STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155282	A. BUILDING 00 B. WING	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SERENITY SPRING SENIOR LIVING AT NORTHWOOD	2515 NEWTON ST JASPER, IN 47547

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: May 13, 14, 15, 16, 17, 20, 21, and 22, 2024 Facility number: 000180 Provider number: 155282 AIM number: 100274190 Census Bed Type: SNF/NF:107 Residential: 24 Total: 131 Census Payor Type: Medicare: 5 Medicaid: 36 Other: 16 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 4, 2024.	F 0000	The plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.			

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

Sarah McKenzie | HFA | 06/15/2024

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

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	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity for 2 of 2 random observations. A staff member was observed standing while assisting to feed a resident, and a staff member walked away from a resident with	F 0550	=”” p=””> SS talked with resident and family about resident rights, care plan scheduled to talk about any concerns. B. How the facility identified other residentsHouse sweep was	07/01/2024

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	visible urine under her chair. (Resident 27, Resident 48) Findings include: 1. On 5/13/24 at 12:02 P.M., Certified Nurse Aide (CNA) 5 was observed standing next to Resident 27 while assisting to feed the resident. 2. During an observation on 5/13/24 at 11:19 A.M., Resident 48 was observed eating in the dining room with a large wet spot under her wheelchair. On 5/13/24 at 11:28 A.M., Licensed Practical Nurse (LPN) 14 sat Resident 48's meal tray in front of her and walked away. During an interview on 5/13/24 at 11:34 A.M., LPN 14 indicated the wet spot was urine. During an interview on 5/16/24 at 4:14 P.M., the Director of Nursing (DON) indicated if a resident was observed with a wet spot under their wheelchair that she would expect staff to bring the resident back to their room and provide care, and then the wet spot and the chair should be cleaned. On 5/16/24 at 2:49 P.M., the Kitchen Manager indicated staff was supposed to sit next to residents while assisting to feed them. On 5/17/24 at 10:30 A.M., a current Assistance with Meals policy, dated 3/2022, was provided and indicated "Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. not standing over residents while assisting them with meals" On 5/20/24 at 1:35 P.M., the Administrator provided an undated Dignity policy that indicated, "Each resident shall be cared for in a		completed to make sure residents know their rights and how to access them. No specific residents were identified. However, all residents have the potential to be affected by the alleged deficiency.C. Measures put into place/system changesCreate a signature page for residents/family to sign upon admission. Give resident/family a copy and keep copy in admission records. Ensure posters are in public areas. Review resident rights in monthly resident council meeting.D. Corrective action will be monitored by audit.DON or designee will audit 2 x weekly for four weeks, 1 time weekly for 4 weeks, then bi-weekly for 4 weeks, and monthly for 3 months/ until compliance is met. This will be covered in QAPI monthly for 6 months/ until compliance is met	

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	manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem...5. When assisting with care, residents are supported in exercising their rights. For example, residents are: e. provided with a dignified dining experience." 3.1-3(t)			
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation and interview the facility failed to provide services based on resident preferences for 1 of 5 residents reviewed. The facility failed to provide ice water to one resident when requested. (Resident 45) Findings include: During an interview on 5/14/24 at 9:39 A.M., Resident 45 indicated she didn't get water unless she asked. During an observation on 5/15/24 at 1:37 P.M., CNA (Certified Nurse Aide) 38 assisted Resident 45 from the commode to her recliner. CNA 38 put the bedside table in front of Resident 45 explaining where her cup of lemonade and box of Kleenex were located. She told Resident 45 her water cup only had a small amount of water in it and asked if she would like the cup filled up. Resident 45 told her yes.	F 0558	A Immediate action taken for the resident identified Resident received fresh ice water.B How the facility identified other residents.House sweep completed. No specific resident was identified. However, all residents have the potential to be affected by the alleged deficiency. C Measures put into place/system changes.Staff to pass water routinely and get fluids for residents as soon as possible upon request.D How corrective action will be monitored.Audit created for staff to sign off Q shift for ice water passed. Monitored by DON or designee 2 x weekly for 4 weeks, then weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 3 months/ until	07/01/2024

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	During an observation on 5/15/24 at 3:16 P.M., Resident 45's water cup had not been filled up. On 5/14/24 at 1:54 P.M., Resident 45's clinical records were reviewed. Diagnosis included, but were not limited to macular degeneration, chronic combined systolic and diastolic heart failure, Sjogren's Syndrome. The most current Quarterly, State Optional MDS (Minimum Data Set) Assessment, dated 4/17/2024, indicated Resident 45 was cognitively intact and required extensive assistance of two for bed mobility, transfers and toilet use, used oxygen and was on hospice. During an interview on 5/17/24 at 1:27 P.M., LPN 19 indicated ice water was not routinely passed, the residents have to ask for it. When she went into a resident's room and saw an empty cup, she would fill it up. On 5/20/24 at 8:57 A.M., the DON (Director of Nursing) provided a current Resident Hydration and Prevention of Dehydration policy, revised October 2017, which indicated "This facility will strive to provide adequate hydration and to prevent and treat dehydration..." On 5/20/24 at 8:57 A.M., the DON provided a current Accommodation of Needs policy, revised March 2021, which indicated "...1. The resident's individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered..." 3.1-3(v)(1) 3.1-46(b)		compliance is met. Will also be monitored in monthly QAPI meeting.	

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F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation			

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	to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on observation, interview, and record review, the facility failed to clarify a Resident's code status for 1 of 1 residents reviewed for Advanced Directives. A Resident's current Physician Orders did not match the signed "DO NOT RESUSCITATE DECLARATION AND ORDER" form. A Resident had a care plan for DNR (Do Not Resuscitate) and CPR (Cardiopulmonary Resuscitation). (Resident 18) Finding includes: On 5/15/24 at 10:00 A.M., Resident 18's clinical record was reviewed. Current diagnoses included, but was not limited to, end stage renal disease, dependence on renal dialysis and diabetes mellitus. The most recent Admission Minimum Data Set (MDS) Assessment, dated 2/17/24, indicated Resident 18 was cognitively intact. Current Physician's orders included, but was not limited to, "ADVANCE DIRECTIVE: Resuscitate (CPR)," start date 3/7/23. A "STATE OF INDIANA OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION ORDER," dated 1/24/23, indicated Resident 18 requested to be a DNR and the form was signed by the Physician on 2/2/23. Current care plans included, but were not limited to: 1. "The resident has impaired cognitive function or impaired thought processes R/T [related to] multiple medical diagnosis...Memory is usually	F 0578	A Immediate action taken for the identified resident. Code status was clarified and changed in PCC immediately.B How the facility identified other residents.House sweep completed. Residents code status was checked and compared to care plan. No specific resident was identified. However, all residents had the potential to be affected by the alleged deficiencyC Measures put into place/system changesEnsuring code status is obtained, verified, signed by family/patient/MD, and scanned into medical records. Ensure residents wishes are followed as ordered. Admissions to verify upon admission.D How corrective action will be monitored.DON or designee will audit Advanced Directives pertaining to medical records, PCC, and MDS 2 x a week for 4 weeks, then once weekly for 4 weeks, then bi-weekly times 4 weeks, and then monthly times 3months/ until compliance is met. Will also discuss in the monthly QAPI meeting.	07/01/2024

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	intact...CPR code status in place..." revised 12/14/23. 2. "...DNR code status is currently in place..." revised 1/27/23. During an interview on 5/15/24 at 1:36 P.M., Licensed Practical Nurse (LPN) 16 indicated if a resident stopped breathing, she would check the computer to verify the resident's code status. At that time, Resident 18's code status was CPR. During an interview on 5/16/24 at 4:16 P.M., the Director of Nursing (DON) indicated that Resident 18 had a CPR code status, but she should have been a DNR. On 5/20/24 at 1:35 P.M., the Administrator provided a current Advance Directives policy, revised December 2016 that indicated, "10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive...Do Not Resuscitate--indicates that, in case of respiratory or cardiac failure, the resident...has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used..." 3.1-4(l)(8)			
F 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and			

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	not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on observation, interview, and record review, the facility failed to ensure the resident right to be free of a physical restraint for 1 of 1 residents reviewed for physical restraints. A bed rail was used as a physical restraint. (Resident 12) Findings include: During an observation on 5/13/24 at 1:54 P.M., Resident 12 was observed in bed with 2 black bed rails that were attached at the top of the mattress 1/3 of the length of the bed. During an interview on 5/13/24 at 2:41 P.M., Resident 12's family member indicated the bed rails were put into place to keep her in bed since	F 0604	A Immediate action taken for the identified resident. Physical restraint eval done immediately.B How the facility identified other residents.House sweep completed and no other specific residents were identified. However, every resident has the potential to be affected by the alleged deficiency.C Measures put into place/ system changes.Physical restraint eval will be done on residents that have assist bars on their beds, and as needed. Care plan will state that assist bars are not a restraint but	07/01/2024

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	she had multiple falls. During an observation on 5/16/24 9:31 A.M., Resident 12 was observed in bed with bed rails up. At that time, she indicated the bed rails are there to keep her from falling out of bed. On 5/15/24 at 2:28 P.M., Resident 12's clinical record was reviewed. Current diagnoses included, but were not limited to hypertension, diabetes mellitus, anxiety, and depression. The most recent Quarterly and State Optional Minimum Data Set (MDS) Assessment, dated 4/30/24 indicated Resident 12 had moderate cognitive impairment and used bed rail's daily. Resident 12's clinical record lacked an order related to the bed rails. Current care plans included, but were not limited to, "The resident uses physical devices bilateral assist bars R/T [related to] weakness," created 10/3/23 with current interventions, "Monitor/document/report to health care provider PRN [as needed] any changes regarding use of assist bars. Educate and discuss with resident and family the risks of benefits of the assist bars regarding its use," dated 10/3/23. A Physical Devise and/or Restraint Evaluation and review, dated 1/25/24 indicated, "Definition of Restraint...A device is considered a restraint if it restricts the resident's freedom of movement, or normal access to one's body, AND the resident is not able to remove the device in the same manner as the staff. NOTE. If it does restrict the resident's freedom of movement, or normal access to one's body, AND the resident is not able to remove the device, you must obtain (1) provider order with justification for medical necessity (2) signed		to help with bed mobility and correctly score MDS.D How corrective action will be monitored.MDS or designee will audit 2 x a week for 4 weeks, then once weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 3 months/ until compliance is met. Will also discuss in QAPI monthly.	

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	permission from POA [power of attorney] or responsible party if required by state...Restraints must be removed at least every 2 hours to allow for repositioning..." The clinical record lacked a restraint evaluation after 1/25/24. The clinical record lacked documentation of informed consent for the bed rails. The clinical record lacked documentation on removal of the restraint at least every 2 hours. The clinical record lacked documentation that Resident 12 could remove the restraint herself. During an interview on 5/16/24 at 9:34 A.M., Licensed Practical Nurse (LPN) 18 indicated the bed rails are used for mobility and she thought the bed rails were assessed under assessments. During an interview on 5/16/24 at 9:41 A.M., Certified Nurse Aide (CNA) 10 indicated the bed rails are used, "because she likes to climb out of bed." During an interview on 5/16/24 at 9:51 A.M., the Director of Nursing (DON) indicated the evaluations should be completed quarterly and the bed rails keep Resident 12 in bed. During an interview on 5/16/24 at 10:35 A.M., LPN 18 indicated restraints are assessed every quarter. On 5/17/24 at 9:52 A.M., the Dementia Care Director provided a current Use of Restraints policy, revised April 2017 that indicated, "Restraints shall only be used to treat the resident's medical symptom(s) and never for			

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	discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented...1. "Physical Restraints" are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts the freedom of movement or restricts normal access to one's body...4. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: a. using bedrails to keep a resident from voluntarily getting out of bed...6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints...9. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative...The order shall include the following: a. The specific reason for the restraint...b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint...16. Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction..." 3.1-26(g) 3.1-26(h)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview, and record review, the facility failed to report an allegation of abuse for 1 of 1 residents reviewed for abuse. A Certified Nurse Aide (CNA) physically removed the resident's fingers and hand from the stand aide lift. (Resident 4) Finding includes: During an interview on 5/13/24 at 2:00 P.M., Resident 4 indicated on 5/4/24 CNA 53 ordered her to do things in an abusive tone and the CNA pulled her fingers one by one off of the sit to	F 0609	A Immediate action taken for the identified resident. Resident interviewed and investigation immediately initiated.B How the facility identified other residents.House sweep was conducted. No other specific residents were identified. However, every resident has the potential to be affected by alleged deficiency.C Measures put into place/system changes.Keeping residents safe from harm and	07/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155282	A. BUILDING 00 B. WING	05/22/2024

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	stand lift. On 5/13/24 at 2:30 P.M., Resident 4's clinical record was reviewed. Current diagnoses included, but were not limited to, anxiety and depression. The most recent Annual (Minimum Data Set Assessment), dated 12/28/23, indicated Resident 4 was cognitively intact and required assistance with transfers. Current Physician's Orders included, but was not limited to, "Activity level: up with assist," dated 10/4/13. Current care plans included, but were not limited to, "The resident has an ADL [activities of daily living] self care performance deficit R/T [related to]...decreased mobility, stress incontinence, Cerebellar Ataxia, diplopia, spinal stenosis E/B [evidenced by] requires extensive assist of staff with ADL care." revised 5/6/21. Current interventions included, but were not limited to, "TRANSFER: Transfers with 1 x assist with sit to stand aide." revised 4/4/24. The record lacked documentation of the allegation, assessment of the resident's hand/fingers and any follow up to the allegation. On 5/22/24 at 1:45 P.M., Licensed Practical Nurse (LPN) 9 provided a copy of CNA 53's criminal background check that indicated a battery charge in which the staff member was found guilty. CNA 53 was arrested on 8/15/21. During an interview on 5/14/24 at 8:35 A.M., the Administrator indicated the Director of Nursing (DON) was aware of the situation, but she was not told about it when it happened. At that time, she indicated she was going to report the allegation.		ensuring Resident Rights. Education with staff regarding abuse, neglect, and proper reporting procedure. Interviewing staff and residents once a week pertaining to resident rights, care, abuse.D How corrective action will be monitoredThe DON or designee audits twice weekly for 4 weeks, then weekly for 4 weeks, then once every 2 weeks for 4 weeks, and then monthly for 3 months/ until compliance is met. Will also discuss in monthly QAPI.	

