STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155251	A. BUILDING 00 B. WING	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HOBART SKILLED NURSING FACILITY, THE	2901 W 37TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 8, 9, 10, and 11, 2024 Facility number: 000154 Provider number: 155251 AIM number: 100289680 Census Bed Type: SNF/NF: 50 Total: 50 Census Payor Type: Medicare: 12 Medicaid: 33 Other: 5 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/16/24.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is 07/31/2024 Facility is respectfully requesting paper compliance for all deficiencies in this POC.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had physician's orders for medications and an assessment to self-administer their own medications for 2 of 2 residents reviewed for self-administration of medication. (Residents 100 and 2)	F 0554	**F554:** **Self Administration** It is the intent of this facility is to ensure residents had a physician order for medications and an assessment to self-administer their own medications.	07/31/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristina Herrera	Executive Director	08/01/2024

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	Findings include: 1. During a random observation on 7/8/24 at 3:19 p.m., Resident 100 was observed in his room in bed. At that time, a tube of over the counter hydrocortisone cream was observed on his over bed table with the cap off as well as an Albuterol Sulfate inhaler. During an interview at that time, the resident indicated he left the medications on his over bed table in case he needed them. During random observations on 7/9/24 at 9:00 a.m. and 3:00 p.m. and 7/10/24 at 8:55 a.m. and 11:42 a.m., the inhaler remained on the resident's over bed table. The record for Resident 100 was reviewed on 7/8/24 at 3:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), pneumonia, emphysema, and anxiety. The Admission Minimum Data Set (MDS) assessment, dated 6/28/24, indicated the resident was cognitively intact. The July 2024 Physician's Order Summary (POS), indicated the resident did not have an order for the Albuterol Sulfate inhaler nor the hydrocortisone cream. The resident also did not have an order to self-administer his medications. There was no Self-Administration of Medication assessment available for review. During an interview on 7/10/24 at 1:35 p.m., Nurse Consultant 1 was informed about the medications at the bedside. At 3:39 p.m., the Consultant indicated the resident's family brought the		Resident #100 and Resident #2 medications at bedside was removed by the regional nurse on 07/11/2024. Resident #100 and #2 Self Administering Medication Assessment was updated on 07/10/2024 by DON/Designee, both residents do not wish to self-administer medications **Identification of Other Residents with the Potential to be Affected:** The DON/Designee completed a 90 day look back of Self-Administering Medications Assessment, an Assessment was completed as needed on 07/15/2024 **Systemic Changes:** 1 On 7/24/2024 the Staff Development Coordinator (SDC)/Designee in-services the Licensed Nurses and Qualified Medication Assistances on the facility's medication storage policy. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **Monitoring:** 2 DON/ADON/ Unit Manager/	

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	medications in for him. She indicated the family was spoken to and a care plan was initiated. 2. During random observations on 7/8/24 at 7:55 a.m., 10:22 a.m., 11:10 a.m., and 1:45 p.m., Resident 2 was observed in bed. At those times, there was an opened tube of Iodosorb (a gel used to treat wet ulcers or wounds) gel with the cap off on top of the dresser by the television set. The record for Resident 2 was reviewed on 7/9/24 at 1:52 p.m. Diagnoses included, but were not limited to, left side hemiplegia, stroke, type 2 diabetes, heart disease, dementia, dysphagia (swallowing difficulties), and adult failure to thrive. The Quarterly Minimum Data Set (MDS) assessment, dated 6/6/24, indicated the resident was moderately impaired for daily decision making. The resident received an enteral feeding of 51% or more through a peg tube. There was no care plan to keep the Iodosorb gel at the bedside. A Physician's Order, dated 6/1/24, indicated to apply Iodosorb gel to the left heel every 72 hours. There was no physician's order to keep the Iodosorb gel at the bedside. During an interview on 7/9/24 at 3 p.m., Nurse Consultant 1 indicated the cream was not to be left in the resident's room nor was there an order to keep the medication at bedside. The current and updated "Self Administration of Medication by Residents" policy, provided by Nurse Consultant 1 on 7/11/24 at 3:00 p.m., indicated if the resident desired to self-administer		Nursing Supervisor will complete visual observation rounds on 6 residents daily across either shift to ensure Medications are not left unattended or at bedside x 2 weeks, then 6 observations three times a week for 2 weeks, then 6 observations weekly x 4, then 6 residents monthly x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **By what date the systemic changes for each deficient will be completed. 07/31/2024**	

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	medications, an assessment was conducted by an Interdisciplinary team. 3.1-11(a)			
F 0623 SS=A Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;			

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	(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is 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			

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	mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interview, the facility failed to ensure the resident's Responsible Party was notified in writing related to a transfer to the hospital for 1 of 1 residents reviewed for hospitalization. (Resident 44) Finding includes: The record for Resident 44 was reviewed on 7/10/24 at 11:12 a.m. Diagnoses included, but were not limited to, stroke, sepsis, dysphagia (difficulty swallowing), type 2 diabetes, and chronic kidney disease.	F 0623	**F-623 Transfer and Discharge Notice** The Executive Director (ED) notified the Medical Director on 07/12/24 of the survey findings, The adHoc Quality Assurance Performance Improvement (QAPI) meeting was conducted with the ED, Director of Nursing (DON) and the Medical Director at this time to review the action plan including audits, reeducation, and compliance monitors further recommendations.	07/31/2024

