but were not limited to, high blood pressure and diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 11/28/22, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 11/22/22 at 9:00 a.m., indicated Insulin Glargine pen 100 unit/milliliter, inject 15 units subcutaneously in the morning. The December 2022 Medication Administration Record (MAR) indicated the dose of Insulin Glargine was not marked as administered at 9:00 a.m. on 12/1/22 with a blood sugar of 119, 12/6/22			

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	with no blood sugar listed, or 12/6/22 with no blood sugar listed. There were no orders or parameters to hold the insulin Glargine. A Physician's Order, dated 11/29/22 at 8:00 a.m., indicated Macrobid (an antibiotic) 100 mg, give one capsule two times a day until 12/6/22. The December 2022 Medication Administration Record (MAR) indicated the Macrobid was not administered on 12/3/22 at 5:00 p.m., 12/4/22 at 8:00 a.m., 12/5/22 8:00 a.m. and 5:00 p.m., 12/6/22 at 8:00 a.m. and 5:00 p.m. Interview with the Nurse Consultant on 12/20/22 at 3:41 p.m., indicated she had no further information to provide. This Federal tag relates to Complaint IN00388811 and IN00388985. 3.1-48(a)(6)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a			

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	resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure AIMS (Abnormal Involuntary Movement, a rating scale that was designed to measure involuntary movements known as tardive dyskinesia) scales were completed and side	F 0758	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set	01/13/2023

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	effects for antipsychotic medications were monitored for 2 of 5 residents reviewed for unnecessary medications. (Residents 12 and E) Findings include: 1. The record for Resident 12 was reviewed on 12/15/22 at 9:59 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, psychotic disturbance, mood disturbance, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 12/6/22, indicated the resident was moderately impaired for daily decision making and she received an antipsychotic medication on a routine basis. A Care Plan, dated 9/9/22, indicated the resident had a mood problem related to being bipolar and having a mood disorder. Interventions included, but were not limited to, administer medications as ordered. Observe and document signs and symptoms of effectiveness and side effects. A Care Plan, dated 9/5/22, indicated the resident received an antipsychotic medication Risperdal related to having bipolar and mood disorder. Interventions included, but were not limited to, complete AIMS test per company process and observe for side effects of the antipsychotic medication. . A Physician's Order, dated 11/23/22, indicated the resident was to receive Risperidone (Risperdal - an antipsychotic medication) 0.25 milligrams (mg) one time a day for bipolar disorder. There was no order to monitor for medication side effects. There was no documentation on the November and December 2022 Medication Administration		forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Residents 12 and E were not harmed by the alleged deficient practice. The physician order has been implemented to include monitoring for side effects of antipsychotic medications each shift for each resident. An AIMS scale assessment has been completed for each resident. Physician and responsible party notifications have been made. Care plans have been updated. 2. All residents receiving antipsychotic medications have the potential to be affected by the alleged deficient practice. An audit has been completed to ensure an AIMS scale assessment is in place and that each resident has side effect monitoring every shift in place. Physician and responsible parties have been notified when required. All care plans have been updated. 3. DON/designee has educated all licensed nurses regarding the need to monitor for side effects with the use of	

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	Records (MAR's) where the resident was being monitored for side effects. There was no AIMS scale available for review. Interview with the Director of Nursing on 12/19/22 at 1:25 p.m., indicated the resident should have been monitored for medication side effects and an AIMS scale should have been completed upon admission. 2. The record for Resident E was reviewed on 12/15/22 at 10:00 a.m. Diagnoses included, but were not limited to, COPD, bipolar disorder, anxiety, major depressive disorder, unspecified dementia with behavioral disturbances, schizophrenia, and dependence on oxygen. The Quarterly Minimum Data Set (MDS) assessment, dated 10/14/22, indicated the resident was cognitively intact. In the last 7 days the resident received an antipsychotic medication 7 times, anti-anxiety medication 7 times, and antidepressant medication 7 times. A Care Plan, revised on 2/1/22 indicated the resident used anti-anxiety medication, antipsychotic medication and antidepressant medication. The approaches were to observe for side effects of each of the medications. Physician's Orders, dated 4/7/22 and updated 9/11/22, indicated Lorazepam (an anti-anxiety medication) 0.5 milligrams (mg). Give 0.5 mg by mouth three times a day for anxiety. Physician's Orders, dated 4/7/22 and updated 5/9/22, indicated Risperidone (an antipsychotic medication) 0.25 mg. Give 0.25 mg by mouth two times a day for bipolar schizophrenia.		antipsychotic medication and the completion of an AIMS scale assessment, per facility protocol. 4. DON/Designee will audit 5 residents, that receive antipsychotic medications, 3 x wk x 4 wks, then 1 x wk x 8 wks for the completion of side effect monitoring and an AIMS scale assessment in place. The DON will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREAT LAKES HEALTHCARE CENTER	2300 GREAT LAKES DR DYER, IN 46311