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	During an interview on 5/16/24 at 9:54 A.M., the DON indicated it was reported to her that CNA 53 was rude to Resident 4 and she did not like the way CNA 53 talked to her. During an interview on 5/20/24 at 10:31 A.M., the Administrator indicated the allegation should have been reported as soon as they found out about it. On 5/20/24 at 1:35 P.M., the Administrator provided a current Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating policy, revised September 2022, that indicated, "If a resident abuse...is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law..."Immediately" is defined as:...b. within 24 hours of an allegation..." 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law,			

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	including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview, and record review, the facility failed to properly investigate an allegation of abuse for 1 of 1 residents reviewed for abuse. A Certified Nurse Aide (CNA) physically removed the resident's fingers and hand from the stand aide lift. (Resident 4) Finding includes: During an interview on 5/13/24 at 2:00 P.M., Resident 4 indicated on 5/4/24 CNA 53 ordered her to do things in an abusive tone and CNA 53 pulled her fingers one by one off of the sit to stand lift. On 5/13/24 at 2:30 P.M., Resident 4's clinical record was reviewed. Current diagnoses included, but were not limited to, anxiety and depression. The most recent Annual (Minimum Data Set) Assessment, dated 12/28/23, indicated Resident 4 was cognitively intact and required assistance with transfers. Current Physician's Orders included, but was not limited to, "Activity level: up with assist," dated 10/4/13. Current care plans included, but were not limited to, "The resident has an ADL [activities of daily living] self care performance deficit R/T [related to]...decreased mobility, stress incontinence, Cerebellar Ataxia, diplopia, spinal stenosis E/B [evidenced by] requires extensive assist of staff with ADL care." revised 5/6/21. Current interventions included, but were not limited to, "TRANSFER: Transfers with 1 x assist with sit to	F 0610	A Immediate action taken for the identified resident Resident interviewed and investigation immediately initiatedB How the facility identified other residentsHouse sweep was conducted. No other specific residents were identified. However, all residents have the potential to be affected by alleged deficiency.C Measures put into place/system changesStaff education regarding abuse, neglect, proper reporting procedure, and amount of time to reportAdministrator or designee to immediately start investigation by interviewing staff and residents. Gather information and analyze.D How corrective action will be monitoredAdministrator will audit grievances, complaints, and reportables 2x weekly for 4 weeks, 1 x weekly for 4 weeks, bi-weekly for 4 weeks, and monthly for 3 months/until compliance is met. Will discuss in monthly QAPI.	07/01/2024

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	stand aide." revised 4/4/24. The clinical record lacked any documentation of the allegation, assessment of the resident's hand/fingers and any follow up to the allegation. On 5/22/24 at 1:45 P.M., Licensed Practical Nurse (LPN) 9 provided a copy of CNA 53's criminal background check that indicated a battery charge in which the staff member was found guilty. CNA 53 was arrested on 8/15/21. During an interview on 5/14/24 at 8:35 A.M., the Administrator indicated the Director of Nursing (DON) was aware of the situation, but she was not told about it when it happened. At that time, she indicated she was going to suspend CNA 53 and investigate the allegation. During an interview on 5/16/24 at 9:54 A.M., the DON indicated it was reported to her that CNA 53 was rude to Resident 4 and she did not like the way CNA 53 talked to her. During an interview on 5/20/24 at 10:31 A.M., the Administrator indicated the allegation should have been properly investigated as soon as they found out about it and CNA 53 should have been suspended. On 5/20/24 at 1:35 P.M., the Administrator provided a current Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating policy, revised September 2022, that indicated, "If a resident abuse...is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law...Investigating Allegations 1. All allegations are thoroughly investigated. The administrator initiates investigations..."			

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	3.1-28(d)			
F 0623 SS=E 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			

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	discharge, under paragraph (c)(1)(i)(B) of this 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			

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	protection and advocacy of individuals with a 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 interview and record review, the facility failed to ensure a notice of transfer or discharge was given to residents or resident representatives for 5 of 5 residents reviewed for hospitalizations. The transfer or discharge notice was not completed and clinical records lacked documentation of residents/representatives receiving a notice of transfer or discharge at the time of the hospitalizations. (Resident 38, Resident 52, Resident 46, Resident 43, Resident 15) Findings include: 1. On 5/14/24 at 2:49 P.M., Resident 38's clinical record was reviewed. Diagnoses included, but were not limited to, dementia.	F 0623	A Immediate action taken for the identified resident. Family was contacted and asked if they received the transfer form, family could not remember and education was provided on what a bed hold policy is and what it is used for. B How the facility identified other residents House sweep was conducted. Records were reviewed on residents; no specific resident was identified. However, all residents	07/01/2024

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	The most recent Annual MDS (Minimum Data Set) Assessment, dated 4/23/24, indicated Resident 38's cognition was severely impaired and she was an extensive assist of 1 staff for bed mobility, transfers, and toileting. Progress notes included, but were not limited to, the following: On 1/30/24 at 3:31 A.M., Nurse's Note: "At 0300 [3:00 A.M.] this nurse and CNA [certified nurse aide] heard a thump and got up to check what sound was and found res. [resident] setting [sic] on floor in front of bedroom door. Res. was setting [sic] on bottom with legs straight out in front of her, walker was behind resident facing the bedroom room ... sending to ER [emergency room] for further eval [evaluation] at this time per MD [Medical Doctor] ..." The clinical record lacked documentation of the representative receiving a notice of transfer or discharge due to residents severe cognitive impairment at the time of hospitalization. During an interview on 5/16/24 at 9:55 A.M., the Administrator indicated she thinks staff are filling out transfer or discharge forms, sending them with the residents, but are not making copies to keep in the residents clinical record. 2. On 5/14/24 at 3:21 P.M., Resident 52's clinical record was reviewed. Diagnoses included, but were not limited to unspecified intellectual disabilities and senile degeneration of brain. The most recent Admission MDS Assessment, dated 2/28/24, indicated Resident 52's cognition was unable to be assessed and was an extensive assist of 2 staff for bed mobility, transfers, and		have the potential to be affected by alleged deficiency. C Measures put into place/system changes Ensure transfers or discharges are completed correctly. Make sure a copy is gave to resident/family and a copy is scanned into medical records. Staff education provided on protocol. D How corrective action will be monitored Medical records or designee to audit transfers and discharges 2x weekly for 4 weeks,1 x weekly for 4 weeks, bi-weekly for 4 weeks and monthly for 3 months/ until compliance is met. Will discuss in QAPI monthly. 62	

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	toileting. Progress notes included, but were not limited to, the following: On 4/25/24 at 1:40 A.M., Nurse's Note: "CNA witnessed resident up et [and] walking in lounge, as CNA was walking toward resident to help resident back to W/C [wheelchair], resident fell hitting his head ... Per NP [Nurse Practitioner] order to send resident to [name of hospital] for eval & treat ... " The clinical record lacked documentation of the representative receiving a notice of transfer and discharge due to residents intellectual disability at the time of hospitalization. 3. On 5/14/24 at 1:54 P.M., Resident 43's clinical record was reviewed. Current diagnosis included, but was not limited to, diabetes mellitus. The most recent Quarterly and State Optional MDS, dated 4/17/24, indicated Resident 43 was cognitively intact, and he was an extensive assist of 2 for bed mobility, transfers, and toileting. Progress notes included, but were not limited to, the following: "1/13/2024 13:14 [1:14 P.M]...Resident continues to throw up and states he does not feel well. This nurse contacted NP [Nurse Practitioner] who noted order to send res [resident] to ER [emergency room] for eval [evaluation] and treat. Daughter notified..." The clinical record lacked documentation of the resident and representative receiving a notice of transfer or discharge at the time of hospitalization. During an interview on 5/16/24 at 9:55 A.M., the Administrator indicated she thinks staff are filling out transfer or discharge forms, sending them with			

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	the residents, but are not making copies to keep in the residents clinical record. 4. On 5/17/24 at 1:25 P.M., Resident 15's clinical record was reviewed. Resident 15 had moderate cognitive impairment and was discharged to the hospital due to hypotension (low blood pressure) and lethargy on 5/11/24 and returned to the facility 5/15/24. Resident 15's clinical record lacked a notice of transfer or discharge, and lacked documentation that it was sent with the resident or given to the resident's representative. On 5/20/24 at 8:57 A.M., a copy of a transfer form, dated 5/11/24, was provided. The form lacked a reason for the discharge, ombudsman information, and appeal rights. 5. On 5/13/24 at 2:36 P.M., Resident 46's clinical record was reviewed. Resident 46 was discharged to the hospital on 1/28/24 and returned to the facility 1/29/24. Resident 46's clinical record lacked a notice of transfer or discharge, and lacked documentation that it was sent with the resident or given to the resident's representative. On 5/16/24 at 9:55 A.M., the Administrator indicated the transfer forms that were provided were what was sent with the residents at the time of discharge. She further indicated the ombudsman was notified of the discharge if he/she was already involved with that resident, but not otherwise. On 5/16/24 at 4:10 P.M., a current Transfer Form policy, dated 3/2017 was provided and indicated "This facility provides a completed and accurate			

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	Transfer Form to a resident transferred or discharged from our facility" 3.1-12(a)(6)(A)			
F 0625 SS=E Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to ensure a bed hold form and policy was given to residents or resident representatives for 5	F 0625	A Immediate action taken for the identified resident. Family was contacted and asked	07/01/2024

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	of 5 residents reviewed for hospitalizations. The bed hold form was not completed and clinical records lacked documentation of residents/representatives receiving a bed hold form and policy at the time of the hospitalizations. (Resident 38, Resident 52, Resident 46, Resident 43) Findings include: 1. On 5/14/24 at 2:49 P.M., Resident 38's clinical record was reviewed. Diagnoses included, but were not limited to dementia. The most recent Annual MDS (Minimum Data Set) Assessment, dated 4/23/24, indicated Resident 38's cognition was severely impaired and she was an extensive assist of 1 staff for bed mobility, transfers, and toileting. Progress notes included, but were not limited to, the following: On 1/30/24, Nurse's Note: "At 0300 [3:00 A.M.] this nurse and CNA [certified nurse aide] heard a thump and got up to check what sound was and found res. [resident] setting [sic] on floor in front of bedroom door. Res. was setting [sic] on bottom with legs straight out in front of her, walker was behind resident facing the bedroom room ... sending to ER [emergency room] for further eval [evaluation] at this time per MD [Medical Doctor] ..." On 2/5/24, Nurse's Notes: "resident very lethargic, arms flaccid, will not open eyes, will not respond to nail bed press or sternal rub ... Primary Care Provider responded with the following feedback: A. Recommendations: send to er ... " The clinical record lacked documentation of the		if they received the bed hold policy. Family was unsure, education provided on what a bed hold policy is and why it is used. B How the facility identified other residents House sweep conducted. Records were reviewed on residents; no specific resident was identified. However, all residents have the potential to be affected by alleged deficiency. C Measures put into place/system changes Ensure transfers or discharges are completed correctly. Make sure copy is gave to resident/family and a copy is scanned into medical records D How corrective action will be monitored Medical records or designee to audit transfers and discharges 2x weekly for 4 weeks,1 x weekly for 4 weeks, bi-weekly for 4 weeks and monthly for 3 months/ until compliance is met. Will discuss in QAPI monthly.	

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	155282	A. BUILDING 00 B. WING	05/22/2024

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	representative receiving a bed hold form and policy at the time of hospitalization due to severe cognitive impairment. 2. On 5/14/24 at 3:21 P.M., Resident 52's clinical record was reviewed. Diagnoses included, but were not limited to unspecified intellectual disabilities and senile degeneration of brain. The most recent Admission MDS Assessment, dated 2/28/24, indicated Resident 52's cognition was unable to be assessed and was an extensive assist of 2 staff for bed mobility, transfers, and toileting. Progress notes included, but were not limited to, the following: On 4/25/24, Nurse's Note: "CNA witnessed resident up et [and] walking in lounge, as CNA was walking toward resident to help resident back to W/C [wheelchair], resident fell hitting his head ... Per NP [Nurse Practitioner] order to send resident to [name of hospital] for eval [evaluation] & treat ... " On 4/29/24, Nurse's Note: "Resident was found on floor next to his chair in the 200 hall lounge ... MD notified and gave order to send out to [name of hospital] ER to eval [evaluation] and treat ... " The clinical record lacked documentation of the representative receiving a bed hold form and policy at the time of hospitalization due to severe intellectual disability. 3. On 5/14/24 at 1:54 P.M., Resident 43's clinical record was reviewed. Current diagnosis included, but was not limited to, diabetes mellitus. The most recent Quarterly and State Optional MDS, dated 4/17/24, indicated Resident 43 was cognitively intact, and he was an extensive assist of 2 for bed			

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	mobility, transfers, and toileting. Progress notes included, but were not limited to, the following: "1/13/2024 13:14 [1:14 P.M]...Resident continues to throw up and states he does not feel well. This nurse contacted NP [Nurse Practitioner] who noted order to send res [resident] to ER [emergency room] for eval [evaluation] and treat. Daughter notified..." The clinical record lacked documentation of the resident and representative receiving a bed hold form and policy at the time of hospitalization. 4. On 5/13/24 at 2:36 P.M., Resident 46's clinical record was reviewed. Resident 46 was discharged to the hospital on 1/28/24 and returned to the facility 1/29/24. Resident 46's clinical record lacked documentation that bed hold information was sent with the resident or given to the resident's representative. During an interview on 5/16/24 at 9:55 A.M., the Administrator indicated she thinks staff are filling out bed hold forms and giving it with the policy to the residents, but were not making copies to keep in the resident's clinical record. On 5/16/24 at 4:10 P.M., the DON provided a current Bed-Holds and Returns policy, dated 3/2022, that indicated "All residents/representatives are provided written information regarding the facility bed-hold policies, which address holding or reserving a resident's bed during periods of absence ... Residents are provided written information about these policies at least twice ... well in advance of any transfer ... at the time of transfer"			

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	3.1-12(a)(25) 3.1-12(a)26			
F 0641 SS=E Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to ensure accuracy of assessments for 14 of 26 resident records reviewed during the survey. MDS (Minimum Data Set) Assessments did not accurately reflect resident status. (Resident 52, Resident 38, Resident 12, Resident 35, Resident 36, Resident 41, Resident 19, Resident 17, Resident 19, Resident 43, Resident 48, Resident 5, Resident 53) Findings include: 1. On 5/14/24 at 10:49 A.M., Resident 36's room was observed. The bed was observed equipped with small grab bars. On 5/16/24 at 1:52 P.M., Resident 36's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's Disease. The most recent Annual MDS Assessment, dated 3/14/24, indicated use of physical restraints in the form of bed rails. Resident 36's clinical record lacked a current physician order for bed rails. Resident 36's clinical record lacked a current care plan related to bed rails. A "Physical Device and/or Restraint Evaluation and Review" form, dated 3/7/24, indicated assist/grab bars were being reviewed for the	F 0641	A Immediate action taken for the identified resident MDS was reviewed and amended immediatelyB How the facility identified other residentsHouse sweep completed. MDS reviewed in house and with corporate MDS, no other specific resident identified. However, all residents have the potential to be affected by alleged deficiency.C Measures put into place/system changesEnsure MDS schedules, and evaluations are complete in a timely manner. Staff education on charting correctly and in a timely manner. Triple checks put into pace.D How corrective action will be monitoredMDS or designee will review 2 x weekly for 4 weeks, 1 x weekly for 4 weeks, and bi-weekly for 4 weeks, then monthly for 3 months/until compliance is met. Will be discussed in QAPI monthly	07/01/2024