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	The Admission Minimum Data Set (MDS) assessment, dated 6/4/24, indicated the resident was cognitively intact. A Nurse's Note, dated 6/25/24 at 2:09 p.m., indicated the resident was noted to have left facial droop and she was not responding as she usually did. Her speech was not clear and she was not responding at her baseline level. Orders were received to send the resident to the emergency room and 911 was contacted. At 2:19 p.m., the resident's nephew was made aware of the transfer and given the contact information for the hospital. The resident was admitted to the hospital with sepsis and returned to the facility on 7/2/24. There was no indication the State transfer form was mailed to the resident's responsible party. During an interview on 7/11/24 at 10:26 a.m., the Social Service Director indicated that social service staff did not mail information out to the family when a resident was sent to the hospital, nursing sent all of the paperwork in the discharge packet, which would include the transfer form. During an interview on 7/11/24 at 2:25 p.m., the Administrator indicated the resident's family should have been mailed a copy of the transfer form since the resident was not at her normal baseline at the time of the transfer. 3.1-12(a)(6)(ii) 3.1-12(a)(6)(iii)		It is the intent of this facility is to provide quality care for all residents. All residents residing in the facility have the potential to be affected by this alleged deficient practice. Resident 44's responsible party was provided with the transfer discharge notice and the bed hold policy. The Executive Director completed audit of the last 30 discharges to ensure the transfer discharge notice and/or bed hold policy was given per facility policy The Nursing and Management staff were educated on the Transfer and discharge, and bed hold policies. The Executive Director will review discharges five days a week for four weeks, then 3 posting a day 3 days a week for four weeks, then 3 postings once a week for six months. Any concerns with transfer discharge and/or bed hold policies will be immediately addressed and corrected. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will	

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			have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. 7/31/2024	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to provide ADL (activities of daily living) assistance to dependent residents related to nail care and the removal of facial hair for 2 of 7 residents reviewed for ADL care. (Residents 44 and 22) Findings include: 1. On 7/8/24 at 11:25 a.m., Resident 44 was in her room seated in a wheelchair. The resident's fingernails were long with a dark substance underneath and she had an accumulation of facial hair. At 3:18 p.m., the resident was observed in bed sleeping. The facial hair remained to her chin and her hands were covered with a blanket. On 7/9/24 at 9:03 a.m. and 3:00 p.m., the resident's	F 0677	**F677 ADL for Dependent Residents** It is the intent of this facility is to Activities of Daily Living assistance to dependent residents related to nail care and removal of facial hair. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** Resident 44 Fingernails were cleaned, and facial hair removed by the aide on 07/12/2024. Shower was provided on 07/12/2024 by the aide. Resident 22 Fingernails were	08/02/2024

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	fingernails remained long and dirty and the gray facial hair remained to her chin. On 7/10/24 at 8:58 a.m. and 11:42 a.m., the resident's fingernails remained long and dirty and the gray facial hair remained to her chin. The record for Resident 44 was reviewed on 7/10/24 at 11:12 a.m. Diagnoses included, but were not limited to, stroke, sepsis, dysphagia (difficulty swallowing), type 2 diabetes, and chronic kidney disease. A 5 day Medicare Minimum Data Set (MDS) assessment was in progress. The resident was identified as being moderately impaired for daily decision making. The Admission MDS assessment, dated 6/4/24, indicated the resident was dependent on staff for personal hygiene. A Care Plan, dated 6/7/24, indicated the resident required assistance with ADL's. There was no care plan indicating the resident preferred long fingernails. The shower schedule indicated the resident was to receive a shower on Wednesday and Saturday evenings. The Task section in the Point of Care charting indicated the resident received a shower on 7/3/24 and a bed bath on 7/4 and 7/5/24. There was no documentation on the Weekly Skin Check/Shower Sheet since the resident was readmitted to the facility on 7/2/24. During an interview on 7/11/24 at 10:40 a.m., Nurse		cleaned, and facial hair removed by the aide on 07/12/2024 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** The DON/Designee completed an audit on residents' nails and facial hair on 07/12/2024, any concerns were immediately addressed. Care plans were reviewed on residents that prefer long nails and facial hair to ensure it indicated person centered care by the MDS nurse/designee on 07/12/2024 **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.** The DON/Designee in-serviced the nursing staff by 07/24/2024 on the following. Resident's preferences, including types of bathing, Hygiene for facial hair and nails. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality**	

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	Consultant 2 was informed the resident had long nails and facial hair and the resident had not had a documented bed bath or shower since 7/5/24. No further information was provided. 2. During random observations on 7/8/24 at 8:03 a.m., 10:33 a.m., and 2:14 p.m., on 7/9/24 at 9:10 a.m., 12:40 p.m., and 3:00 p.m., and on 7/10/24 at 9:00 a.m., 9:30 a.m., and 11:15 a.m., Resident 22 was observed sitting in a wheelchair. At those times, his fingernails were long and he was unshaven. During an interview on 7/8/24 at 8:03 a.m., the resident indicated he would like his nails trimmed because they were starting to break off. The record for Resident 22 was reviewed on 79/24 at 9:50 a.m. Diagnoses included, but were not limited to, type 2 diabetes, Urinary Tract Infection (UTI), dementia without behaviors, high blood pressure, obstructive and reflux uropathy (a condition where urine cannot drain into the urinary tract), and anxiety disorder. The 5/30/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and was dependent on staff for personal hygiene. The Care Plan, dated 2/13/24, indicated the resident had an ADL self care deficit. There was no documentation to indicate if the resident had his nails trimmed recently. A shower sheet, dated 7/1/24, indicated the resident received a shower and a shave. During an interview on 7/10/24 at 9:30 a.m., CNA 3 indicated staff shave and trim nails on shower		**assurance program will be put into place.** DON/Designee will complete visual observation on 10 random residents weekly for nail care and facial hair x 4 weeks, then 5 random residents weekly x 4 weeks, then 3 random residents monthly x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. Compliance 08/02/2024	