(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
	Physician's Orders, dated 4/7/22, indicate Bupropion (an antidepressant medication) HCl ER (XL) 300 mg. Give 1 tablet by mouth one time a day for depression. The 11/2022 and 12/2022 Medication Administration Record (MAR) indicated there was no documentation of the monitoring of signs and symptoms of side effects for the psychotropic medication. Interview with the Nurse Consultant on 12/20/22 at 3:18 p.m., indicated documentation of monitoring the side effects of the psychotropic medication was lacking in the clinical record. 3.1-48(a)(3)			
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. Based on observation, record review, and interview, the facility failed to ensure a resident was free from significant medication errors related to not priming an insulin pen prior to administration for 1 of 5 residents observed during medication pass. (Resident 40) Finding includes: On 12/19/22 at 9:00 a.m., LPN 2 was observed preparing medications for Resident 40. She had checked the resident's blood sugar and it was 221, the LPN indicated the resident was going to receive 19 units of Novolog (a fast acting insulin) based on her routine order and her sliding scale order. The LPN dialed the Novolog flex pen to 19 units. She proceeded to enter the residents room,	F 0760	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Resident 40 was not harmed by the alleged deficient	01/13/2023

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	she sanitized her hands, donned gloves, wiped the resident's left upper arm with an alcohol pad and then she administered the insulin. She did not prime the insulin pen prior to giving the resident her dose. The record for Resident 40 was reviewed on 12/19/22 at 10:00 a.m. Diagnoses included, but were not limited to, type 2 diabetes and heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 11/28/22, indicated the resident was moderately impaired for daily decision making and she received insulin. The December 2022 Physician's Order Summary (POS), indicated the following: Insulin Aspart Solution Pen-injector 100 UNIT/ML Inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units above 400 or below 60 call the Physician, subcutaneously three times a day for diabetes inject 2-10 units into the skin three times a day (3 milliliter) injection pen and inject 15 unit subcutaneously three times a day for diabetes. The Novolog Flex Pen manufacturer's recommendations indicated the pen must be primed before each injection to ensure no air was present. To prime the insulin pen, turn the dosage knob to the 2 units indicator. With the pen pointing upward, push the knob in all of the way. Interview with the Director of Nursing on 12/19/22 at 1:30 p.m., indicated the insulin pen should have		practice. Nurse educated regarding priming the insulin pen prior to administration. The physician and responsible party were notified of the insulin pen not being primed prior to use. 2. All residents receiving insulin via an insulin pen have the potential to be affected by same alleged deficient practice. 3. DON/Designee has educated all licensed nurses regarding the Medication Administration policy and how to prime an insulin pen prior to administration of the insulin. 4. DON/Designee will observe 3 nurses a wk x 4 wks, then 1 nurse a wk x 8wks for priming of the insulin pen prior to administration of insulin. DON/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	been primed. 3.1-48 (c)(2)			
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's			

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	responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. Based on observation, record review, and interview, the facility failed to ensure residents with dental concerns received the necessary services related to a follow up for a tooth extraction for 1 of 1 residents reviewed for dental services. (Resident M) Finding includes: During an interview on 12/13/22 at 2:44 p.m., Resident M indicated he had issues with his teeth. He had seen the dentist but had no follow up since then. The record for Resident M was reviewed on 12/19/22 at 10:15 a.m. The resident was admitted to the facility on 3/28/22. Diagnoses included but were not limited to, respiratory failure, tracheostomy, psychotic disorder, schizoaffective disorder, sleep apnea, high blood pressure, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 10/4/22 indicated the resident was cognitively intact. The resident had no issues with his teeth. There was no Care Plan for dental issues. A dental visit, dated 9/14/22, indicated a	F 0791	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Resident M was not harmed by the alleged deficient practice. The resident has a scheduled dental appointment with an outside provider. The physician was notified of the resident needing a referral for an outside dental provider for the need of an extraction. The resident care plan has been updated. 2. All residents have the potential to be affected by the alleged deficient practice. All residents have had their last	01/13/2023