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	resident, and were not being used as a restraint. 2. On 5/16/24 at 1:59 P.M. Resident 14's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety, and psychotic disorder. The most recent Quarterly MDS Assessment, dated 5/7/24, indicated Resident 14 had taken an anticoagulant medication. The MDS also indicated the Resident did not take an antiplatelet medication. Current physician orders included, but were not limited to: Clopidogrel Bisulfate (an antiplatelet medication) Oral Tablet 75 mg (milligrams) by mouth one time a day, dated 12/27/23. Aspirin (an antiplatelet medication) 81 mg by mouth one time a day, dated 12/27/23. Resident 14's clinical record lacked a current physician's order for an anticoagulant medication. 3. During an observation on 5/14/24 at 10:39 A.M., Resident 48's bed was observed with small grab bars. On 5/15/24 at 8:59 A.M., Resident 48's clinical record was reviewed. Current diagnoses included, but were not limited to, dysphagia and muscle weakness. The most recent Quarterly and State Optional Minimum Data Set (MDS) Assessment, dated 3/26/24, indicated resident 48 used bed rails daily. No other assessment for use of bed rails was documented. Resident 48's clinical record lacked an order related to a bed rails. Resident 48's clinical record lacked a care plan			

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	related to a bed rails. 4. On 5/14/24 at 1:54 P.M., Resident 43's clinical record was reviewed. Current diagnosis included, but was not limited to, diabetes mellitus. The most recent Quarterly and State Optional MDS, dated 4/17/24, indicated Resident 43 was cognitively intact and received an anticoagulant. Resident 43's record lacked an order for an anticoagulant during the look back period. Current care plans included, but were not limited to, "The resident is on anticoagulant therapy," revised 2/19/24 and interventions included, but were not limited to, "...Monitor resident condition based on clinical practice guidelines or clinical standards of practice r/t [related to] use of Plavix [antiplatelet]..." revised 2/19/24. 5. On 5/14/24 at 9:58 A.M., Resident 19's bed was observed without bed rails. On 5/14/24 at 1:41 P.M., Resident 19's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety and atherosclerotic heart disease The most recent Quarterly MDS Assessment, dated 4/10/24, indicated resident was cognitively intact, an extensive assist of 1 staff for bed mobility, transfers, toileting, had pneumonia, and used a restraint (bed rail) daily. During an interview on 5/17/24 at 11:00 A.M., the MDS Coordinator indicated pneumonia was marked in error and should have been taken off the MDS Assessment, dated 4/10/24. 6. On 5/14/24 at 9:50 A.M., Resident 17 was			

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	observed asleep in her bed without bed rails. On 5/16/24 at 2:47 P.M., Resident 17's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and bipolar. The most recent Annual MDS Assessment, dated 4/23/24, indicated Resident 17's cognition was mildly impaired, supervised with set up from staff for bed mobility, transfers, toileting, and used a restraint (bed rail) daily. 7. On 5/13/24 at 10:32 A.M., Resident 52's bed was observed pushed up to the wall on the left side and without bed rails. On 5/14/24 at 3:21 P.M. Resident Resident 52's clinical record was reviewed. Diagnoses included, but were not limited to unspecified intellectual disabilities and senile degeneration of brain. The most recent Admission MDS Assessment, dated 2/28/24, indicated Resident 52's cognition was unable to be assessed, was an extensive assist of 2 staff for bed mobility, transfers, toileting, and used a restraint (bed rail) daily. 8. On 5/13/24 at 10:00 A.M., Resident 38's bed was observed without bed rails. On 5/14/24 at 2:49 P.M., Resident 38's clinical record was reviewed. Diagnoses included, but were not limited to dementia. The most recent Annual MDS Assessment, dated 4/23/24, indicated Resident 38's cognition was severely impaired and she was an extensive assist of 1 staff for bed mobility, transfers, toileting, and used a restraint (bed rail) daily.			

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	9. On 5/14/24 at 9:54 A.M., Resident 41's bed was observed without bed rails. On 5/16/24 at 3:22 P.M., Resident 41's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The most recent Quarterly MDS Assessment, dated 4/24/24, indicated Resident 41's cognition was unable to be assessed, she was an extensive assist of 2 staff for bed mobility and transfers, totally dependent on 2 staff for transfers, and used a restraint (bed rail) daily. 10. On 5/14/24 at 1:54 P.M., Resident 45's clinical records were reviewed. Diagnosis included, but were not limited to, macular degeneration, chronic combined systolic and diastolic heart failure, Sjogren Syndrome. The most current Quarterly MDS (Minimum Data Set) Assessment and State Optional MDS, dated 4/17/2024, indicated Resident 45 was cognitively intact and required extensive assistance of two for bed mobility, transfers and toilet use, used oxygen and was on hospice, and had physical restraints, bed rails used daily. Review of the Physical Device and/or Restraint Evaluation and Review, dated 5/1/24, indicated: Which device(s) are you recommending and/or reviewing for this resident? (check all that apply) a. Assist/Grab bar(s) Assist bars increase resident independence with bed mobility. Assist bars increase resident's independence with bed mobility, such as turning side to side in bed, from lying to sitting position on side of bed with transfers. Care planning for use of physical devices Focus: The resident uses physical devices			

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	assist bars to bed R/T (related to) increases resident's independence with bed mobility, turning side to side and from lying to sitting on side of bed for transfers. Goal: Resident will demonstrate the appropriate use of assist bars to bed to increase her independence with bed mobility. Intervention: Monitor/document/report to health care provider PRN any changes regarding use of assist bars to bed. 11. On 5/14/24 at 3:18 P.M., Resident 3's clinical records were reviewed. Diagnosis included but was not limited to, cerebral ischemia, depression, cerebral infarction, occlusion and stenosis of bilateral carotid arteries. The most current Quarterly MDS (Minimum Data Set) Assessment and State Optional MDS, dated 3/25/24, indicated Resident 3 was mildly impaired cognitively, required extensive assistance of two for bed mobility, transfers, and toilet use, had physical restraints, bedrail used daily. Review of Physical Device and/or Restraint Evaluation and Review, dated 4/28/24, indicated: Which device(s) are you recommending and/or reviewing for this resident? (check all that apply) a. Assist/Grab bar(s) Potential resident safety risks have been evaluated for this device/restraint (e.g., potential entrapment, accident hazards, potential negative outcome, physical restraint, potential negative psychosocial outcome, etc.). How will the assist/grab bar(s) benefit and/or allow the resident to reach their highest level of independence? grab bars helps res.(resident), help staff in positioning Would the assist/grab bar(s) be a restraint for this			

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	resident? (Refer to "Definition of Restraint" above.) no Care planning for use of physical devices Focus: The resident uses physical devices bilateral assist bars R/T weakness Goal: Resident will demonstrate the appropriate use of physical device(s) by review date Device assist bars Intervention: Monitor/document/report to health care provider PRN any changes regarding use of assist bars Intervention: Educate and discuss with resident & family the risks and benefits of the assist bars regarding its use. 12. On 5/16/24 at 3:19 P.M., Resident 53's clinical records were reviewed. Diagnosis included, but were not limited to, Type II diabetes mellitus with hyperglycemia, amputation at level between knee and ankle of left lower leg, and difficulty in walking. The most current Admission MDS assessment, dated 3/13/24, indicated Resident 53 was cognitively intact, required partial assistance with bed mobility, substantial maximal assistance for transfer and toilet use, and had physical restraints, bed rails used daily. Resident 53's clinical record lacked a Physical Device and/or Restraint Evaluation and Review. Current care plan for "The resident uses physical devices bilateral assist bars related to weakness", dated 3/9/24 indicated the following interventions: Monitor/document/report to health care provider PRN (as needed) any changes regarding use of bilateral assist bars, dated 3/9/24. Educate and discuss with resident the risks and benefits of the bilateral assist bars regarding its			

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	use, dated 3/9/24. Resident 53's clinical record did contain a signed Consent for bed rail use, dated 3/9/24. During an interview on 5/17/24 at 11:00 A.M., the MDS Coordinator indicated bedrails were not restraints and when she was trained she was told to mark that. She indicated that was an error in coding and training and no one in the building was on physical restraints. 13. On 5/14/24 at 2:44 P.M., Resident 35's clinical records were reviewed. Diagnosis included, but were not limited to, Type II diabetes mellitus with diabetic polyneuropathy, non-pressure chronic ulcer of right foot, acute osteomyelitis of right ankle and foot. The most current Quarterly MDS (Minimum Data Set) Assessment and State Optional MDS, dated 4/30/24, indicated Resident 35 was cognitively intact, required supervision of one for bed mobility, transfers and toilet use, had no pressure ulcers, no venous ulcers, no diabetic foot ulcers and no other open lesions of the foot. Wound notes dated 5/15/24 indicated: Date wound 1st noted 4/1/24 Diabetic ulcer left heel 1 cm (centimeter) x 1 cm x 0.2 cm 100% granulation No drainage Seen by wound specialist Debridement on 5/15/24 Right heel drsg (dressing) present yes Drsg intact yes Resident goes to WCC (Wound Care Clinic)			

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	During an interview on 5/17/24 at 11:00 A.M., the MDS Coordinator indicated diabetic foot ulcers should have been marked yes on Resident 35's MDS. On 5/17/24 at 9:35 A.M., a current non dated "Physical Device and/or Restraint Evaluation and Review" Form was provided by the Director of Nursing (DON) and indicated " ... Definition of Restraint: A device is considered a restraint if it restricts the resident's freedom of movement, or normal access to one's body ... If it does restrict the resident's freedom of movement ... you must obtain (1) provider order with justification for medical necessity (2) signed permission from Power of Attorney (POA) or responsible party if required ... Restraints must be removed at least every 2 hours to allow for repositioning and checking for areas of skin irritation ... " During an interview on 5/17/24 at 11:00 A.M., the MDS Coordinator indicated bed rails were not used as physical restraints and that most residents only use the mobility bars, which do not restrict movement, and not bed rails. The MDS Assessments were marked as use of "restraints" in error she believed because that's how she was taught in training. "No one in the building uses a physical restraint." At that time, she indicated there was not a policy for MDS Assessments but it was their policy to use the RAI (Resident Assessment Instrument) Manual. 3.1-31(c)(13)			
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered			

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	care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to develop a comprehensive person-centered care plan with resident specific needs for 4 of 22 residents reviewed for care plan development and implementation. Resident on hospice did not have a care plan for hospice, resident did not have a care plan for eating meals at a bedside table in the main dining room, residents that were taking an antianxiety, diuretic, and antidepressant did not have care plans for use. (Resident 19, Resident 5, Resident 48, Resident 45) Findings include: 1. On 5/14/24 at 1:41 P.M., Resident 19's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety and atherosclerotic heart disease The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/10/24, indicated Resident 19 was cognitively intact, an extensive assist of 1 staff for bed mobility, transfers, toileting, and was on hospice. Current Physician's Orders included, but were not limited to, the following: Admit to [name of hospice company] with diagnosis of atherosclerotic heart disease (ASHD), ordered 4/4/24 Progress notes included, but were not limited to, the following: On 4/4/24 at 2:00 P.M., Note Text: "Resident	F 0656	A Immediate action taken for the identified resident Care plan was amended and ensured that care matched with the care planB How the facility identified other residentsHouse sweep completed. Care plans were reviewed, and no specific resident was identified. However, all residents have the potential to be affected by alleged deficiency.C Measures put into place/system changesEnsure baseline care plan is developed and person- centered, also consistent with resident rights and all care needs within 48 hours and in place within 7 days. Audit care plan and ensure care matches with care plan, revised as necessary. Will do admission audit.D How corrective action will be monitoredMDS to audit 2 x weekly for 4 weeks, then 1 time weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 3 months.	07/01/2024

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	155282	A. BUILDING 00 B. WING	05/22/2024

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	admitted to [name of hospice company] with diagnosis of ASHD. Comfort meds [medications] ordered." Resident 19's clinical record lacked a care plan related to hospice. During an interview on 5/17/24 at 11:00 A.M., the MDS (Minimum Data Set) Coordinator indicated residents on hospice should have a hospice care plan in their clinical record and nurses on the floor should be putting it in when they get the order for hospice. During an interview on 5/20/24 at 3:15 P.M., the Director of Nursing (DON) indicated Resident 19 was on hospice he should have a hospice care plan. 2. On 5/15/24 at 8:59 A.M., Resident 48's clinical record was reviewed. Current diagnoses included, but were not limited to, dysphagia and muscle weakness. The most recent Quarterly and State Optional Minimum Data Set (MDS) Assessment, dated 3/26/24, indicated resident 48 received an antianxiety and antidepressant medication. Current Physician Order's included, but were not limited to, "Ativan 0.5MG [milligrams]... by mouth three times a day for anxiety/agitation," start date 2/3/24 and "traZODone...[sic]50MG...Give q tablet by mouth at bedtime," start date 1/3/24. The clinical record lacked a care plan related to Resident 48 receiving an antianxiety medication (Ativan). The clinical record lacked a care plan related to Resident 48 receiving an antidepressant medication (Trazodone).			

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	During an interview on 5/16/24 at 4:16 P.M., the DON indicated the MDS Coordinator should have developed a care plan specific to the antianxiety medication and antidepressant medication. 3. On 5/14/24 at 3:55 P.M., Resident 5's clinical records were reviewed. Diagnosis included, but were not limited to, Alzheimer's disease, bipolar disorder, atherosclerosis of native arteries of bilateral legs, and fracture of shaft of humerus. The most current Quarterly MDS (Minimum Data Set) and State Optional MDS Assessment, dated 5/8/24 indicated Resident 5 was mildly impaired cognitively, required supervision of one for bed mobility and transfers and extensive assist of one for toilet use. She had the following medications: antipsychotic, antianxiety, hypnotic, anticoagulant, antibiotic and diuretic. Current physician orders included, but were not limited to the following: olanzapine oral tablet 20 MG (milligrams) Give 1 tablet by mouth one time a day for bipolar disorder, dated 2/7/2024 lorazepam oral tablet 0.5 MG Give 0.5 mg by mouth three times a day for anxiety, dated 2/6/2024 Lasix oral tablet 40 MG Give 40 mg by mouth one time a day for edema, dated 2/21/2024 apixaban oral tablet 5 MG Give 5 mg by mouth two times a day for pulmonary embolism, dated 2/6/2024 amoxicillin-pot (potassium) clavulanate oral tablet 875-125 MG Give 1 tablet by mouth two times a day for bone/joint infection until 05/20/2024, dated 11/20/2023			

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	doxycycline hyclate oral tablet 100 MG Give 100 mg by mouth two times a day for infection until 05/20/2024, dated 11/20/2023 Belsomra oral tablet 5 MG Give 5 mg by mouth one time a day related to insomnia, dated 2/29/2024 Resident 5's clinical records lacked a care plan for diuretic and anticoagulant use. During an interview on 5/17/24 at 11:00 A.M., the MDS Coordinator indicated she started the care plans and there should be one in the records for medications, especially black box warnings like anticoagulants. 4. On 5/13/24 at 11:27 A.M., Resident 45 was observed in the dining room seated off to the side by self eating off bedside table. On 5/14/24 at 11:09 A.M., Resident 45 was observed with a bedside table sitting in front of her in the dining room during lunch. On 5/14/24 at 1:54 P.M., Resident 45's clinical records were reviewed. Diagnosis included, but were not limited to, macular degeneration, chronic combined systolic and diastolic heart failure, Sjogren Syndrome. The most current Quarterly MDS (Minimum Data Set) and State Optional MDS Assessment, dated 4/17/2024, indicated Resident 45 was cognitively intact and required extensive assistance of two for bed mobility, transfers and toilet use, used oxygen and was on hospice, and had physical restraints, bed rails used daily. Current physician orders included, but were not			

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	limited to the following: (Name of Hospice Company) to eval. (evaluate), dated 2/29/2024 Resident 45's clinical records lacked a care plan for hospice and use of a bedside table in the dining room. During an interview on 5/15/24 at 11:00 A.M., Resident 45 indicated she had no idea why they have her sitting in the dining room at a bedside table. During an interview on 5/16/24 at 11:06 A.M., CNA 33 indicated Resident 45 used a bedside table in the dining room because she preferred to sit alone, did not see well, and the tables were not low enough for her to reach her plate. During an interview on 5/17/24 at 11:00 A.M., the MDS Coordinator indicated residents on hospice should have hospice care plans. Nurses on the floor should put a care plan in when they get an order for hospice. On 5/17/24 at 9:52 A.M., the Dementia Care Coordinator provided a current Care Plans, Comprehensive Person-Centered policy, revised March 2022, which indicated "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident." On 5/17/24 at 10:00 A.M., the DON (Director of Nursing) indicated it was the policy of the facility to follow the physician's orders and care plan interventions.			