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	days. When asked if a resident wanted their nails or a shave done more often, the CNA indicated they would try to do it, but they focus on shower days. During an interview on 7/11/24 at 8:41 a.m., the Administrator indicated all documentation regarding showers and personal hygiene was completed in the point of care (POC) on the computer. 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure areas of bruising were assessed and monitored for 1 of 1 resident reviewed for skin conditions non-pressure related(Resident 100), failed to administer medications according to physician's orders related to not following parameters for 1 of 6 residents reviewed for unnecessary medications (Resident 44), and failed to identify and assess a resident's edema (swelling) for 1 of 1 resident reviewed for edema. (Resident 250) Findings include:	F 0684	**F684 Quality of Care** The Executive Director (ED) notified the Medical Director on 07/12/24 of the survey findings, The adHoc Quality Assurance Performance Improvement (QAPI) meeting was conducted with the ED, Director of Nursing (DON) and the Medical Director at this time to review the action plan including audits, reeducation, and compliance monitors further recommendations. It is the intent of this facility is to	07/31/2024

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	1. On 7/8/24 at 10:31 a.m., Resident 100 was observed in his room in bed. Areas of reddish/purple discolorations were observed on his left and right forearms. During an interview at that time, the resident indicated the bruises may have been from lab draws, but he wasn't sure. The record for Resident 100 was reviewed on 7/8/24 at 3:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), pneumonia, emphysema, anemia, and anxiety. The Admission Minimum Data Set (MDS) assessment, dated 6/28/24, indicated the resident was cognitively intact and he required partial to moderate assistance with bed mobility and transfers. The Weekly Wound Evaluation, dated 7/5/24, indicated the resident had skin tears to the left and right upper arm. There was no documentation related to the bruising on the left and right forearms. The Weekly Skin Check form, dated 7/9/24, indicated the resident had no new skin issues. There was no documentation in the nursing progress notes related to the resident's bruising and when they were observed. During an interview on 7/10/24 at 1:35 p.m., Nurse Consultant 1 was informed of the arm discoloration. A Change in Condition Evaluation, dated 7/10/24 at 3:30 p.m., indicated the resident had discolorations/bruising to his bilateral upper and lower extremities at various stages of healing.		provide quality care for all residents. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** Residents 100 had no negative outcome relating to this alleged deficiency. Resident 100 was assessed, and MD was notified. Orders placed to monitor bruising until healed. Resident 44 had no negative outcome relating to this alleged deficiency. Resident 44 was assessed MD, notified and no new orders. Orders placed to monitor edema to right hand. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents with orders with parameters have the potential to be affected by the same alleged deficient practice. Therefore, this plan of correction applies to all residents of the facility that have orders that are modified relating to the parameters set in the orders. The DON/designee completed an audit identifying resident with orders with parameters. The DON/designee affirmed that all resident receiving medication with parameters are being carried out	

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	155251	A. BUILDING 00 B. WING	07/11/2024

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	The facility policy titled, SWAT Program (Skin-Weight-Assessment-Team Program) Guidance, provided by Nurse Consultant 1 on 7/11/24 at 3:00 p.m., indicated skin alterations such as bruising would appear on the Weekly Skin Assessments and would be followed by the Clinical Management staff for progress. Those conditions/alterations would be care planned and managed and treated as per physician order. 2. The record for Resident 44 was reviewed on 7/10/24 at 11:12 a.m. Diagnoses included, but were not limited to, stroke, sepsis, dysphagia (difficulty swallowing), type 2 diabetes, hypertension, and chronic kidney disease. A 5 day Medicare Minimum Data Set (MDS) assessment was in progress. The resident was identified as being moderately impaired for daily decision making. A Physician's Order, dated 6/10/24, indicated the resident was to receive Midodrine HCl (a medication to treat low blood pressure) 2.5 milligrams (mg) with meals for hypotension (low blood pressure), hold the medication if the systolic (top number) blood pressure was over 130. The June 2024 Medication Administration Record (MAR) indicated the resident's blood pressure for the morning dose of medication on 6/18 was 132/74 and her blood pressure for the HS (bedtime) dose on 6/24/24 was 133/76. The resident received the Midodrine on both dates. A Physician's Order, dated 7/6/24, indicated the resident was to receive Midodrine HCl 2.5 mg, give 1 tablet with meals for hypotension, hold the		as documented in the order. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.** The DON/Designee in-serviced the ALL-nursing staff by 03/17/2023 on the following. 1 Following a physician's order 2 Medication parameters 3 Identification of bruising, skin tear, edema ETC. 4 Monitoring of bruising, skin tear, edema ETC. STOP and WATCH TOOL for all staff Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place.** **Monitoring:** 1 Starting on 7/12/2024 the DON/ADON/ Unit Manager/ Nursing Supervisor will complete visual observation rounds on 6 residents daily across either shift to ensure Medications are administered within the parameters of the order x 2 weeks, then 6 observations three times a week for 2 weeks, then 6 observations weekly x 4, then 6 residents monthly. Corrective	