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	recommendation for the extraction of tooth #25. A dental visit, dated 10/5/22, indicated the resident had his teeth cleaned. The dentist's last visit in the facility was on 11/10/22 and the resident was not seen. There was no follow up for the tooth extraction recommendation. Interview with the Nurse Consultant on 12/20/22 at 2:20 p.m., indicated the resident had not seen the dentist after 10/5/22 and had not had the tooth extracted. 3.1-24(a)(3)		dental visit audited for follow up needs and all follow up implemented as recommended. 3. DON/designee have educated all licensed nursing staff and social service regarding the Dental Services policy with an emphasis on “obtaining services to meet the needs of each resident”. 4. DON/Designee will audit each resident dental progress note after each dental visit for any follow up recommendations, this will be an on-going practice. The DON will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	
F 0809 SS=E Bldg. 00	483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the			

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	following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. Based on observation, record review, and interview, the facility failed to ensure meals were served in a timely manner for 1 of 3 units. (West Unit) Findings include: 1. On 12/15/22 at 1:25 p.m., the first cart of lunch trays arrived on the West Unit and staff started passing them out. A list of meal times, provided by the facility as current, indicated on the West Unit, breakfast was to be served from 8:00 a.m. to 8:15 a.m., lunch was to be served from 12:45 p.m. to 1:00 p.m., and dinner was to be served from 6:15 p.m. to 6:30 p.m. 2. On 12/16/22 at 7:25 a.m., Dietary staff had brought down the beverage cart to the West Unit. At 8:02 a.m., the first cart of breakfast trays arrived on the unit. At 8:11 a.m., the second breakfast cart was delivered to the West Unit. At 8:14 a.m., two CNAs were passing trays on the middle hall and one CNA was preparing beverages. At 8:18 a.m., the third cart was delivered to the	F 0809	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. No residents were identified as being harmed by the alleged deficient practice. 2. All residents have the potential to be affected by the same alleged deficient practice. 3. The Dietary Manager and the ED / Designee have in-serviced the dietary and nursing employees regarding the Meal Time Delivery Schedule and on food delivery. The Dietary Manager and the ED / Designee will monitor and	01/13/2023

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	unit. No trays from the second cart had been passed. CNA 1 started passing trays from the third cart rather than the second cart. She was not in the area when the second cart was delivered. At 8:22 a.m., CNA 2 opened the second cart and CNA 1 told him, "No, we are doing this one first." She was referring to the third cart. She said that cart had been there longer, even though she wasn't in the area when the second cart was delivered. At 8:28 a.m., the first tray was served from the second cart. At 8:36 a.m., staff stopped serving from the second cart. They had to call down to the kitchen for more glasses and milk. Staff continued to serve the second cart at 8:42 a.m. At 8:50 a.m., staff had to call down to the kitchen again for more coffee cups. A CNA returned with more cups at 9:02 a.m. The last tray on the cart was served at 9:10 a.m. 3. On 12/19/22 at 9:12 a.m., the first cart of breakfast trays arrived on the West Unit. The second cart of trays arrived at 9:15 a.m., the third cart arrived at 9:30 a.m., and the fourth cart arrived at 9:42 a.m. A list of meal times, provided by the facility as current, indicated on the West Unit breakfast was to be served from 8:00 a.m.-8:15 a.m., lunch was to be served from 12:45 p.m. to 1:00 p.m., and dinner was to be served from 6:15 p.m. to 6:30 p.m. Interview with the Administrator on 12/19/22 at 3:00 p.m., indicated the dietary staff were		audit the Meal Time Delivery Schedule according to the following schedule: 5 x a week for 4 weeks, 3 x a week for 4 weeks and 2 x a week for 4 weeks. The Dietary Manager and the ED / Designee will provide a report on a monthly basis at the QAPI Meeting to the interdisciplinary team. The audits will be reviewed and trended in QAPI for 6 months and randomly thereafter to ensure compliance.	