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	3.1-35(a)			
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 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 observation, interview, and record review, the facility failed to ensure residents had care plan conferences and care plans were revised for 1 of 2 residents reviewed for accidents and 3 of 5 residents reviewed for unnecessary medications. A resident moved out of the locked dementia unit and a resident's sleep medication was changed	F 0657	A Immediate action taken for the identified resident Care plan was amended and ensured that care matched with the care planB How the facility identified other residentsHouse sweep completed. Care plans	07/01/2024

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	but the care plans were not revised. Residents did not have care plan conferences timely. (Resident 38, Resident 12, Resident 5, Resident 48) Findings include: 1. On 5/13/24 at 11:27 A.M., Resident 38 was observed waiting for lunch in the main dining room. On 5/14/24 at 2:49 P.M., Resident 38's clinical record was reviewed. Diagnoses included, but were not limited to, dementia without behaviors. The most recent Annual MDS (Minimum Data Set) Assessment, dated 4/23/24 indicated Resident 38's cognition was severely impaired and she was an extensive assist of 1 staff for bed mobility, transfers, and toileting. A current Dementia Care Plan, revised 10/13/23, included, but was not limited to, the following interventions: Resident resides on the locked dementia unit and is participating in dementia care activities, initiated 1/28/24 Progress notes indicated Resident 38 was moved from the locked dementia unit onto the 300 Hall 2/22/24. During an interview on 5/17/24 at 1:48 P.M., the Director of Nursing (DON) indicated the care plan intervention that she was on the locked dementia unit should have been revised because she was no longer on the locked dementia unit. 2. On 5/15/24 at 2:28 P.M., Resident 12's clinical record was reviewed. Current diagnoses included, but were not limited to hypertension, diabetes mellitus, anxiety, and depression. The most recent		were reviewed, and no specific resident was identified. However, all residents have the potential to be affected by alleged deficiency.C Measures put into place/system changesEnsure baseline care plan is developed within 48 hours and in place within 7 days. Audit care plan and ensure care matches with care plan, revised as necessary. Implement weekly care plan meeting. IDT team will review a few residents to audit weekly. D How corrective action will be monitoredMDS to audit 2 x weekly for 4 weeks, then 1 time weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 3 months/until compliance is met. Will review in monthly QAPI.	

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	Quarterly and State Optional Minimum Data Set (MDS) Assessment, dated 4/30/24 indicated Resident 12 had moderate cognitive impairment. Resident 12 failed to receive a care plan conference after 12/1/23. 3. On 5/15/24 at 8:59 A.M., Resident 48's clinical record was reviewed. Current diagnoses included, but were not limited to, dysphagia and muscle weakness. The most recent Quarterly and State Option Minimum Data Set (MDS) Assessment, dated 3/26/24, indicated Resident 48's cognition was unable to be assessed. Resident 48 failed to receive a care plan conference after 1/15/24. During an interview on 5/16/24 at 9:10 A.M., the SSD indicated care plan conferences should be completed every 90 days. During an interview on 5/20/24 at 10:30 A.M., the SSD indicated it is the facility's policy to complete care plan conferences every quarter. 4. On 5/14/24 at 3:55 P.M., Resident 5's clinical records were reviewed. Diagnosis included, but were not limited to, Alzheimer's disease, bipolar disorder, atherosclerosis of native arteries of bilateral legs, and fracture of shaft of humerus. The most current Quarterly MDS (Minimum Data Set) Assessment and State Optional MDS, dated 5/8/24 indicated Resident 5 was mildly impaired cognitively, required supervision of one for bed mobility and transfers and extensive assist of one for toilet use. She had the following medications: antipsychotic, antianxiety, hypnotic, anticoagulant, antibiotic and diuretic.			

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	Current physician orders included, but were not limited to the following: Belsomra oral tablet 5 MG Give 5 mg by mouth one time a day related to insomnia, dated 2/29/2024 A current care plan for "The resident has sleep disturbance and utilizes Ambien for insomnia", dated 2/6/2024. The care plan was not revised when the Ambien was discontinued and Belsomra was ordered. Progress Notes included, but was not limited to the following: 2/29/2024 10:47 A.M. Psychopharmacological Med/Physical Restraint Note Text: "Pharmacy rec [recommends] at this time to d/c [discontinue] ambien [sic] and start belsomra [sic] 5 mg PO [by mouth] QHS [every bedtime] for insomnia. Psych [Psychiatric] NP [Nurse Practitioner] accepted this change, orders updated at this time." During an interview on 5/17/24 at 1:48 P.M., the Director of Nursing (DON) indicated floor nurses and/or the DON should be revising care plans immediately after a change occurs. On 5/17/24 at 9:52 A.M., The Dementia Care Coordinator provided a Care Plans, Comprehensive Person-Centered policy, revised March 2022, which indicated, "...11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change..." 3.1-35(a) 3.1-35(c)(2)(C) 3.1-35(d)(2)(B) 3.1-35(e)			

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure adequate supervision to prevent accidents for 2 of 2 residents reviewed for falls. Neurological checks were not completed after a fall, new interventions were not put into place after falls, and interventions on care plans were not followed for residents at risk for falls resulting in multiple falls. (Resident 38, Resident 52) Findings include: 1. On 5/14/24 at 9:00 A.M., non-skid strips were not observed on the floor in front of the toilet in Resident 38's bathroom. On 5/14/24 at 2:49 P.M., Resident 38's clinical record was reviewed. Diagnoses included, but were not limited to, dementia. The most recent Annual MDS (Minimum Data Set) Assessment, dated 4/23/24 indicated Resident 38's cognition was severely impaired, she was an extensive assist of 1 staff for bed mobility, transfers, and toileting, and had 1 fall since the last MDS Assessment which was a Quarterly Assessment completed on 1/25/24.	F 0689	A Immediate action taken for identified resident Staff education provided for risk management and nuero checks. Education to staff also on proper footwear for residents. Non-skid strips applied to floor.B How the facility identified other residentsHouse sweep completed. Care plans reviewed and facility sweep done. No other specific resident identified.C Measures put into place/system changesDON or designee will review risk assessments and care plans to ensure care matches person- centered care planD MDS or designee to audit 2 x weekly for 4 weeks, then once weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 3 months/until compliance met. Will go over in monthly QAPI.	07/01/2024

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	A current Risk for Falls Care Plan, revised 5/4/22, included, but was not limited to, the following interventions: Keep Dycem in chair to help prevent resident from sliding out, initiated 8/3/22 Resident to wear appropriate footwear when ambulating or mobilizing in wheelchair, initiated 2/1/22 A current Fall Care Plan, revised on 12/1/23, included, but was not limited to, the following interventions: Non skid strips in front of toilet, initiated 2/7/24 Resident to wear appropriate footwear when ambulating or mobilizing in wheelchair, 2/20/23 All Fall risk assessments from 1/1/24 through 5/17/24 were reviewed and indicated the following: 1/30/24 8.0 (Low risk) 2/7/24 17.0 (High risk) Falls were reviewed from 1/1/24 through 5/17/24. Resident 38 had the following 3 falls: Fall #1 1/30/24 3:00 A.M. Unwitnessed fall. Found resident sitting on floor in front of bedroom door. Resident indicated she was attempting to go to restroom. Resident was not using walker. Resident did not ring for assistance before getting up. A Nurse's note, dated 1/30/24, indicated " ... foot wear was not on feet properly ... Knot on top R [right] frontal lobe [forehead] approx [approximately] 4 centimeters (cm) X 3 cm present. Red mark on res [resident] left upper back approx 7 cm X 5 cm. Res c/o [complained of] pain to head ... Sending to ER [Emergency Room] ... " Nurse's note, dated 1/30/24, indicated "Resident back from			

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	ER ... will continue with neuro [neurological] checks until completed. " The following neuro checks were completed: 3:00 A.M., 3:30 A.M., (resident to ER at 4:17 A.M. and returned at 7:45 A.M.), 9:49 A.M., and 4:09 P.M.; 1/31/24 5:29 A.M., 1:53 P.M.; 2/1/24 3:30 A.M., 9:49 A.M., 1:43 P.M.; 2/2/24 5:45 A.M. New interventions from fall IDT (interdisciplinary team) meeting note, dated 2/1/24, included: therapy to evaluate for safety, remind resident to use walker, keep non slip socks on resident when in bed or when shoes are off. Care plan for resident was not updated with a new intervention. Fall #2 2/6/2024 1:10 P.M. Unwitnessed fall. Resident found on floor sitting against wall in bathroom. A 4 inch diameter red area noted on back. Neuro checks were completed on 2/6/24 at 3:49 P.M.; 2/7/24 at 2:00 A.M., and 10:21 A.M. Intervention: Non skid strips placed in front of toilet and therapy referral made. Care plan was updated with new intervention, but non-skid strips were not placed in front of toilet. Fall #3 2/7/24 11:08 A.M. Unwitnessed fall. Resident found on floor leaning against wall next to the toilet. Neuro checks were completed at 11:14 A.M., 6:15 P.M.; 2/8/24 AT 2:00 A.M., 10:00 A.M., 6:11 P.M.; 2/9/24 2:11 A.M., and 10:00 A.M. Intervention from fall IDT meeting, dated 2/7/24, included: resident currently working with therapy, continue antibiotic for UTI (urinary tract infection). No new interventions were put into place and the care plan was not updated. During an interview on 5/17/24 at 11:45 A.M., the MDS Coordinator indicated Resident 38's Annual MDS Assessment, dated 4/23/24, indicating only			

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	1 fall was an error and after reviewing her clinical record, it should say she had 3 falls. On 5/20/24 at 3:40 P.M., the DON indicated it was Resident 38's room, it should have non skid strips in front of the toilet in her bathroom, and she did use that bathroom. The DON indicated she had moved from the locked dementia unit to the 300 Hall (on 2/22/24) and the non skid strips must not have been put down for her. At that time, she indicated there should be a Dycem in her wheelchair and sometimes they would move it to the recliner when she would sit in it, but the dycem was not observed in the recliner seat or the room. On 5/17/24 at 11:00 A.M., non-skid strips were not observed on the floor in front of the toilet in Resident 38's bathroom. On 5/20/24 at 3:40 P.M., the Director of Nursing (DON) observed that non-skid strips were not on the floor in front of the toilet in Resident 38's bathroom. At that time, she observed there was not a Dycem in Resident 38's wheelchair. 2. On 5/13/24 at 11:28 A.M., Resident 52 was in the main dining room sitting in a Broda chair that was not locked. On 5/13/24 at 11:33 A.M., Resident 52 was sitting in the main dining room in a Broda chair that wasn't locked and trying to scoot out of it making the chair start rolling backwards. On 5/14/24 at 9:44 A.M., Resident 52 was by the nurse's station at the crosswalk, covered up with his eyes closed and sitting in a Broda chair without staff present. The Broda chair was not locked.			

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	155282	A. BUILDING 00 B. WING	05/22/2024

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	On 5/14/24 at 3:21 P.M. Resident Resident 52's clinical record was reviewed. Diagnoses included, but were not limited to unspecified intellectual disabilities, senile degeneration of brain, and displaced fracture of upper end of right humerus (upper arm). Resident 52 was admitted on 2/24/24. The most recent Admission MDS Assessment, dated 2/28/24, indicated Resident 52's cognition was unable to be assessed, was an extensive assist of 2 staff for bed mobility, transfers, toileting, and he had no falls or fractures within last 6 months prior to admission. A current Fall Care Plan, revised on 4/12/24, included, but was not limited to, the following interventions: Soft mat to be placed on wall side of bed to prevent injury, initiated 4/11/24 Resident likes to put self on floor, initiated 4/11/24 Resident is non-compliant with safety, initiated 4/12/24 Soft mat to bedside while in bed every shift, initiated 3/11/24 A current Behavior Care Plan, revised on 4/25/24, included, but was not limited to, the following intervention: Resident prefers the following diversional activities: picture books, magazines, and TV, initiated 4/25/24 All Fall Risk Assessments completed from 2/24/24 through 5/17/24 were reviewed and indicated the following: 2/24/24 15.0 (High risk)			

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	3/9/24 10 (Low risk) 3/25/24 17.0 (High risk) 4/12/24 17.0 (High risk) Progress notes were reviewed and included, but were not limited to, the following: 4/10/24 3:28 A.M., Behavior note: Resident threw head back while staff putting him to bed, hitting his head against the wall. Resident has a 3 centimeter (cm) x 3 cm red mark that is blanchable to back of the head. No neuro checks were completed. Care plan was updated with the following intervention: Soft mat to be placed on wall side of bed to prevent injury, initiated 4/11/24 4/29/24 2:38 P.M., Physician's note: "This patient is being seen today regarding recent falls as well as increased insomnia and continued behavioral problems. The patient is not sleeping at night, nor during the day really either. He is a major fall risk and keeps having recurrent falls due to not listening and non compliance ... He has been sent out for falls as well, some with injuries ..." 5/3/24 2:10 P.M., Progress note: "At 12:15 P.M., Resident was on the floor in his room and he hit his head on the trash can. There is a 'gash' above his right eye. He had already been placed on the floor by staff d/t [due to] he wouldn't stay in his chair. This was the safest measure ... " No neuro checks were performed. Falls were reviewed from admission on 2/24/24 through 5/17/24. Resident 52 had the following 5 falls: Fall #1 3/9/24 at 1:45 A.M. Unwitnessed fall. Resident found laying in hallway outside his room on the floor. Progress note indicated " ... will notify			