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	medication if the systolic (top number) blood pressure was greater than 110. The July 2024 MAR, indicated the Midodrine was given at the following dates and times when the resident's systolic blood pressure was greater than 110: - 7/6 at 12:00 p.m., blood pressure 128/68 - 7/6 at 5:00 p.m., blood pressure 126/72 - 7/7 at 5:00 p.m., blood pressure 134/78 - 7/8 at 12:00 p.m., blood pressure 146/73 - 7/9 at 5:00 p.m., blood pressure 134/67 During an interview on 7/10/24 at 1:35 p.m., Nurse Consultant 1 indicated the resident's medication should have been held as ordered. 3. On 7/8/24 at 9:30 a.m., Resident 250 was observed sitting in her wheelchair. The resident indicated she had swelling in her right hand and right arm. The resident's hand was observed to be visibly swollen. On 7/9/24 at 10:49 a.m., the resident was observed in the dining hall. The resident indicated the swelling in her arm was better, but her hand was worse. The resident's hand was remarkably swollen. On 7/9/24 at 1:36 p.m., the resident was observed sitting in her room with family. The resident's right arm was not elevated, and her right hand was swollen. On 7/9/24 at 2:59 p.m., the resident was observed asleep in her wheelchair. The right hand remained swollen and was not elevated. On 7/10/24 at 9:23 a.m., the resident was in her room using her left hand to brush her teeth. Her right hand was observed to still be swollen.		actions will be completed immediately, and staff will be re-educated to ensure medications will not be unattended or at bedside. 2 An Ad hoc QAPI meeting was held with the Medical Director on 07/12/2024 to discuss the above stated plan to ensure that the alleged deficient practice does not reoccur. Findings of audits and corrective actions were discussed. No further recommendations were made by the Medical Director at this time. 3 A QAPI meeting will be held weekly for 4 weeks, then monthly to ensure continued compliance with the decrease the risk of medications improperly stored. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **By what date the systemic changes for each deficient will be completed. 07/31/2024**	

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	The record for Resident 250 was reviewed on 7/9/24 at 2:16 p.m. The diagnoses included, but were not limited to, anemia, heart failure, hypertension (high blood pressure), chronic kidney disease, and a right artificial shoulder joint. The Admission Minimum Data Set (MDS) assessment, dated 7/1/24, indicated the resident was cognitively intact for daily decision making. The resident required substantial/maximum assistance for personal hygiene, toileting, shower/bathing, oral hygiene and rolling left to right. The resident was dependent with dressing upper and lower body dressing. During an interview on 7/10/24 at 9:31 a.m., Nurse Consultant 2 indicated the resident's hand should have been assessed by nursing staff. During an interview on 7/10/24 at 1:39 p.m., Nurse Consultant 2 indicated she had no additional information to provide. 3.1-37(a)			
F 0687 SS=D Bldg. 00	483.25(b)(2)(i)(ii) Foot Care §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such			

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	appointments. Based on observation, record review, and interview, the facility failed to ensure a Podiatrist's recommendations were followed related to thick, painful, and fungal toenails for 1 of 7 residents reviewed for ADLs (activities of daily living). (Resident 40) Finding includes: On 7/8/24 at 11:00 a.m., Resident 40 was observed with long, thick and yellow discolored toenails. During an interview at that time, the resident indicated he had seen the Podiatrist and was told he had a fungus on his toenails. The record for Resident 40 was reviewed on 7/9/24 at 1:00 p.m. Diagnoses included, but were not limited to, stroke, left side hemiplegia, major depressive disorder, heart disease, and atrial flutter. The Annual 5/15/24 Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident had an impairment of functional range of motion to one side for his upper and lower extremity. A Podiatry Exam Note, dated 1/26/24, indicated the resident had pain on the on left great toe, left 2nd toe, left 3rd toe, left 4th toe, left 5th toe, right great toe, right 2nd toe, right 3rd toe, right 4th toe, and right 5th toe. All toenails were yellow, brown and crumbly and were thickened to 3 millimeters (mm). The assessment and plan was all the mycotic (an infection with a fungus or a disease caused by a fungus) nails were debrided in both length and thickness. The plan for the painful mycotic nails was for a prescription for Cyclopirex (used to treat fungal infections) cream to be	F 0687	**F687 Foot Care** It is the intent of this facility to ensure recommendation by the Podiatrist are followed. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The DON/Designee notified MD on 7/12/2024 related to Ciclopirox not administered as ordered. No new orders, Resident will see Podiatry on August 30,2024 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** The DON/Designee completed a 90 day look of Podiatry notes for recommendations and notified MD of any discrepancies on 07/15/2024 **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.** The DON/Designee in-serviced the nursing staff by on the following on 07/24/2024 1 Following Podiatry Recommendations Additionally, any staff that fails to comply with the points of this in-service will be further	08/02/2024

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	applied to nails daily for 6 months or until healed. There was no physician's order for the Cyclopirex cream. A Podiatry Exam Note, dated 4/18/24, indicated the resident had pain on the on left great toe, left 2nd toe, left 3rd toe, left 4th toe, left 5th toe, right great toe, right 2nd toe, right 3rd toe, right 4th toe, and right 5th toe. All toenails were yellow, brown and crumbly and were thickened to 4 mm. All the mycotic nails described were debrided in both length and thickness. During an interview on 7/11/24 at 8:41 a.m., Nurse Consultant 2 indicated she could not find any additional information regarding the medication that was ordered for the resident's mycotic toenails in January 2024. 3.1-47(a)(7)		educated/disciplined as indicated. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place.** **Monitoring:** DON/designee will audit Podiatry Notes monthly x 6 months for implementation of recommendations. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **By what date the systemic changes for each deficient will be completed. 08/02/2024**	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates			