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	compromised and they were having a problem with the meals being served on time. This Federal tag relates to Complaint IN00388811. 3.1-21(c)			
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 and interview, the facility failed to serve and prepare food under sanitary conditions related to dirty food equipment and a dirty tray in the dry storage room for 1 of 1 kitchens observed. This had the potential to affect the 106 residents who received food from the kitchen. (The Main Kitchen)	F 0812	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and	01/13/2023

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	Findings include: During the Brief Kitchen Sanitation Tour on 12/13/22 at 9:43 a.m. with Cook 1, the following was observed: a. A dirty tray with garbage and food debris was sitting on the dry storage shelving unit b. Two ovens were dirty with built up food grime c. The stove top was dirty with built up food grime d. The meat slicer was dirty and had food debris on it Interview with the Dietary Food Manager on 12/19/22 at 9:10 a.m., indicated the food equipment was in need of cleaning. 3.1-21(i)(3)		executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. No residents were identified as being harmed by the alleged deficient practice. The pieces of equipment identified have been cleaned. 2. All residents have the potential to be affected by the same alleged deficient practice. An audit of the kitchen was completed and any equipment identified as needing cleaned has been cleaned per facility protocol. Kitchen Cleaning Logs have been updated and reviewed with the Dietary Department. 3. The Dietary Manager / Designee has educated and reviewed with Dietary employees the Kitchen Cleaning Log. The Kitchen Cleaning Log identifies the cleaning tasks that are to be performed on a daily basis. 4. The Dietary Manager / Designee will audit the Kitchen Cleaning Log and equipment on the following schedule to ensure completion of the cleaning functions: 5 x a week for 4 weeks, 3 x a week for 4 weeks and 2 x a week for 4 weeks. The	

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			Dietary Manager and the ED / Designee will provide a report on a monthly basis at the QAPI Meeting to the interdisciplinary team. The audits will be reviewed and trended in QAPI for 6 months and randomly thereafter to ensure compliance.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;			

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	(ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			

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	Based on interview and record review, the facility failed to ensure the resident's medical record was complete and accurate related to meal consumption logs for 1 of 6 residents reviewed for nutrition. (Resident 114) Finding includes: The record for Resident 114 was reviewed on 12/16/22 at 10:38 a.m. Diagnoses included, but were not limited to dementia, depression, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 12/4/22, indicated the resident was cognitively intact for daily decision making. A Care Plan, dated 10/27/22, indicated the resident had a potential for altered nutritional status/nutrition related problems related to history of dementia, high blood pressure, and depression. The CNA task sheet for Amount Eaten was reviewed for the last 30 days. There were no meal consumptions logged for the following days and meals: - 11/21/22: breakfast and lunch - 11/22/22: breakfast, lunch, and dinner - 11/23/22: breakfast, lunch, and dinner - 11/24/22: breakfast, lunch, and dinner - 11/30/22: breakfast and lunch - 12/1/22: breakfast and lunch - 12/2/22: breakfast - 12/5/22: breakfast and lunch - 12/6/22: dinner - 12/11/22: dinner - 12/13/22: breakfast and lunch - 12/17/22: dinner - 12/18/22: breakfast and lunch	F 0842	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. Resident 114 was not harmed by the alleged deficient practice. The family and MD were notified of the omissions in the resident's meal consumption record. 2. All other residents that receive a PO diet have the potential to be affected by the alleged deficient practice. An audit was performed of all residents' meal consumptions for the last 7 days to ensure meal consumption was documented appropriately. Any resident identified as not having meal consumption recorded had their family and MD notified immediately and a weight was obtained. 3. Nursing staff were educated on the policy, "Clinical Documentation Standards" with emphasis on meal consumption	01/13/2023