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	family in the morning ... ", but no documentation of notification was found. The following neuro checks were completed: 3/9/24 1:45 A.M., 2:10 A.M., 2:45 A.M., 3:15 A.M., 3:45 A.M., 1:56 P.M. and 9:33 P.M.; 3/10/24 4:57 A.M., and 9:50 P.M.; 3/11/24 5:01 A.M., 1:25 P.M., and 9:22 P.M.; 3/12/24 5:19 A.M., and 11:22 A.M. IDT meeting note, dated 3/11/24 (late entry), indicated new intervention: floor mat beside bed while in bed will be placed. Care plan updated. Fall #2 3/25/24 3:00 P.M. Witnessed fall. A visitor to the facility witnessed the resident scoot his bottom to sit on Broda chair foot rest, then he scooted himself to the floor while sitting in the 200 Hall Lounge Room. Neuro checks were not completed. Visitor indicated he did not hit his head. IDT meeting note, dated 4/5/24, indicated new intervention: Resident continues to lower himself on the floor. Care plan updated. Fall #3 4/12/24 7:13 A.M. Witnessed fall. As staff entered dining room, Resident 52 was in the dining room, had taken off his pants and incontinence pad, stood up, and fell hitting his head on the AC (air conditioner) unit. The following neuro checks were completed: 4/12/24 at 6:45 A.M., 7:15 A.M., 7:42 A.M.; 4/13/24 12:45 A.M., 4:45 P.M.; 4/14/24 12:01 A.M. and 9:58 P.M.; 4/15/24 4:56 P.M.; 4/16/24 2:44 A.M.; 4/17/24 5:13 P.M. IDT meeting note, dated 4/12/24 (late entry), indicated new intervention: Resident is high fall risk, resident is non compliant with safety and transfers self, and resident is unable to complete BIMS (Brief Interview for Mental Status) Assessment. Care plan updated. Fall #4			

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	4/25/24 1:40 P.M. Witnessed fall. Staff witnessed resident up and walking in 200 Hall Lounge Room. As staff was walking toward resident, resident fell hitting his head. Laceration to back of the head. Order obtained from Nurse Practitioner (NP) to send Resident 52 to ER for evaluation. A progress note, dated 4/25/24 at 4:32 P.M., indicated "EMS [Emergency Medical Services] on scene to transport resident to ER." A progress note, dated 4/25/24 at 6:13 P.M., indicated "Resident returned to [facility name] with no new orders. Hospital records indicated " ... Patient had an abrasion to the posterior occipital region of his head nothing requiring suturing, no active bleeding ..." The clinical record lacked documentation of an IDT meeting note, post fall risk evaluation, or new interventions put into place after fall. Care plan was not updated. Fall #5 4/29/24 3:59 P.M. Unwitnessed fall. Resident found on floor next to his chair in the 200 Hall lounge room. Hematoma [bruise] present to back of head and small amount of blood on wall where resident hit his head. Order obtained from Medical Doctor (MD) to send to ER for evaluation. An ER summary, dated 4/29/24, indicated resident had a Computed Tomography (CT) scan of the head which showed "Right parietal and right parieto-occipital [top and back of head] scalp hematoma". A progress note, dated 4/29/24 at 8:38 P.M., indicated resident returned to facility with no new orders. Hospital records indicated that the resident had history of a subdural hematoma (blood between the brain and it's outermost covering) on 2/25/22 and the physical exam indicated "Hematoma to the time [sic] of his head with abrasion left of the whole hematoma no palpable skull fracture and abrasion lateral to the left eye not requiring suturing, no active bleeding.			

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	IDT meeting note, dated 5/3/24, indicated resident has a history of falls, BIMS Assessment unable to be completed. Resident has history of getting on to the floor and crawling. Care plan updated. Neuro checks were not performed On 5/16/24 at 11:03 A.M., Resident 52 was by the nurse's station at the crosswalk, sitting in a Broda chair lifting his legs and using them in an attempt to scoot himself down in the chair, without staff present. The Broda chair was not locked and started rolling forward. On 5/16/24 at 11:13 A.M., Resident 52 sitting in the unlocked Broda chair in the crosswalk. Certified Nurse Aide (CNA) 4 pushed him in the Broda chair from the crosswalk to the main dining room, pushed him up to the table, did not lock the Broda chair, and left resident at the table. Resident 52 started lifting his butt and legs to scoot out of chair rocking the chair. On 5/20/24 at 3:40 P.M., the DON observed Resident 52's bed had been moved and the left side was against the wall now. There was not a soft mat on the wall. During an interview on 5/17/24 at 11:00 A.M., the MDS Coordinator indicated Resident 52 did come to the facility with a fracture from a fall so the Admission MDS Assessment should have been marked as having at least one fall and fracture in the 6 months prior to admission. During an interview on 5/20/24 at 9:36 A.M., the Activities Director indicated there was not a lot Resident 52 could do with activities but he liked magazines and listening to music. She indicated she tried to talk to him once a day and staff would try to talk to him too.			

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	During an interview on 5/20/24 at 3:15 P.M., the DON indicated she wouldn't expect staff to lock his Broda chair if he was in it because she taught staff that would be a restraint, but after reviewing falls, it may not be a bad idea to at least lock one wheel. She indicated she did not believe his restlessness was from lack of activities. She indicated he was restless because he was hurting before and with medication changes, he was not as restless and having less falls. She indicated he was not aware and could not make decisions about his safety. During an interview on 5/20/24 at 3:40 P.M., the DON indicated his Fall Care Plan should have been revised because of the bed being moved and there was not a soft mat on the wall. During an interview on 5/20/24 at 3:15 P.M., the DON indicated she would consider Resident 38 and Resident 52 a "high risk to fall". There should be an IDT meeting, a new intervention placed, revision of the care plan with the new intervention, and a fall risk evaluation should be completed after each fall as part of risk management. It should all be done during the IDT meeting shortly after fall. At that time, she indicated that she was unsure what the protocol was for neuro checks but they should be done after unwitnessed falls and if the resident would hit their head. She thought the neuro checks were to be done every 15 minutes for an hour, then every 30 minutes for 2 hours, then hourly for 2 hours, then every 8 hours. It should equal out to about 2 days of monitoring and if the resident went to ER and returned to the facility before neuro checks should be complete, then she would expect nurse to continue to do neuro checks as long as needed to finish and as needed. A current			

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	Neurological Check Protocol for the facility was requested at that time, but was not provided during the survey period. During an interview on 5/17/24 at 10:23 A.M., the DON indicated she would expect staff to follow orders and interventions on care plans and revise the care plans as needed. The facility didn't have a policy about following orders and interventions, but that would be their policy. During an interview on 5/17/24 at 11:00 A.M., The MDS Coordinator indicated there was not a policy for the MDS Assessment, but they use the RAI (Resident Assessment Instrument) Manual. On 5/17/24 at 11:47 A.M., a current Falls Policy, revised March 2018, was provided by the DON and indicated " ... While many falls are isolated individual incidents, a few individuals fall repeatedly. Those individuals often have an identifiable underlying cause ... the staff and physician will identify pertinent interventions to try to prevent subsequent falls ... staff will try various relevant interventions based on assessment of the nature of falling ... the staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling ... risks of serious adverse consequences can sometimes be minimized even if falls cannot be prevented ... If interventions have been successful in fall prevention, the staff will continue with current approaches and will discuss periodically with the physician whether these measures are still needed ... If the individual continues to fall, the staff and physician will re-evaluate the situation ... " On 5/17/24 at 11:47 A.M., a current Neurological			

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	Assessment Policy, revised October 2010, was provided by the DON and indicated " ... Neurological assessments are indicated: ... b. following an unwitnessed fall c. Following a fall or other accident/injury involving head trauma ... Perform neurological checks with the frequency as ordered or per falls protocol ... " 3.1-45(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.			

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	§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure a resident received services and assistance to prevent and treat urinary tract infections (UTI) for 1 of 1 residents reviewed for UTIs. A resident with recurrent UTIs was not treated appropriately, and incontinence care provided lacked appropriate infection control practices to prevent infection. (Resident 36) Finding includes: On 5/14/24 at 2:38 P.M., Resident 36's clinical record was reviewed. Diagnosis included, but were not limited to, Parkinson's Disease and dementia. The most recent Annual MDS (Minimum Data Set) Assessment, dated 3/14/24, indicated no cognitive impairment, no toileting program, and a UTI in the previous 30 days. Resident 36 was frequently incontinent of bladder, and required extensive assistance of one staff with toileting. Current physician orders included, but were not limited to, the following: UTI-Stat Oral Liquid 30ml (milliliters) one time a day for urinary health, dated 5/21/23. Allergies included, but were not limited to, ciprofloxacin (an antibiotic). A current urinary tract infection care plan, dated 1/25/24, indicated to monitor/document/report to	F 0690	A Immediate action taken for identified resident Staff education provided and audit performed on peri careB How the facility identified other residentsHouse sweep completed. No specific resident was identified. However, all residents have the potential to be affected by alleged deficiency.C Measures put into place/system changesStaff education provided. Random audits to determine if more education is needed.D How corrective action will be monitoredIP nurse or designee to audit staff 2 x a week for 4 weeks, one time a week for 4 weeks, bi-weekly for 4 weeks, then 1 x monthly for 3 months/until compliance is met. Will discuss monthly in QAPI.	07/01/2024

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	health care provider as needed for signs and symptoms of UTI including altered mental status and/or behavioral changes, dated 1/26/24. A progress note on 1/5/24 at 4:04 P.M. indicated "Physician was notified via fax regarding behaviors observed yesterday by physical therapy ... Awaiting reply from [physician]" The clinical record lacked a documented reply from the physician. A care plan review note on 1/10/24 at 10:56 A.M. indicated "... Resident is progressing with care and is stable at this time ..." Resident 36 experienced a fall on 1/20/24 and again on 1/22/24. An IDT (Interdisciplinary team) note on 1/23/24 at 9:30 A.M. indicated "... Resident is having cognitive changes as well as a fall. In past reviews resident was found to have a UTI when multiple falls occur. Nursing staff to notify physician for evaluation of UTI ..." A physician communication note on 1/23/24 at 10:15 A.M. indicated "[Physician] called at this time in r/t [related to] fall yesterday, function decline, and brain fog that has been occurring. Order given for UA [urinalysis] with CS [culture and sensitivity] if indicated at this time" A urinalysis was obtained on 1/24/24 at 2:35 A.M., 16 hours and 20 minutes after the order from the physician was obtained. The lab was then sent to the hospital on 1/25/24 at 12:35 A.M., 22 hours after it was obtained, and 38 hours and 20 minutes after the order was obtained. On 1/25/24 at 6:40 A.M., the urinalysis results			

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	were faxed to the physician and a new order for Keflex 500mg TID [three times a day] x10 days was placed. A culture and sensitivity, resulted on 1/28/24, indicated the presence of Providencia rettgeri (a bacteria), resistant to Ampicillin, Cefazolin, and Nitrofurantoin. The urinalysis also indicated the presence of Aerococcus urinae (a bacteria), resistant to Erythromycin. On 1/29/24, the Keflex was discontinued and a new order for Cefdinir (an antibiotic) 300mg twice a day for 7 days was placed. A progress note dated 2/26/24 at 4:42 P.M. indicated "resident seems to be slightly confused. States she doesn't want to be late for work, resident knows where her bathroom is located but is asking staff where it is, also stated someone was in her bathroom and she had to go use another bathroom , which neveroccurred [sic]. Will continue to monitor" On 2/27/24 at 9:37 A.M., a new order was received for Vesicare (a medication used for overactive bladder) 5mg twice a day instead of once daily. A progress note on 2/28/24 at 12:55 P.M. indicated "fax sent to [physician] regarding res [resident] increased confusion" On 2/29/24, an order was placed for a UA with C&S if indicated, and collected 3/4/24. An incident note from 3/3/24 at 12:14 P.M. indicated "Son was called to let him know of resident's slip and he laughed and said shes hard headed and knows she isn't supposed to get up ..."			

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	A medication note dated 3/4/24 at 11:42 A.M. indicated "The system has identified a possible drug allergy for the following order: Cipro [an antibiotic] Oral Tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet by mouth two times a day for UTI" On 3/4/24 at 4:30 P.M., the order for Ciprofloxacin was discontinued due to allergy, and a new order given for Keflex 500mg TID x 5 days for UTI while awaiting the culture results. The urine culture was resulted on 3/6/24, and indicated the presence of Escherichia coli and Aerococcus urinae. A progress note on 3/6/24 at 2:44 P.M. indicated "New order received from [physician] office to extend Keflex 5 more days. Order updated and faxed to pharmacy" Resident 36 experienced a fall on 3/9/24 and again on 3/10/24 with increased confusion. A fax was sent to the physician 3/10/24 at 7:20 P.M. regarding falls and continued confusion. On 3/11/24 at 2:30 P.M. a Urine specimen was collected for UA with C&S. A urine culture result, dated 3/13/24, indicated the presence of Citrobacter freundii (a bacteria associated with urinary tract infections). A note from the physician on the report indicated "Urine culture grew contamination. I do feel the recent Keflex she took cleared up her UTI. I do not know the reason for her current confusion ..." A progress note dated 3/13/24 at 2:34 P.M. indicated "Spoke with [physician]'s nurse, states UA was clear. No UTI. To schedule appt w/ [hospital] Neurology for increased confusion. Appt scheduled on Friday 3-15-24 at 10:45AM ..."			

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	155282	A. BUILDING 00 B. WING	05/22/2024

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A communication note on 3/14/24 at 3:53 P.M. indicated "... Called son to see if he would agree to have psych see his mom. He agreed that is would be beneficial ..."

Resident 36 experienced a fall on 3/14/24, 3/21/24, and 3/23/24.

A progress note on 3/23/24 at 12:55 A.M. indicated "Resident found on floor, laying in front of her recliner with her head pointed towards her door ... Resident is confused and states "I was chasing butterflies then had to get food off the floor and fell" ..."

An IDT note on 3/25/24 at 9:25 A.M. indicated " ... Psych consult obtained. Neurology notified of hallucinations Medication changes have been made Continue to monitor"

A progress note on 3/25/24 at 1:12 P.M. indicated "Resident has had multiple falls this month. Resident has had a major change. She is hallucinating and very forgetful. Resident gets very upset when she realizes that she is hallucinating or forgetful. Resident has Neurology followingher [sic] and med changes have been made with no change. Psych consult was made ..."

On 3/25/24, a new order was placed for a UA with C&S if indicated d/t increase confusion.

A urine culture result, dated 3/28/24, indicated the presence of urogenital flora and mixed enteric organisms. A new order was placed for Keflex 500mg three times a day for 5 days.

A progress note dated 4/15/24 at 3:56 A.M.