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	that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure a splint was ordered and in place as recommended by therapy for 1 of 1 resident reviewed for limited range of motion (ROM). (Resident 40) Finding includes: During an observation on 7/8/24 at 11:02 a.m., Resident 40 was observed with a left hand contracture (fixed tightening of muscle, tendons, ligaments, or skin which prevents normal movement of the associated body part.) The resident was not able to voluntarily open his left hand, he had to use his right hand to lift it and open it. During an interview at that time, the resident indicated he had a splint and it was supposed to be on at night, however, he had to ask staff to put on the splint, because they did not put it on every night. He indicated the splint was not placed on his left hand the previous night. At that time, the splint was observed on top of the night stand. During an interview on 7/9/24 at 9:13 a.m., the resident indicated the splint was not placed on his	F 0688	**F688 Increase/Prevent Decrease in ROM/Mobility** It is the intent of this facility to ensure therapy recommendations for splints are ordered and in place. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The Rehab Director/Designee reassessed resident 40 on 7/12/2024 for splint and new orders written. Resident 40's physician was notified of splint not applied and new order obtained and care plan updated on 07/12/2024, by the DON/Designee. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	07/31/2024

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	left hand the previous night. The record for Resident 40 was reviewed on 7/9/24 at 1:00 p.m. Diagnoses included, but were not limited to, stroke, left side hemiplegia (paralysis on one side of the body), major depressive disorder, heart disease, and atrial flutter (abnormal heart rhythm). The Annual 5/15/24 Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making. The resident had an impairment of functional range of motion to one side for his upper and lower extremity. There was no care plan for the contracted left hand or for splint use. There was no Physician's Order for the splint to be donned at night time. An Occupational Therapy (OT) Note, dated 5/14/24, indicated a splint was applied to the left upper extremity and the resident tolerated it for 11.5 hours. An OT Note, dated 5/27/24, indicated reviewed the splint wear/care schedule with the patient and he tolerated it for 6 hours. During an interview on 7/10/24 at 9:30 a.m., CNA 2 and CNA 3 indicated they thought the resident was supposed to have his splint on every morning when he got up. CNA 3 indicated the resident did his own thing and put his splint on himself, but would also take it off himself. CNA 2 indicated she believed he had taken it to therapy and they would put it on for him.		**action will be taken.** The Rehab Director/Designee reassessed residents with splints for necessity and recommendations for splints and wear time provided to DON/Designee on 07/12/2024. The DON/Designee verified orders place in EMR for splints to include length of time to be worn and care plans updated on 07/12/2024 **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.** The DON/Designee in-serviced the nursing staff by on the following on 07/24/2024 1 Splints – donning and doffing, length of time for splint to be worn. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place.** **Monitoring:** DON/designee will audit residents with splints 5 times a week for 4 weeks, to ensure splint is applied and worn for correct length of time, then 3 times a week x 4 weeks, then once a month x 4 months. If the facility is within 95% compliance at the end of the 6	

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	During an interview on 7/10/24 at 9:45 a.m., COTA 1 indicated the resident was to wear his splint every night while sleeping. He had come down to therapy and asked her to put on his splint and she had helped him put it on. He would come down to therapy from time to time to ask questions or want to exercise. During an interview on 7/10/24 at 2:00 p.m., the Director of Rehab indicated there was no order for the hand splint and there was no care plan developed. The resident was to wear the left hand splint every night while sleeping. 3.1-42(a)(2)		months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **By what date the systemic changes for each deficient will be completed. 07/31/2024**	
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			

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	clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on random observations, record review, and interview, the facility failed to ensure a suprapubic foley catheter (urinary catheter that is inserted into the bladder from a small cut in the lower abdomen) bag and tubing was kept off the floor for 1 of 1 resident reviewed for urinary catheters. (Resident 22) Finding includes: During random observations on 7/8/24 at 8:03 a.m., 10:33 a.m., and 2:14 p.m., Resident 22 was observed sitting in a wheelchair. At those times, a foley catheter bag was observed under the wheelchair and the bottom of the bag was touching the floor. During random observations on 7/10/24 at 9:00 a.m., 9:30 a.m., and 11:15 a.m., the resident was observed sitting in a wheelchair. At those times, a foley catheter bag and tubing were observed under the wheelchair and both were on the floor. The record for Resident 22 was reviewed on 79/24 at 9:50 a.m. Diagnoses included, but were not limited to, type 2 diabetes, urinary tract infection	F 0690	**F690 Bowel, Bladder Incontinence, Catheter, UTI** It is the intent of this facility to ensure catheter tubing and bag is kept off the floor. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The DON/Designee secured resident 22's catheter tubing and bag to prevent touching the floor on DATE. Resident 22 assessed by the DON/Designee on 07/12/2024 and no negative outcome. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** The DON/Designee completed an audit of residents with indwelling	07/31/2024

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	(UTI), dementia without behaviors, high blood pressure, obstructive and reflux uropathy (a condition where urine cannot drain into the urinary tract), and anxiety disorder. The 5/30/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and was dependent on staff for personal hygiene. The resident had an indwelling catheter. A Care Plan, revised on 7/8/24, indicated the resident has a suprapubic catheter. Physician's Orders, dated 2/14/24 and discontinued on 2/24/24, indicated Amoxicillin (an antibiotic)oral tablet 500 milligrams (mg), give 1 tablet by mouth every 12 hours for a complicated UTI. Physician's Orders, dated 7/8/24, indicated suprapubic catheter 14 French with 5 milliliter (ml) balloon. During an interview on 7/10/24 at 1:30 p.m., Nurse Consultant 1 indicated the foley catheter and tubing should not have been on the floor. The undated "Catheters" policy, provided as current by Nurse Consultant 1 on 7/11/24 at 3:00 p.m., indicated insertion, ongoing care, and catheter removal protocols should adhere to professional standards of practice and facility policy and procedure, with adherence to infection prevention and control techniques. 3.1-41(a)(2)		catheters to ensure tubing and bag not touching the floor on 07/15/2024 **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.** The DON/Designee in-serviced the nursing staff by on the following on 07/24/2024 1 Catheter Care 2 Infection Control Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place.** **Monitoring:** DON/designee will audit residents with Catheters to enure tubing and bag are not touching the floor 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a month x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any	