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	Interview with the Nurse Consultant on 12/20/22 at 3:41 p.m., indicated she had no further information to provide. 3.1-50(a)(1)		documentation. 4. Director of nursing/designee will audit 10 residents' weekly x 4 weeks, then 5 residents' weekly x 8 weeks to ensure accurate meal consumption has occurred. The results of the audit will be reviewed in the Quality Assurance Committee monthly meeting for 6 months or until 100% compliance 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.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment as well as the kitchen area was clean and in good repair related to dirty floors, marred walls, and wash basins stored on the floor in 1 of 1 kitchen areas and on 1 of 3 units. (The Main Kitchen and West Unit) Findings include: 1. During the Environmental tour with the Director of Maintenance and the Director of Housekeeping on 12/21/22 at 11:10 a.m., the following was observed:	F 0921	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.**	01/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155218	A. BUILDING 00 B. WING	12/21/2022

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	West Unit: a. In Room 105, the walls were marred in the entry way, behind bed one, and in the bathroom. There was rust on the pipes under the sink in the bathroom. Two residents resided in the room. b. In room 111, the wall behind bed two was marred and gouged. The base of the closet door was marred and gouged. Two residents resided in the room. c. In room 115, the wall behind bed one was marred. There was a brown dried substance on the floor near the bed. The bathroom walls were stained and there was a wash basin stored on the bathroom floor uncovered. Two residents resided in the room. d. In room 116, there were two wash basins stored on the bathroom floor uncovered. Two residents resided in the room. e. In room 120, the wall behind bed two was marred. There was a dried brown substance on the wall behind bed one and there was a wash basin stored on the bathroom floor uncovered. Two residents resided in the room. f. In room 121, there were two wash basins stored on the bathroom floor uncovered. Two residents resided in the room. g. In room 123, the walls were marred throughout the room. Two residents resided in the room. h. In room 135, there were two wash basins stored on the bathroom floor uncovered. Two residents resided in the room. Interview with the Maintenance and		1. Residents in Rooms 105, 111, 115, 116, 120, 121, 123 and 135 were not harmed by the alleged deficient practice. The Maintenance Director has completed the repairs identified for Rooms 105, 111, 115, 116, 120, 121, 123 and 135. The Housekeeping Department has cleaned the resident rooms identified, 105, 111, 115, 116, 120, 121, 123 and 135. The DON / Designee is following the wash basin procedure for Rooms 115, 116, 120, 121 and 135. The floor in the kitchen has been cleaned and food debris and garbage removed. 2. All residents have the potential to be affected by the same alleged deficient practice. An audit was conducted of resident rooms any room identified with marred walls, dirty floors, and wash basins has been corrected or repaired. 3. The ED/Designee has educated the maintenance director on the facility protocol for daily rounds and identification of needed repairs and timely completion. The ED/Designee has educated the housekeeping manager on the facility protocol for daily rounds and identification of housekeeping issues and needs with timely correction. The ED/Designee has	

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	Housekeeping Directors at the time, indicated all of the above were in need of cleaning and/or repair. 2. During the Brief Kitchen Sanitation Tour on 12/13/22 at 9:43 a.m. with the Cook 1, the following was observed: a. The floors throughout the kitchen were dirty with food debris and garbage. Interview with the Dietary Manager on 12/19/22 9:10 a.m., indicated the floors were in need of cleaning. 3.1-19(f)		educated the dietary manager on the facility protocol for maintaining the kitchen floor in a clean manner that is free from food debris and garbage. The DON / Designee has educated Nursing staff on the Wash Basin Procedure. 4. The Maintenance Director makes daily rounds of the facility to identify physical plant issues that need to be addressed, prioritized and take corrective action. This is an ongoing practice. The Housekeeping Director / Designee makes daily rounds of the facility to identify potential housekeeping issues that need to be addressed, prioritized and take corrective action. This is an ongoing practice. The DON / Designee will audit 5 resident rooms 3 x weekly x 4 weeks, then 5 resident rooms 1 x weekly x 8 weeks to ensure the proper storage of wash basins. The ED/Designee will audit the kitchen floor for cleanliness 3 x weekly x 4 weeks, then 1 x weekly x 8 weeks. The Maintenance Director, Dietary Manager, and Housekeeping Director / Designee will provide a report on a monthly basis at the QAPI Meeting to the interdisciplinary team. The ED will round with the Maintenance/Housekeeping director to ensure compliance and report results to QAPI for a	

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			minimum if 6 months. The DON / Designee will include this information in the Nursing Department's monthly report at the QAPI meeting for 6 months.	