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	indicated "Res. having delusions tonight stating she is picking up golf balls, and putting them in a bucket that she holds up (which nothing is in her hand), then tells me she is going to get in her care [sic], pointing outside her window. Res. also stated she fell and got self up, but the way she describes would not be possible. Notified MD of behavior to see if we can obtain a UA. Urine has strong malodorous smell to it" A progress note dated 4/17/24 at 11:18 A.M. indicated "New order received [for] UA with C&S if indicated ... d/t increased confusion ..." Order was received 55 hours after physician was notified. A urinalysis result, dated 4/17/24 indicated the presence of dark, yellow, and turbid urine, a white blood cell count of 5-10 (high), and many bacteria. A physician note on the urinalysis result, dated 4/18/24, indicated "Urinalysis is clear; she does have a few red cells and she has an appointment with Urology. Please cancel urine culture" A progress note dated 4/18/24 at 4:12 P.M. indicated "Resident pushing on exit doors in dining room and then pulled fire alarm out of frustration because the door wouldn't open. Resident continues to be non-compliant and aggressive towards staff when trying to assist. Will continue to monitor behaviors" Resident 36 experienced a fall on 4/19/24. On 4/19/24, Resident 36 was moved to the secured unit, and diagnosed with dementia on 4/26/24. A progress note dated 4/30/24 at 2:22 A.M. indicated "During routine check and change res. [resident] was noted to have yellow/white chunky			

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	vaginal discharge ..." A urinalysis was obtained on 5/1/24, and the culture resulted on 5/4/24. The urine culture indicated the presence of Providencia rettgeri and Kocuria rosea. An order was placed on 5/7/24 for Cefdinir (an antibiotic) 300mg twice a day related to cramp and spasm; incontinence, until 5/8/24. A CT of abdomen and pelvis result, dated 5/10/24, indicated a mildly obstructing calculus (stone) within the distal right ureter measuring up to 4-5 mm (millimeter) in size, and development of a moderate size right-sided staghorn calculus with additional left-sided nethrolithiasis as well. 5/12/24 5:52 A.M. "Res. [resident] cont. [continues] on ATB [antibiotic] for UTI. Res. is having mucous in urine at this time. Res. [resident] just recently had a CT scan of bladder and kidneys and we are awaiting results at thit [sic] time. Urine remains dark and malodorous ..." 5/12/24 8:50 P.M. "correction-noted to 5-12 charting, res. just completed ATB therapy for UTI" On 5/17/24 at 10:23 A.M., the Director of Nursing (DON) indicated nothing had been done related to Resident 36's behaviors in January because the resident wasn't having behaviors before that time. She indicated she was unsure of why the urinalysis ordered on 1/23/24 was not sent until 1/25/24, and did not know why the UA completed on 3/11/24 was indicated as clear, when bacteria were present. She indicated she was unsure why an antibiotic was given on 3/28/24 since the UA was clear. She indicated Resident 36 was moved			

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	to the locked unit after she became increasingly aggressive, confused, and delusional. She indicated Resident 36's recent decline in status with behaviors had progressed quickly, and was part of the reason for her recent dementia diagnosis. The DON indicated staff could have called to follow up with the urologist when the CT was resulted showing kidney stones. On 5/20/24 at 8:34 A.M., Certified Nurse Aide (CNA) 5 and CNA 7 were observed assisting Resident 36 with toileting. CNA 7 washed her hands with a 3 second lather and put on gloves. CNA 5 put gloves on while in the doorway entering the bathroom. CNA 5 then touched the door, the resident's wheelchair, a walker, and the hand rail by the toilet. CNA 5 then obtained a gait belt from the other side of the room, and applied it around the resident. Both CNAs assisted the resident to a standing position, and both assisted to pull down her pants and brief. Resident 36 sat on the toilet, and CNA 5 touched the inside of the used brief, then removed it. The brief was visibly wet. Without removing or changing gloves, CNA 5 obtained a clean brief, and opened it touching the inside of it while applying it to the resident. When the resident indicated she was finished, CNA 7 obtained a disposable wipe, and wiped the inside of the resident's thighs, then the creases at the top of the legs, then the groin area. With the same wipe, CNA 7 then wiped down the middle of the resident's peri area. CNA 7 then removed her gloves and put a new pair on without sanitizing in between. Both CNAs assisted the resident to stand and pulled up the new brief and pants. CNA 5 removed her gloves, left the room for 5 seconds, then returned and applied hand sanitizer in the doorway. CNA 7 removed her gloves, and washed her hands with a 2 second lather.			

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	On 5/20/24 at 9:17 A.M., a current Handwashing/Hand Hygiene policy, dated 8/2019, was provided and indicated "Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers" On 5/20/24 at 9:17 A.M., a current Urinary Tract Infections/Bacteriuria policy, dated 4/2018, was provided and indicated "The physician and nursing staff will review the status of individuals who are being treated for a UTI and adjust treatment accordingly ... When a resident has a persistent or recurrent urinary tract infection after treatment with antibiotics, the physician will review the situation carefully with the nursing staff and consider other or additional issues ... before prescribing additional courses of antibiotics" 3.1-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided consistent with the resident's orders and care plans for 1 of 1 residents reviewed for respiratory care, and 2 of 2 random observations. Oxygen concentrators were caked with dust, and	F 0695	A Immediate action taken for identified resident Oxygen orders reviewed and oxygen rate set according to order, tubing changed, and filter cleaned.B How the facility	07/01/2024

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	oxygen orders were not being followed. (Resident 14, Resident 28, Resident 45) Findings include: 1. On 5/14/24 at 10:53 A.M., Resident 14 was observed sitting in the dining room with oxygen on via nasal cannula. The oxygen concentrator was set at 2.5lpm (liters per minute). On 5/14/24 at 2:49 P.M., Resident 14's clinical record was reviewed. Diagnosis included but were not limited to, acute respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/7/24, indicated a severe cognitive impairment, no behaviors, extensive assistance of 1 staff with bathing, transfers, and toileting, and used oxygen. Current physician orders included, but were not limited to: 02 (oxygen) at 3 liters per nasal cannula, dated 12/28/23. Change 02 tubing and humidity , clean 02 concentrator filter one time a day every Sunday, dated 12/31/23. A current oxygen therapy care plan, dated 12/29/23, indicated to provide oxygen therapy as ordered, dated 12/29/23. On 5/15/24 at 9:22 A.M., Resident 14 was observed in a wheelchair in the hall with no oxygen on, and no tubing visible. A portable oxygen tank was observed covered on the back of the wheelchair. On 5/15/24 at 1:43 P.M.., Resident 14 was		identified other residentsHouse sweep completed. No specific resident identified. However, all residents have the potential to be affected by alleged deficiency.C Measures put into place/system changesOxygen orders reviewed and rate of flow ensured. Orders for tubing to be changed weekly put into PCC and audits for cleaning of filter and machine put into place.D How corrective action will be monitoredDON or designee to audit 2 x weekly for 4 weeks, 1 x weekly for 4 weeks, bi-weekly for 4 weeks, and then monthly for 3 months/ until compliance is met. Will discuss in QAPI monthly.	

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	observed sitting in the dining area with oxygen on via nasal cannula between 3.5 and 4lpm. The filter on the back of the concentrator was observed to be too large for the opening with no backing. The filter was caked with dust. The machine indicated it was last serviced 8/16/23. At that time, Qualified Medication Aide (QMA) 3 indicated the oxygen was supposed to be set at 3lpm, and was unsure who cleaned the filters. On 5/16/24 at 3:00 P.M., the Director of Nursing (DON) indicated the order to change the oxygen concentrator filter was put in as a nursing order and therefore did not cross over to the system to be able to check off that it had been done. 2. On 5/15/24 at 1:58 P.M., Resident 28's oxygen filter on the side of the oxygen machine was observed to be caked with dust. Resident 28 was sitting in his recliner wearing O2 per nasal cannula at 2 lpm with gauze on the tubing to protect his ears. On 5/16/24 at 9:11 A.M., Resident 28 was observed sitting in his recliner with O2 on at 2 lpm per nasal cannula. The filter on the side of the oxygen machine remains dusty. On 5/15/24 at 2:49 P.M., Resident 28's clinical records were reviewed. Diagnosis included, but were not limited to chronic respiratory failure with hypoxia. The most current Annual MDS (Minimum Data Set) Assessment and State Optional MDS, dated 3/7/24, indicated Resident 28 was cognitively intact, required, extensive assistance of one for bed mobility and toilet use, limited assistance of one for transfers, and used oxygen. Current physician orders included, but were not			

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	limited to the following: Change out O2 tubing every Sunday night (Label with initials and date). Clean filter on the back of the concentrator (wash with soap and water, rinse, squeeze out excess water and replace) one time a day every Sunday, dated 1/28/2024 Oxygen 2L (liters) via NC (nasal cannula) as desires as needed for SOA (shortness of air), dated 3/24/2023 Monitor placement of foam cannula tubing protectors to oxygen tubing and ensure it is in correct place behind pt (patient's) ears every shift for protection, dated 2/20/2023 Oxygen at 2 LPM (liters per minute) per nasal cannula via O2 concentrator and/or tank at bed time for SOA related to chronic respiratory failure with hypoxia, dated 3/23/2022 The current care plan for "The resident has oxygen therapy R/T (related to) Ineffective gas exchange", dated 3/24/2022, included, but was not limited to the following intervention, "Oxygen therapy as ordered. Resident puts oxygen on ad lib during the day." 3. On 5/15/24 at 8:45 A.M., Resident 45 was observed sitting in her recliner wearing O2 at 3.5 lpm per nasal cannula. On 5/15/24 at 1:56 P.M., the filter on back of Resident 45's oxygen machine was observed to be caked with dust, humidification bottle dated 4/29/24. On 5/14/24 at 1:54 P.M., Resident 45's clinical records were reviewed. Diagnosis included, but were not limited to, macular degeneration, chronic			

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	combined systolic and diastolic heart failure, Sjogren's Syndrome. The most current Quarterly MDS (Minimum Data Set) Assessment and State Optional MDS, dated 4/17/2024, indicated Resident 45 was cognitively intact and required extensive assistance of two for bed mobility, transfers and toilet use, used oxygen and was on hospice, and had physical restraints, bed rails used daily. Current physician orders include, but were not limited to the following: Oxygen via nasal cannula 1-4 liters per minute as needed for dyspnea, hypoxia, O2 saturation less than 88% or acute angina. Call provider/practitioner with nursing report two times a day for hypoxia related to chronic combined systolic (congestive) and diastolic (congestive) heart failure, dated 1/19/2024 Resident 45's clinical records lacked orders to change oxygen tubing or humidification bottle and clean filter. Resident 45's clinical records lacked documentation in TAR (Treatment Administration Record) about changing O2 tubing or humidification bottle. During an interview on 5/16/24 at 8:59 A.M., LPN (Licensed Practical Nurse) 18 indicated she thought (name of company) serviced the oxygen machines, and they come on Tuesday and Thursdays. She was not sure who cleaned the filters, but the nurses changed the tubing and water bottles on night shift. During an interview on 5/16/24 at 9:32 A.M., the DON indicated (name of company) serviced the			

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	oxygen machines and came weekly. They had shown staff how to clean the filters so they should be clean. On 5/17/24 at 11:47 A.M., the DON provided a current Respiratory Therapy-Prevention of Infection policy, revised November of 2011, which indicated "...9. Wash filters from oxygen concentrators every seven days with soap and water. Rinse and squeeze dry..." 3.1-47(a)(6)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to			

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	residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure posted nurse staffing sheets were posted daily during the survey for 2 of 9 days reviewed during the survey process. Post nurse staffing was not updated over the weekend. (May 18, May 19) Finding includes: On 5/20/24 at 6:06 A.M., the posted nurse staffing sheet in the main lobby was dated 5/17/24. Staffing sheets were not completed for May 18, May 19. During an interview on 5/20/24 at 8:58 A.M., the Director of Nursing (DON) indicated night shift is in charge of placing the posted nurse staffing sheet in the lobby, and it should be posted each day including Saturday's and Sunday's. On 5/16/24 at 3:17 P.M., the Dementia Care Director provided the Posting Direct Care Daily Staffing Numbers policy, revised July 2016 that indicated, "Our facility will post, on a daily basis for each shift.."	F 0732	A Immediate action taken for identified issue Staffing paper for the correct day was posted immediatelyB How the facility identified other residentsHouse sweep completed. No residents were affected.C Measures put into place/system changesKeep daily staffing papers, schedules, and shift key logs into a binder separated by month and update as needed. Corporate to do PBJ reportingD How corrective action will be monitoredStaffing coordinator to audit 5 days a week for 4 weeks, then 3 x weekly for 4 weeks, bi-weekly for 4 weeks and monthly for 3 months/until compliance is met. Will address in QAPI monthly	07/01/2024

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

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	155282	A. BUILDING 00 B. WING	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SERENITY SPRING SENIOR LIVING AT NORTHWOOD	2515 NEWTON ST JASPER, IN 47547

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	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 interview and record review, the facility failed to ensure residents were free from unnecessary medications for 5 of 6 residents reviewed for unnecessary medications. Resident's as needed anti-anxiety medication was ordered for greater than 14 days. A resident had a Physician's Order for an antipsychotic with an unacceptable diagnosis. (Resident 45, Resident 3, Resident 14, Resident 19, Resident 48) Findings include: 1. On 5/15/24 at 8:59 A.M., Resident 48's clinical record was reviewed. Current diagnoses included, but were not limited to, dysphagia and muscle weakness. The most recent Quarterly and State Option Minimum Data Set (MDS) Assessment, dated 3/26/24, indicated Resident 48's cognition was unable to be assessed, and she received an antipsychotic. Current Physician Order's included, but were not limited to, "SEROquel [antipsychotic] Oral Tablet 25 MG [milligrams]...Give 25 mg by mouth one time a day related to DEMENTIA IN OTHER DISEASES CLASSIFIED ELSEWHERE, UNSPECIFIED SEVERITY, WITHOUT BEHAVIORAL DISTURBANCE, PSYCHOTIC DISTURBANCE, MOOD DISTURBANCE, AND ANXIETY."	F 0758	A Immediate action taken for identified resident Hospice orders put into PCC B How the facility identified other residentsHouse sweep completed. No specific resident was identified. However, all residents have the potential to be affected by alleged Deficiency.C Measures put into place/system changesOrders reviewed. PRN orders discontinued if over 14 days, will contact residents MD for further instruction and hospice orders put into place.D DON or designee will audit 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 3 months/until compliance is met, Will talk about in QAPI monthly	07/01/2024

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	155282	A. BUILDING 00 B. WING	05/22/2024

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	Current care plans included, but were not limited to, "The resident is on antipsychotic medication therapy R/T [related to] trouble sleeping and dementia." During an interview on 5/16/24 at 10:31 A.M., the Director of Nursing (DON) indicated dementia is not an acceptable diagnosis for an antipsychotic. 2. On 5/15/24 at 2:28 P.M., Resident 12's clinical record was reviewed. Current diagnoses included, but were not limited to hypertension, diabetes mellitus, anxiety, and depression. The most recent Quarterly and State Optional Minimum Data Set (MDS) Assessment, dated 4/30/24 indicated Resident 12 had moderate cognitive impairment and received an antianxiety medication. Current Physician Orders included, but were not limited to, "LORazepam [sic] [antianxiety] Tablet 0.5 MG. Give 1 tablet by mouth every 4 hours as needed for Restlessness..." start date, 11/29/22. A review of the April and May Medication Administration Record (MAR) indicated Resident 12 received Lorazepam on 4/21/24 and 5/5/24.3. On 5/14/24 at 2:49 P.M., Resident 14's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety, and psychotic disorder. The most recent Quarterly MDS Assessment, dated 5/7/24, indicated a severe cognitive impairment, and resident was taking an antianxiety medication. Current physician orders included, but were not limited to: Ativan Oral Tablet 0.5 MG (milligrams) Give 0.5 mg by mouth every 12 hours as needed for increased			