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	155251	A. BUILDING 00 B. WING	07/11/2024

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			written Action Plan will be monitored by the Administrator weekly until resolved. **By what date the systemic changes for each deficient will be completed. 07/31/2024**	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure enteral tube feedings were infusing at the correct time and flow rate through a peg tube (a tube inserted directly into the stomach for nutrition) for 2 of 3 residents reviewed for tube feeding. (Residents 2 and 251)	F 0693	**F693 Tube Feeding Mgt/Restore Eating Skills** It is the intent of this facility is to ensure enteral feeding are infusing at the correct time and rate. **What corrective action will be**	07/31/2024

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	Findings include: 1. On 7/8/24 at 7:55 a.m., Resident 2 was observed lying in bed. At that time, an enteral tube feeding was infusing at 55 cubic centimeters (cc) an hour through the peg tube. At 10:22 a.m., the resident's enteral feeding was observed to be turned off. On 7/8/24 at 10:48 a.m., 11:10 a.m., 11:30 a.m., and 1:45 p.m., the resident was in bed and the enteral tube feeding remained off. The record for Resident 2 was reviewed on 7/9/24 at 1:52 p.m. Diagnoses included, but were not limited to, left side hemiplegia, stroke, type 2 diabetes, heart disease, dementia, dysphagia (swallowing difficulties), and adult failure to thrive. The Quarterly Minimum Data Set (MDS) assessment, dated 6/6/24, indicated the resident was moderately impaired for daily decision making. The resident received an enteral feeding of 51% or more through a peg tube. A Care Plan, dated 4/11/24, indicated the resident required a feeding tube related to dysphagia (difficulty swallowing). The approaches were to administer feedings and flushes as ordered. Physician's Orders, dated 7/6/24, indicated Glucerna 1.5 at 65 cc per hour for 20 hours, turn off at midnight and turn on at 4:00 a.m. The resident was NPO (nothing by mouth). During an interview on 7/10/24 at 1:30 p.m., Nurse Consultant 1 indicated the tube feeding should have been on and infusing as ordered by the physician.2. On 7/8/24 at 9:20 a.m., the resident		**accomplished for those residents found to have been affected by the deficient practice.** Resident 2 and 251 were assessed by the DON/Designee on 07/12/2024, no negative outcome related to enteral feeding not infusing during the correct time, he enteral feeding was turn on by the DON/Designee on 7/10/2024. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** The DON/Designee completed an audit of resident receiving enteral feeding for flow rate and correct infusing time, physician orders and care plan updated on 07/10/2024 **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.** The DON/Designee in-serviced the nursing staff by on 07/24/2024 on following. 1 Following a physicians orders 2 Enteral Feeding 3 Care plans for enteral feeding Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated.	

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	was observed awake lying in bed. He indicated he received tube feeding every day. The tube feed was not infusing at the time. The tube feeding bottle was dated 7/7/24, and the tube feeding water bag was dated 7/3/24. On 7/8/24 at 1:35 p.m., the tube feeding was observed off. The tube feeding water bag was dated 7/3/24. On 7/9/24 at 3:00 p.m. and 4:03 p.m., the resident was observed asleep in bed and the tube feeding was not infusing. On 7/10/24 at 8:58 a.m., the resident was observed asleep in bed. The tube feeding was infusing, and the start time was listed on the tube feeding bottle as 12:00 a.m. On 7/10/24 at 9:26 a.m., the tube feeding was no longer infusing and all contents were thrown away. The record for Resident 251 was reviewed on 7/8/24 at 3:08 p.m. Diagnoses included, but were not limited to, stroke, dysphagia (difficulty swallowing), hemiplegia (paralysis on one side of the body), COPD, gastrostomy status, and hypertension (high blood pressure). The Admission Minimum Data Set (MDS) assessment, dated 6/14/24, indicated the resident was cognitively intact for daily decision making. The resident had impairment on one side of the upper and lower extremities. Oral hygiene required partial/moderate assistance. The resident had a feeding tube and had a mechanically altered diet. A Care Plan, dated 6/13/24, indicated the resident required tube feeding related to inadequate oral		**How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place.** **Monitoring:** DON/designee will audit residents receiving enteral feeding for correct flow rate, physician orders, correct infusing time and care plan five times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **By what date the systemic changes for each deficient will be completed. 07/31/2024**	

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	intake and need for nutritional support. The interventions were to administer tube feeding as ordered and to check for tube placement. A Care Plan, dated 6/10/24, indicated the resident had swallowing difficulties and required enteral feedings related to dysphagia. Interventions were to provide oral care every shift and to provide feedings as ordered. A Physician's Order, dated 6/14/24, indicated to administer daily tube feeding at 70 milliliters (ml)/ hour for 16 hours. The feeding was to be started at 3:00 p.m. and turned off at 7:00 a.m. A Physician's Order, dated 6/7/24 indicated to change the tube feeding tubing every 24 hours. The July 2024 Medication Administration Record (MAR) indicated tube feeding tubing was signed out as being changed every 24 hours on the following dates: 7/3/24, 7/4/24, 7/5/24, 7/6/24, 7/7/24, and 7/8/24. During an interview on 7/10/24 at 9:00 a.m., QMA 1 indicated the nurses turn the tube feeding off at 7:00 a.m. During an interview on 7/10/24 at 9:31 a.m., the Nurse Consultant 2 indicated she understood the tube feeding concerns for Resident 251 and had no additional information to provide. 3.1-44(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.			