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	anxiety, dated 3/25/24. No stop date was documented for the medication. 4. On 5/14/24 at 3:18 P.M., Resident 3's clinical records were reviewed. Diagnosis included, but were not limited to cerebral ischemia, depression, cerebral infarction, and occlusion and stenosis of bilateral carotid arteries. The most current Quarterly MDS (Minimum Data Set) Assessment and State Optional MDS, dated 3/25/24, indicated Resident 3 was cognitively moderately impaired, and required extensive assistance of two for bed mobility, transfers, and toilet use. Current physician's orders included, but were not limited to the following: lorazepam oral tablet 0.5 MG (milligram) Give 0.5 mg by mouth every 2 hours as needed for anxiety, dated 2/7/2024 Admit to [name of company] hospice with Dx (diagnosis) of I67.82 (cerebral ischemia), dated 2/7/2024 5. On 5/14/24 at 1:54 P.M., Resident 45's clinical records were reviewed. Diagnosis included, but were not limited to, macular degeneration, chronic combined systolic and diastolic heart failure, Sjogren's Syndrome. The most current Quarterly MDS (Minimum Data Set) Assessment and State Optional MDS, dated 4/17/2024, indicated Resident 45 was cognitively intact and required extensive assistance of two for bed mobility, transfers and toilet use, used oxygen and was on hospice, and had physical restraints, bed rails used daily. Current physician orders included, but were not			

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	limited to the following: [name of company] hospice to eval. (evaluate), dated 2/29/2024 lorazepam oral tablet 0.5 MG Give 0.5 mg by mouth every 30 minutes as needed for pain/restlessness, dated 3/1/2024 6. On 5/14/24 at 1:41 P.M., Resident 19's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety and atherosclerotic heart disease. The most recent Quarterly MDS Assessment, dated 4/10/24, indicated resident was cognitively intact, an extensive assist of 1 staff for bed mobility, transfers, toileting, and taking an antianxiety medication. Current Physician's Orders included, but were not limited to, the following: lorazepam (antianxiety) 0.5 mg (milligram), Give 1 tablet by mouth every 2 hours as needed for anxiety , ordered 4/4/24 A current "Black Box Warning" (the highest safety- related warning that medications can have assigned by the Food and Drug Administration) Care Plan, dated 1/13/24, included, but was not limited to, the following intervention: Black box warning: Lorazepam, initiated 1/13/24 The MAR for April 2024 was reviewed and indicated Resident 19 was administered lorazepam from the as needed order on 4/11/24, 4/17/24, and 4/24/24. The May 2024 MAR was reviewed and indicated Resident 19 was administered lorazepam from the as needed order on 5/15/24.			

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	During an interview on 5/16/24 9:52 A.M., the DON indicated PRN (as needed anti-anxieties should only be scheduled for 14 days. On 5/17/24 at 1:27 P.M., a current Psychotropic Medication Use Policy, revised July 2022, was provided by the Administrator and indicated " ... 12. Psychotropic medications are not prescribed or given on a PRN [as needed] basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days ... If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order ... " 3.1-48(a)(2) 3.1-48(a)(4)(6)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			

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	§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to maintain safe and secure storage of medications for 3 of 4 medication carts observed and 1 of 3 medication storage rooms observed. Loose pills were observed in the medication carts, and refrigerator temperature logs were not filled out completely in the medication room. Findings include: 1. On 5/17/24 at 8:44 A.M., the medication cart on the PARF (Therapy to Home) Hall was reviewed. The medication cart was observed with the following loose pills in the drawers: 1 small oval white pill At that time, LPN (Licensed Practical Nurse) 19 indicated nurses on nights were supposed to go through the medication cart to make sure it was clean. She indicated she did it when she was here also. Pharmacy came once a month to review the carts. On 5/17/24 at 9:50 A.M., 300 Hall medication cart was reviewed. The medication cart was observed with the following loose pills in the drawers: 1 oblong white pill with L484 on one side 1 small oval white pill with 15 on one side 1 small oval white pill with 316g on one side	F 0761	A Immediate action taken for identified issue Med cart was immediately cleaned out and checked for loose pills, also temp log started immediatelyB How the facility identified other issues of the same natureHouse sweep completed. No specific issues identifiedC Measures put into place/system changesTemp logs put into place, medication carts to be cleaned out nightly, and medications checked for proper labeling and expiration date.D DON or designee to audit 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 3 months/until compliance is met. Will talk about in monthly QAPI.	07/01/2024

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	At that time, LPN 37 indicated she only worked weekends and was not sure when medication carts were cleaned. She indicated she did clean paper out of the medication cart. On 5/17/24 at 9:59 A.M., the 200 Hall medication cart was reviewed. The medication cart was observed with the following loose pills in the drawers: 1 round red pill with ph32 on one side 1 rectangular white pill with 10 on one side CTN on other side At that time, LPN 18 indicated pharmacy came at least once a month and checked medication carts. She indicated she checked the carts when she worked. 2. On 5/17/24 at 10:15 A.M., the Med Room 200-300 Hall on Crossroads was reviewed. The temperature log for the supplement fridge was missing a temperature for 5/14/24 P.M., 5/15/24, 5/16/24, and 5/17/24. The temperature log for the medication fridge was missing a temperature for 5/15/24 P.M., 5/16/24, and 5/17/24 A.M. At that time, LPN 18 indicated night shift usually checked temperatures. The following medications were observed sitting on the counter in the medication room: 2 bottles of Miralax and 2 bottles of geri-tussin DM (dextromethorphan and guaifenesin) for a resident discharged on 2/23/24. At that time, LPN 18 indicated she was not sure why the medications were sitting there. She indicated they could not be sent back to pharmacy and had to be destroyed. On 5/17/24 at 11:47 A.M., the DON (Director of Nursing) provided at Storage of Medications policy, revised November 2020, that indicated			

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	"...2. Drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. 3. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner..." On 5/20/24 at 9:29 A.M., the Clinical Care Leader provided a Refrigerator and Freezer policy, revised December 2014, which indicated "... 2. Monthly tracking sheets for all refrigerators and freezers will be posted to record temperatures..." 3.1-25(m) 3.1-25(r)			
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			

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	standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure distribution and food service was provided in accordance with professional standards for food service safety for 2 of 2 meals observed, and 1 of 1 meal services observed in the kitchen. (Main Kitchen, Locked Unit Dining Room) Findings include: During a lunch observation on 5/13/24 from 11:56 A.M. through 12:02 P.M., Qualified Medication Aide (QMA) 3 was observed taking cookies out of the packaging with bare hands, and placing on the food trays to serve to the residents. Certified Nurse Aide (CNA) 5 was observed to also touch cookies with bare hands before serving to residents. On 5/16/24 at 10:36 A.M., a meal service was being observed in the kitchen. While preparing the cups and utensils, Dietary Aide 21 was observed transferring coffee mugs with bare hands to the trays touching the insides of the mugs. Dietary Aide 21 was also observed touching the inside lids of the handled cups with bare hands before filling them with drinks. On 5/16/24 at 2:49 P.M., the Kitchen Manager indicated staff was not supposed to handle cups by the inside or underside of lids, and should not have been handling food with bare hands during meal service. During a breakfast observation on 5/20/24 at 7:50 A.M., QMA 3 was observed to touch toast with bare hands while applying jelly to them before serving to the residents.	F 0812	A Immediate action taken for identified issue Staff education was provided regarding touching food with hands, how you should handle dish ware, glove use, and washing handsB How the facility identified other issuesHouse sweep completed of other depts/dietary. No specified issue identified. However, all residents have the potential to be affected by alleged allegation. C Measures put into place/system changesStaff education put into place and random audits being done by dietary managerD Dietary manager or designee to audit twice weekly for 4 weeks, then weekly for 4 weeks, then b-weekly for 4 weeks, and then monthly for 3 months/until compliance is met. Will go over in monthly QAPI.	07/01/2024

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	On 5/17/24 at 10:30 A.M., a current Food Preparation and Service policy, dated 4/2019, was provided and indicated "Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of food-borne illness ... Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks" 3.1-21(i)(2) 3.1-21(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies,			

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	and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed for 2 of 4 residents during observation of incontinence care and 1 of 3 observations of obtaining a blood sugar with a glucometer. Gloves were not changed between dirty and clean tasks during peri care and staff cleaned a glucometer for an unmeasurable amount of time. (Resident 7, Resident 11, Resident 43). Findings include: 1. On 5/16/24 at 10:35 A.M., Qualified Medication Aide (QMA) 59 obtained a blood glucose level on Resident 43. After obtaining the blood glucose level, QMA 59 wiped the glucometer for an unmeasureable amount of time (less than 2 seconds) and placed the glucometer in the medication cart drawer. At that time, he indicated he typically lets the machine dry a minute. 2. On 5/20/24 at 10:04 A.M., incontinence care was performed on Resident 11 by Certified Nurse Aide (CNA) 10 and CNA 12. CNA 12 removed the soiled brief and applied cream to Resident 11's bottom, removed gloves, and placed new gloves on. CNA 12 failed to perform hand hygiene from dirty to clean tasks. 3. On 5/20/24 at 9:20 A.M., CNA 10 and CNA 12 were observed providing incontinence care to Resident 7. Both CNAs used Alcohol-based hand rub (ABHR) and put on gloves. CNA 12 pulled down the residents covers. CNA 10 unfastened incontinence pad and pulled it down and they rolled Resident 7 on her left side while CNA 12 held her there. CNA 10 wiped the resident from	F 0880	A Immediate action taken for identified resident Staff education provided on hand washing/sanitizing and change of gloves. B How the facility identified other residents A facility sweep was performed, and no specific resident was identified. However, all residents have the potential to be affected by alleged deficiency. C Measures put into place/system changes Staff education provided, IP nurse trained, and education provided about infection control policies and procedures. D DON or designee to audit twice weekly for 4 weeks, then once weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 3 months/until compliance is met. Will discuss in monthly QAPI.	07/01/2024

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	155282	A. BUILDING 00 B. WING	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SERENITY SPRING SENIOR LIVING AT NORTHWOOD	2515 NEWTON ST JASPER, IN 47547

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	front to back once with a wipe, rolled the wet incontinence pad and dirty bed pads under the resident. Then CNA 12 slid a clean bed pad and clean incontinence pad under the dirty bed pad. CNA 12 removed her gloves, did not sanitize her hands, and put gloves back on. Resident 7 was then rolled to her right side. CNA 12 grabbed the wet incontinence pad and dirty bed pads out from under the resident and put them into a trash bag while CNA 10 held the resident and pulled the clean incontinence pad and bed pad out from under Resident 7. CNA 12 took off his gloves, did not sanitize his hands, and put on new gloves. CNA 10 and CNA 12 pulled up and fastened the resident's clean brief, then grabbed the bed pad and moved the resident up in bed before taking off their gloves and covering up the resident before leaving the room. During an interview on 5/20/24 at 2:49 P.M., the Infection Preventionist (IP) indicated she would expect staff to sanitize their hands between glove changes while performing incontinence care. During an interview on 5/16/24 at 12:02 P.M., Licensed Practical Nurse (LPN) 61 indicated she cleaned the glucometer before and after each resident since the glucometer is used on multiple residents. She indicated to use one wipe to clean thoroughly and one wipe to wrap around the glucometer and let it dry for 2 minutes with the wipe around it. During an interview on 5/16/24 at 4:31 P.M., QMA 59 indicated the glucometer should air dry for at least 2 minutes. On 5/20/24 at 9:17 A.M., a Handwashing/Hand Hygiene Policy, revised August 2019, was provided by the IP and indicated " ... 7. Use an			

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	alcohol-based hand rub ... m. after removing gloves ... " On 5/20/24 at 1:35 P.M., a current Blood Sampling-Capillary (Finger Sticks) policy, revised September 2014 indicated, "Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses...8. Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use." 3.1-18(b)(2) 3.1-18(l)			
F 0883 SS=E Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education			

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	regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on interview, and record review, the facility failed to properly document influenza and pneumococcal vaccines being offered to residents for 3 of 5 residents reviewed for influenza and pneumococcal vaccination. Clinical records lacked the vaccine consent/refusal date, the reason why it was refused, and a date education was provided	F 0883	A Immediate action taken for identified resident 3 of 5 residents were identified and we asked again if they still wanted to refuse and had them sign a consent/refuse form. A copy was kept, and a copy was	07/01/2024

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	to the resident and/or resident representative. (Resident 19, Resident 4, Resident 36) Findings include: 1. On 5/14/24 at 1:41 P.M., Resident 19's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety and atherosclerotic heart disease. The most recent Quarterly MDS Assessment, dated 4/10/24, indicated resident was cognitively intact. Resident 19 was 79 years old and was admitted to the facility on 10/10/23. Resident 19's immunization history was reviewed for his influenza and pneumonia vaccination status. The following vaccination lacked documentation of a refusal date, the reason why it was refused, and a date education was provided to the resident and/or resident representative: Influenza 2. On 5/13/24 at 2:30 P.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, anxiety and depression. The most recent Quarterly MDS Assessment, dated 2/14/24, indicated Resident 4 was cognitively intact. Resident 4 was 71 years old and was admitted to the facility on 10/4/13. Resident 4's immunization history was reviewed for her influenza and pneumonia vaccination status. The following vaccinations lacked documentation of a consent/refusal date, the reason why it was refused, and a date education was provided to the resident and/or resident representative: Pneumococcal Polysaccharide (PPSV23)-Refused		made for medical records.B How the facility identified other residents.House sweep completed. Medical records were reviewed. No specific resident was identified. However, all residents have the potential to be affected by alleged deficiency.C Measures put into place/system changeImmunizations will be in the admission packet. Residents may consent/decline and sign. A copy will go to medical records and a copy will be put in a immunizations binder.D IP nurse or designee will audit 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 3 months/until compliance is met. Will go over in monthly QAPI	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Pneumococcal Conjugated (PCV13)-no record of consent to administer or refusal 3. On 5/14/24 at 2:38 P.M., Resident 36's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's disease. The most recent Annual MDS Assessment, dated 3/14/24 indicated Resident 36 was cognitively intact. Resident 36 was 67 years old and admitted to the facility on 4/15/23. Resident 36's immunization history was reviewed for her influenza and pneumonia vaccination status. The following vaccinations lacked documentation of a consent/refusal date, the reason why it was refused, and a date education was provided to the resident and/or resident representative: Influenza-no record of consent to administer or refusal Pneumococcal Conjugated (PCV13)-no record of consent to administer or refusal During an interview on 5/20/24 at 2:49 P.M., the Infection Preventionist (IP) indicated that newly admitted residents should have the influenza and pneumococcal vaccines offered to them at admission and the other residents were usually offered prior to the influenza season annually. The pharmacy they use, would usually tell her if a resident was due for a pneumococcal vaccine and they would even come into the facility and give the vaccine if needed. During an interview on 5/21/24 at 9:30 A.M., the IP indicated all 4 of the residents refused vaccines but the reason and education given was not clearly documented. She indicated the consent/refusal forms should have been			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	completed and scanned into the clinical record. On 5/13/24 at 11:50 A.M., a current Resident Immunizations Policy, revised 3/8/22, was provided by the Administrator and indicated " ... Purpose [is] to provide residents and clients the opportunity to receive immunizations as they fit into their healthcare goals [and] to provide guidance for the location's immunization program including recommended vaccinations. Upon admission, each client, resident and/or resident representative will receive the Vaccination Information Statements (VIS) for influenza and pneumococcal vaccines ... review current vaccinations and provide and document education on the benefits and potential side effects of the vaccinations for which the client/resident is eligible ... If the client, resident and/or resident representative consent to vaccination, obtain written consent if required by state regulation or if written consent is not required, obtain and document verbal consent ...complete screening questions prior to administering vaccination ... administer vaccination or refer to Provider or Pharmacy for vaccine administration ... if the resident and/or resident representative chooses not to be vaccinated after discussion of benefits, document declination ... residents will be reviewed for vaccine eligibility annually or when the Adult Immunization Schedule changes ... education, consent, and screening are required prior to administration of each dose of any vaccine given ... " 3.1-13(a)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions			