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	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, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate and ordered by the physician for 3 of 4 residents reviewed for respiratory care. (Residents 13, 251, and 254) Findings include: 1. During random observations on 7/8/24 at 8:07 a.m., 10:20 a.m., 11:10 a.m., and 11:30 a.m., on 7/9/24 at 9:12 a.m., 9:52 a.m., 12:50 p.m., and 3:00 p.m., and on 7/10/24 at 9:00 a.m. and 11:30 a.m., Resident 13 was observed lying in bed and wearing oxygen per nasal cannula. The center of the oxygen bubble was below the 3 liter mark and above the 2.5 liter mark. The record for Resident 13 was reviewed on 7/9/24 at 9:30 a.m. Diagnoses included, but were not limited to, stroke, type 2 diabetes, dysphagia (difficulty swallowing), and anemia. The 4/30/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident did not receive oxygen and was currently on hospice. There was no care plan for oxygen therapy. Physician's Orders, dated 7/8/24, indicated oxygen at 2 liters continuous as needed to maintain an oxygen saturation of 90%.	F 0695	**F695 Respiratory/Tracheostomy Care and Suctioning** It is the intent of this facility is to ensure oxygen is set at the correct flow rate and ordered by the physician. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** Resident 13 , 251, 254 were assessed by the DON/Designee on 07/12/2024, no negative outcome related to oxygen flow rate and concentrator set at correct oxygen flow rate and MD notified, and care plans updated on 07/12/2024 by the DON/Designee. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** The DON/Designee completed an audit of resident receiving oxygen for correct oxygen flow rate, physician orders and care plan	07/31/2024

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	During an interview on 7/11/24 at 8:45 a.m., Nurse Consultant 2 indicated the oxygen should have been on as ordered by the physician.2. On 7/8/24 at 9:21 a.m., Resident 251 was observed lying in bed wearing oxygen via nasal cannula. The oxygen flow rate was set at 2.5 liters. On 7/8/24 at 1:34 p.m., the resident was observed asleep in bed. Oxygen was in place via nasal cannula. The oxygen was set at 2.5 liters. On 7/9/24 at 9:22 a.m., the resident's oxygen was on and in place. The oxygen flow rate was set at 2.5 liters. On 7/9/24 at 1:38 p.m., the resident was observed asleep in bed with oxygen in place. The oxygen was set at 2.5 liters. On 7/10/24 at 8:58 p.m., the resident was observed in bed wearing oxygen via nasal cannula. The oxygen rate was set above 2.5 liters. The record for Resident 251 was reviewed on 7/8/24 at 3:08 p.m. Diagnoses included, but were not limited to, stroke, dysphagia (difficulty swallowing), hemiplegia (paralysis on one side of the body), COPD, gastrostomy status, and hypertension (high blood pressure). The Admission Minimum Data Set (MDS) assessment, dated 6/14/24, indicated the resident was cognitively intact for daily decision making. The resident had impairment on one side of the upper and lower extremities. The resident was dependent with eating, toileting, shower/bathing, lower body dressing and upper body dressing. Oral hygiene required partial/moderate assistance. The resident had a feeding tube and had a		updated on 07/12/2024 **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.** The DON/Designee in-serviced the nursing staff by on the following. 1 Following a physician's order 2 Oxygen Administration 3 Care plans for oxygen therapy Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place.** **Monitoring:** DON/designee will audit residents receiving oxygen for flow rate, physician order for oxygen and care plan five times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be	

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	mechanically altered diet. A Baseline Care Plan, dated 6/7/24, indicated the resident required oxygen therapy. A Physician's Order, dated 7/8/24 at 3 p.m., indicated to continuously administer oxygen at 2 liters/minute via nasal cannula. A Physician's Order, dated 7/8/24 at 3 p.m., indicated to check oxygen flow rate every shift. A Daily Skilled Nurse's Note, dated 7/7/24 at 1:13 a.m., indicated the resident was wearing oxygen at 3 liters via nasal cannula. A Daily Skilled Nurse's Note, dated 7/6/24 at 1:12 a.m., indicated the resident was wearing oxygen at 3 liters via nasal cannula. A Daily Skilled Nurse's Note, dated 7/5/24 at 1:10 a.m., indicated the resident was wearing oxygen at 3 liters via nasal cannula. A Daily Skilled Nurse's Note, dated 7/3/24 at 9:23 p.m., indicated the resident was wearing oxygen at 3 liters via nasal cannula. A Physician's Progress Note, dated 6/18/24 at 1:38 p.m., indicated the resident was dependant on supplemental oxygen and was on 3 liters via nasal cannula at the time. The July 2024 Treatment Administration Record (TAR), indicated oxygen was signed out as being given at 2 liters every shift on the following dates: 7/8/24, 7/9/24, and 7/10/24. During an interview on 7/10/24 at 9:31 a.m., Nurse Consultant 2 indicated Resident 251's oxygen was		monitored by the Administrator weekly until resolved. **By what date the systemic changes for each deficient will be completed. 07/31/2024**	