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	The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a safe, functional, sanitary, and comfortable environment for residents for 2 of 5 halls observed, and 1 of 1 common area observed. (Locked Unit, Room 211) Findings include: 1. On 5/14/24 at 11:02 A.M., the bathroom vent in room 419 was observed caked with dust. On 5/20/24 at 8:07 A.M., the same was observed. 2. On 5/14/24 at 11:12 A.M., the bathroom vent in room 415 was observed caked with dust, and an unlabeled tube of zinc oxide was observed on the back of the toilet. The back of the room door was observed with a metal strip coming away from the door. On 5/20/24 at 8:15 A.M., the same was observed. 3. On 5/14/24 at 11:06 A.M., the bathroom door of room 424 was observed with scuff marks, chipping away at the door, and the room floor was sticky. On 5/20/24 at 8:14 A.M., the bathroom in room 424 was the same. The floor was not sticky. 4. On 5/14/24 at 10:49 A.M., the grab bar behind the toilet in room 422 was observed with a loose fastener on the right side not attached to the wall. The vent in the bathroom was caked with dust. On 5/20/24 at 8:12 A.M., the same was observed in room 422. A stack of uncovered briefs was observed sitting on the back of the toilet.	F 0921	A Immediate action taken for identified issue Vent panel was replaced immediately, personal items were labeled and put away, and doors were checked and finished. B How the facility identified other residents. House sweep completed. No other specific issues were identified. However, all residents have the ability to be affected by alleged deficiency. C Measures put into place/system changes Maintenance to do weekly walk through and fix any issues that present. Staff educated on safe and clean environment. IP to walk through weekly to look for personal items that don't belong out or are not labeled. D Administrator or facility designee to audit 2 x weekly for 4 weeks, then 1 time weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 3 month/until compliance is met. Will discuss in QAPI monthly.	07/01/2024

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	5. On 5/14/24 at 10:57 A.M., two unlabeled and uncovered toothbrushes were observed on the shared bathroom sink in room 421 in a cup. A denture cream tube and two tubes of toothpaste were observed on the sink unlabeled. Scuff marks were observed on the bottom of the bathroom door. On 5/20/24 at 8:11 A.M., the same was observed, but the denture cream tube and toothpaste had been put up in the cabinet. 6. On 5/14/24 at 11:08 A.M., Room 417 was observed to be shared by two residents. The call light box had one call light attached to it, and the cord was observed wrapped on one of the beds. No call light was observed for the other side of the room. The bathroom was observed with clean briefs on the back of the toilet, uncovered. On 5/20/24 at 8:13 A.M., the same was observed. 7. On 5/13/24 at 11:30 A.M., the common area in the locked unit was observed with a register under the window that was missing the cover on the bottom with exposed wires. On 5/20/24 at 8:23 A.M., the same was observed. 8. On 5/20/24 at 8:23 A.M., a chair seat in the common are of the locked unit was observed not attached to the legs. 9. During an observation on 5/13/24 at 2:06 P.M., Room 211 had paint chipped off in multiple areas around the door frame to the bathroom, and the inside of the bathroom door had a large chipped area on the bottom. On 5/20/24 at 11:50 A.M., the same was observer in room 211.			

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	During an interview on 5/20/24 at 2:22 P.M., the Maintenance Director indicated staff should tell him when there is an issue with the environment or put in a work order. On 5/20/24 at 1:35 P.M., the Administrator provided a current Homelike Environment policy, revised February 2021 that indicated, "Residents are provided with a safe, clean, comfortable environment...2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting..." 3.1-19(f)(5)			
F 9999 Bldg. 00	#1. 3.1-14 PERSONNEL (u) In addition to the required in-service hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This State rule was not met as evidenced by: Based on record review and interview, the facility	F 9999	A Immediate action taken for alleged deficiency Dementia training provided to staff B How facility identified other staff members Staff training and education reviewed and revised. C Measures put into place/system changes Training updated in orientation binder; on-going training scheduled during orientation.	07/01/2024

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	155282	A. BUILDING 00 B. WING	05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	failed to provide documentation of staff completing dementia-specific training for 9 of 10 employee records selected for review. (QMA 51, RN 82, LPN 59, CNA 91, RN 74, LPN 67, CNA 97, LPN 14, CNA 53) Findings include: On 5/20/24 at 10:00 A.M., employee files were reviewed and included, but were not limited to, the following information: QMA (Qualified Medication Aide) 51 lacked dementia inservice hours for 2023 or 2024. RN (Registered Nurse) 82 lacked dementia inservice hours for 2023 or 2024. LPN (Licensed Practical Nurse) 59 lacked dementia inservice hours for 2023 or 2024. CNA (Certified Nurse Aide) 91 lacked dementia inservice hours for 2023 or 2024. RN 74 lacked dementia inservice hours for 2023 or 2024. LPN 67 lacked dementia inservice hours for 2023 or 2024. CNA 97 lacked dementia inservice hours for 2023 or 2024. LPN 14 lacked dementia inservice hours for 2023 or 2024. CNA 53 lacked dementia inservice hours for 2023 or 2024. On 5/20/24 at 3:30 P.M., the Administrator		Once complete a copy will be placed in the dementia training binder and employee file. D HR or designee to audit dementia training 2 x a week for 4 weeks, then once weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 3 months/ until compliance is met.	

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	provided a list of employees and their completed inservices. The inservices did not indicate how many hours they were worth. At that time, the DON (Director of Nursing) indicated she was unable to discern how many hours each inservice was worth, and that all of the inservice information had been kept at the corporate office, which the facility did not have current access. On 5/21/24 at 11:04 A.M., the Administrator indicated staff should have 6 hours of dementia training annually. On 5/21/24 at 9:29 A.M., a current All Staff In-Service Training policy, dated 8/2022, was provided and indicated "All staff must participate in initial orientation and annual in-service training ... Completed training is documented by the staff development coordinator, or his or her designee and includes ... the hours of training completed." #2. 3.1-13 ADMINISTRATION AND MANAGEMENT (w) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The			

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	director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to provide documentation of the Dementia Care Director completing dementia-specific training for 1 of 1 Dementia Directors reviewed. (Dementia Care Director) Finding includes: On 5/20/24 at 10:00 A.M., employee files were reviewed. The Dementia Care Director lacked the minimum 12 hours with 3 months of employment or additional hour of dementia education since hire date on 10/18/23. On 5/20/24 at 3:30 P.M., the Administrator provided a list of employees and their completed inservices. The inservices did not indicate how many hours they were worth. At that time, the DON (Director of Nursing) indicated she was unable to discern how many hours each inservice was worth, and that all of the inservice information had been kept at the corporate office, which the facility did not have current access. On 5/21/24 at 11:04 A.M., the Administrator indicated the Dementia Care Director should have 12 hours of dementia training. On 5/22/24 at 9:30 A.M., the DON indicated the facility policy for Dementia Care Director inservice hours was based on the state regulation and			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	provided a copy of that regulation.			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: May 13, 14, 15, 16, 17, 20, 21, and 22, 2024 Facility number: 000180 Residential Census: 24 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	The plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours			

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	155282	A. BUILDING 00 B. WING	05/22/2024

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	of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to provide documentation of staff completing dementia-specific training for 4 of 5 employee records selected for review. (LPN 24, CNA 35, CNA 38, LPN 29 Findings include: On 5/22/24 at 10:40 A.M., employee files were reviewed and included, but were not limited to, the following information: LPN (Licensed Practical Nurse) 24 lacked dementia inservice hours for 2023 or 2024. CNA (Certified Nurse Aide) 35 lacked 1.5 dementia inservice hours for 2023 or 2024.	R 0120	A Immediate action taken for identified issue Review of employee folders, training reviewed and updated accordingly B House sweep completed. Personal files in review and updating with training and education. C Measures put into place/system changes Orientation binder put together with pertinent information and necessary training to be completed. A copy will be placed in a binder and a copy will be	07/01/2024

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	CNA 38 lacked dementia inservice hours for 2023 or 2024. LPN 29 lacked 1.5 dementia inservice hours for 2023 or 2024. On 5/22/24 at 2:04 P.M., the Administrator indicated the Assisted Living staff should have 6 hours of dementia training annually. On 5/21/24 at 9:29 A.M., a current All Staff In-Service Training policy, dated 8/2022, was provided and indicated "All staff must participate in initial orientation and annual in-service training ... Completed training is documented by the staff development coordinator, or his or her designee and includes ... the hours of training completed"		placed in their personal file. HR or designee will audit new hire orientation packet and annual training. D Administrator or designee will audit 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 3 months/until compliance is met.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to assure the dishwasher was maintained in accordance with state and local sanitation and safe food handling standards and hand washing done correctly. The facility failed to use chemical test strips to test the chlorine in a low temperature dishwasher. One staff member failed to use correct hand washing technique. (Kitchen) Findings include: During an interview on 5/20/24 at 10:45 A.M., Cook 41 indicated the dishwasher was a chemical dishwasher. She took a strip and placed it in the rinse cycle which tested 150 ppm (parts per	R 0273	A Immediate action taken for identified issue AL manager called ECO lab and ordered test strips, as soon as the strips came in they started checking Dish washer chemicals 3 times daily.B House sweep done in kitchen to check appliances to make sure in good working order.C Measures put into place/system changesAudit being performed daily for dishwashing chemicals and should remain between 50-100 PPMD AL manager or designee	07/01/2024

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	million) on the Hydrion Test Strip with an expiration date of 6/30/23. On 5/20/24 at 12:00 P.M., RCA (Resident Care Aide) 63 washed her hands between passing trays. She got soap, no lather, turned off faucet with bare hand and continued to serve trays. On 5/20/24 at 12:05 P.M., Cook 41 provided a Dish Machine Temperature Log, not chemical log. The temperature log did not have temperature readings for 5/19/24 Afternoon or Evening or a temperature reading for 5/20/24 Morning. All rinse temperatures were logged as 180. During an interview on 5/21/24 at 1:52 P.M., QMA 57 indicated the dishwasher was a chemical dishwasher but they didn't use test strips on the machine, and only used the strip on the Multi-quest sanitizer. QMA 57 ran a cycle and temperature at the rinse cycle was 120 degrees. She indicated the dishwasher gets hotter the more you use it and will get up to 180 degrees. During an interview on 5/21/24 at 1:58 P.M., the Assisted Living Manager indicated the dishwasher was chemical. (name of service company) came to the facility every month and tested the dishwasher but did not send results here. The dishwasher was leased through (name of equipment supplier). She did not have a manual because the dishwasher had been here since building had been here. She indicated they just test the temperature because that was what they were always asked for. There had not been any problems with nausea or vomiting among the residents. The Assisted Living Manager indicated the model was ES2000 Dish machine by (name of service company).		to audit 2 x weekly, then 1 x weekly, then bi-weekly, and then monthly for 3 months/until compliance is met.	

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	On 5/21/24 at 2:10 P.M., the (name of service company) web site indicated model ES2000 Dish Machine was a low temperature chemical machine. During an interview on 5/22/24 at 1:45 P.M., LPN 9 indicated staff should lather at least 15 seconds. Staff should wash their hands while working in the dining room/kitchen after passing 3 trays to residents and in the kitchen when going from one task to the next. On 5/22/24 at 11:52 A.M., a policy was requested for the dishwasher but was not provided. On 5/22/24 at 11:52 A.M., the DON (Director of Nursing) provided a Handwashing/Hand Hygiene policy, revised August 2019, which indicated "...Washing Hands 1. Wet hands first with water, then apply an amount of product recommended by the manufacturer to hands. 2. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 3. Rinse hands with water and dry thoroughly with a disposable towel. 4. Use towel to turn off the faucet..."			
R 0274 Bldg. 00	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance (g) There shall be an organized food service department directed by a supervisor competent in food service management and knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour			

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	classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation.			
	Based on observation and interview the facility failed to provide an organized food service department directed by a supervisor competent in food service management. The supervisor of the kitchen failed to have current training and experience in food service supervision and management. (Kitchen) Findings include: During an interview on 5/22/24 at 10:12 A.M., the Assisted Living Manager indicated she was the one in the kitchen who had the ServSafe Certificate, it expired and no one had told her how to renew it.	R 0274	A Immediate action taken for identified issue Contacted Dietician and asked her to provide routine services to AL and she confirmed that she would. B How facility identified other issues House sweep completed. No specific issues noted	07/01/2024

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	During an interview on 5/22/24 at 11:42 A.M., the DON (Director of Nursing) indicated they did not have a Kitchen Manager in Assisted Living. She indicated the dietician comes to Assisted Living monthly. She indicated the Assisted Living Manager was the supervisor of the kitchen. On 5/22/24 at 11:42 A.M., a policy for the Kitchen Manager was requested but not provided.		C Measures put into place/system changes Dietician to review care plans and menus, education on food safety and Infection control provided to staff. D AL manager or designee will audit dieticians schedule and education 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, then bi-weekly for 4 weeks, and then monthly for months.	
R 0434 Bldg. 00	410 IAC 16.2-5-13(a) Dining Assistants - Deficiency (a) Each dining assistant shall successfully complete a sixteen (16) hour training program for dining assistants that has been approved by the department. Based on interview and record review, the facility failed to ensure dining assistants successfully completed a training program for dining assistants that had been provided by the department for 2 of 6 dining assistants reviewed. (Assisted Living Manager, Cook 41) Findings include:	R 0434	A Immediate action taken for alleged deficiency Contacted Dietician and asked her to provide routine services to AL and she confirmed that she would.B How facility identified other issuesNo specific issues identified after completing the house sweep.C Measures put	07/01/2024

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	On 5/22/24 at 11:06 A.M., the Assisted Living Manager provided a list of dining assistants that included the following: Assisted Living Manager Cook 41 At that time, the Assisted Living Manager indicated there was no current training program for dining assistants. At that time, the DON (Director of Nursing) indicated the facility did not have a policy related to dining assistant training. .		into place/system changesAL manager and cook to complete Serve Safe program. Dietician to provide additional food safety education to staff.D AL manager or designee to audit education 2 x a week for 4 weeks, then 1 x a week for 4 weeks, then bi-weekly for 4 weeks, and then monthly for 3 months/until compliance is met.	