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	on at the incorrect flow rate. 3. On 7/8/24 at 9:27 a.m. Resident 254 was observed awake in her wheelchair. The resident was wearing oxygen via nasal cannula. The oxygen flow rate was set above 3 liters. On 7/08/24 at 1:36 p.m., the resident was observed awake in her wheelchair. Oxygen was in place via nasal cannula. Oxygen was administered from a portable oxygen tank and was set at 3 liters. On 7/9/24 at 9:59 a.m., the resident was observed in her wheelchair. The resident was using oxygen via a portable oxygen tank. The oxygen flow rate was set at 3 liters. On 7/09/24 at 10:51 a.m., the resident was observed asleep in bed. Oxygen was in place via nasal cannula and the flow rate was set at 3 liters. The record for Resident 254 was reviewed on 5/29/24 at 3:47 p.m. Diagnoses included, but were not limited to, COPD, hypertension (high blood pressure), heart failure, depression, and dysphagia (difficulty swallowing). The Admission Minimum Data Set (MDS) assessment, dated 6/20/24, indicated the resident was severely impaired for daily decision making. The resident had no impairment of her upper and lower extremities and used a wheelchair. The resident required supervision or touching assistance for eating and oral hygiene. The resident was dependent with toileting, personal hygiene, shower/bathing, lower body dressing, and upper body dressing. A Baseline Care Plan, dated 6/14/24, indicated the resident received oxygen therapy.			

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	There was no further care plan related to oxygen use. A Daily Skilled Nursing Note, dated 6/16/24, indicated the resident was on 2 liters of continuous oxygen. A Physician's Progress Note, dated 6/18/24 at 1:34 p.m., indicated the resident was oxygen dependent and to continue supplemental oxygen per orders. A Physician's Progress Note, dated 7/5/24 at 8:06 a.m., indicated the resident was dependent on supplemental oxygen at 3 liters via nasal cannula. A Daily Skilled Nursing Note, dated 7/9/24, indicated the resident was on 2 liters of continuous oxygen. There were no physician's orders to administer oxygen listed on the Physician's Order Summary. During an interview on 7/10/24 at 9:31 a.m., the Nurse Consultant 2 indicated there should have been an oxygen order and a oxygen care plan for Resident 254. 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			

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	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 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 and interview, the facility failed to post the daily staffing sheet which indicated how many staff were working in the facility and the facility census in a timely manner. This had the potential to affect the 50 residents who resided in the facility. Finding includes:	F 0732	**-732 Posting of staff** It is the intent of this facility to post the daily staffing sheet to indicate how many staff are working in the facility. What corrective action will be accomplished for those residents found to have been affected by the deficient practice.	08/02/2024

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	On 7/8/24 at 7:33 a.m., the daily staffing sheet located by the front desk in the main lobby was dated 7/5/24. During an interview on 7/11/24 at 2:58 p.m., the Administrator indicated the staffing sheets should have been changed daily over the weekend.		The SSD/Designee assessed all residents on 07/15/2024, no negative outcome related to the cited practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents' rooms have the potential to be affected by the cited practice, therefore this plan of correction applies to all rooms in the facility. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The DON/Designee in-serviced the scheduler on posting the daily staffing sheet on 07/15/2024. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. The DON/Designee will audit the posting of the daily staffing sheet 5random times a week to include weekdays and weekends x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be	

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	155251	A. BUILDING 00 B. WING	07/11/2024

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			stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. Date: 7/31/2024	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair, related to personal items not contained in a shared environment, discolored floor tile, missing caulk around toilet bases, leaking toilets, dried tube feeding on the base of poles, and urine odors in 1 of 2 units. (West Unit) Findings include: During the Environmental tour on the West Unit with the Maintenance Director on 7/10/24 at 2:36 p.m., the following was observed: a. Room 9: the floor tile was discolored, the caulk	F 0921	**F-921 Environment** **It is the intent of this facility to ensure residents environment is clean and in good repair.** What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Maintenance Director/Designee replaced the tile and caulked around the base of toilet in room 9, replaced the tile in room 7's bathroom on 07/12/2024. The DON/Designee removed the pink wash basin from room 7's bathroom, cleaned the feeding	07/31/2024

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	around the base of the toilet was missing and discolored and the toilet was leaking around the base. There were tooth brushes and hair brushes sitting out on the bathroom counter not contained. Two residents shared the bathroom b. Room 40: there was a strong urine odor. c. Room 18: there was dried tube feeding on the base of the tube feeding pole. d. Room 7: the bathroom tile floor was discolored and there was a pink wash basin under the sink that was not contained. Two residents resided in this room and used the bathroom. e. Room 20: there was dried tube feeding on the base of the tube feeding pole. During an interview on 7/10/24 at 2:56 p.m., the Maintenance Director indicated he would start correcting the environmental concerns today. The facility had plans to remodel all the rooms and had currently been completing 1 room a month. 3.1-19(f)		pole in room 20 and room 18, toothbrushes and hair brushed were replaced and new items labeled and stored placed in residents' drawers on 07/12/2024 The Housekeeping Director cleaned room 40 floors to remove urine odor on 07/12/2024 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents rooms have the potential to be affected by the cited practice, therefore this plan of correction applies to all rooms in the facility. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The DON/Designee in-serviced nursing staff on the proper storage of resident personal items and cleaning feeding tube poles on 07/12/2024. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined. The ADM/Designee in-serviced the maintenance director and housekeeping supervisor on room cleanliness and keeping rooms in good repair on DATE. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. How the corrective action will be	

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			monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. The DON/Designee will observe 10 random rooms weekly for storage of personal items and cleanliness of feeding tube poles x 4 weeks, then 5 random rooms weekly x 4 weeks, then 3 random rooms monthly x 4 months. The ADM/Designee will observe 10 random rooms for odors, leaking toilets, discolored tiles and missing caulking around toilets weekly x 4 weeks, then 5 random rooms weekly x 4 weeks, then 3 random rooms monthly x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By 07/31/2024 the systemic changes for each deficient will be completed. Date: 7/31/2024	

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