STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155717	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALPHA HOME - A WATERS COMMUNITY	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00411354. Complaint IN00411354 - No deficiencies related to the allegations are cited. Survey dates: August 7, 8, 9, 10, and 11, 2023 Facility number: 000376 Provider number: 155717 AIM number: 100275510 Census Bed Type: SNF/NF: 56 Total: 56 Census Payor Type: Medicare: 1 Medicaid: 46 Other: 9 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 17, 2023.	F 0000	Alpha home would like to request desk review related to event ID: 6QWE11	
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.			

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

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	Based on observation, interview, and record review, the facility failed to ensure the call light was in reach of a resident who was able to use it for 1 of 9 residents reviewed for call lights within reach (Resident 26). Findings include: On 8/7/23 at 12:24 p.m., Resident 26's call light was observed on the floor, up against the wall. On 8/8/23 at 12:08 p.m., Resident 26's call light was observed on the floor, up against the wall. On 8/10/23 at 9:24 a.m., the Executive Director (ED) indicated Resident 26's was able to move and use her call light independently. On 8/8/23 at 10:12 a.m., Resident 26's record was reviewed. Her diagnoses included, but were not limited to, anoxic brain damage (damage to the brain due to lack of oxygen), tracheostomy status (opening in windpipe to relieve obstruction when breathing), seizures (sudden attack of illness, epileptic fit), altered mental status (this condition causes changes in consciousness), cognitive communication deficit, aphasia (loss of ability to understand or express speech due to brain damage), dyspnea (difficult or labored breathing), oropharyngeal dysphagia (impairment in the production of speech due to brain damage), and personal history of cardiac arrest. Her current physician orders as of 8/8/23 indicated to keep her call light in reach. A fall care plan, dated 8/30/22 with revisions, indicated be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed. The resident needed	F 0558	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 9/8/2023. Facility is respectfully requesting paper compliance for all deficiencies in this POC. It is the policy of this facility to ensure call lights are within reach What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #26 call light was placed in an accessible location for the resident. 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 that currently reside in the facility have the potential to be affected by the alleged deficient practice. Director of Nursing or designee completed a facility wide audit on 8/30/2023 to verify residents call lights are placed in an accessible location to where the resident is in their room. What measures will be put in	09/08/2023

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	prompt response to all requests for assistance. A bed rail care plan, dated 10/17/22 with revisions, indicated the resident benefited from ¼ inch side rails. An intervention indicated to place her call light within reach and encourage her to use it for assistance as needed. A self-care deficit care plan, dated 6/15/23, indicated to ensure that my call light was in reach at all times and encourage her to use the call light to call for assistance. A late loss ADL (activities of daily living) care plan, dated 8/31/22 with revisions, indicated to keep her call light in reach. A current policy, titled, "Call Lights," with no date, was provided by the Director of Nursing (DON), on 8/10/23 at 2:12 p.m. A review of the policy indicated, " ...It is the policy of the facility to have a system in place to allow the staff to respond promptly to a resident's call for assistance ...Always place the call light in an accessible location to where the resident is located in their room. Tell the resident where it is. Be sure they know how to use It ...." 3.1-3(v)(1)		place and what systemic changes will be made to ensure that the deficient practice does not recur The Director of Nursing or designee completed education with facility staff on 8/30/23 related to residents call light accessibility to where the resident is located in their room. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated The Director of Nursing or designee will complete a call light placement audit on 10 random residents daily Monday through Friday. 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 Call light placement *audit tool will be completed 5 days a week on 10 random residents 4 weeks,3 days a week on 10 random residents, x 2 months, then weekly on 10 random residents 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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			written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. September 8, 2023	
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			

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	the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on observation and interview, the facility failed to ensure a resident had an order for an advanced directive for 1 of 1 resident (Resident 29). Findings include: On 8/8/23 at 10:30 a.m., a comprehensive record review was conducted for Resident 29. Her diagnoses included but were not limited to chronic viral hepatitis C, atrial fibrillation (irregular heart rate), dysphagia (difficulty swallowing), generalized anxiety disorder, hearing loss, anemia, muscle weakness, depression, GERD (gastro-esophageal reflux), neuralgia (nerve pain), vitamin deficiency and heart failure. Resident 29's record lacked an order for advance directives. Resident 29 had a care plan dated 8/23/22 indicating resident requests that CPR (cardiopulmonary resuscitation) measures be attempted when needed. During an interview on 8/8/23 at 10:21 a.m. with QMA (Qualified Medication Assistant) 10, she	F 0578	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 9/8/2023. Facility is respectfully requesting paper compliance for all deficiencies in this POC. It is the policy of this facility to ensure call lights are within reach **F 578** It is the policy of the facility to ensure that residents have an order for an Advanced Directive in the Electronical Medical Record. **What corrective action will be accomplished for those residents found to have been affected by the deficient**	09/08/2023

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	indicated she did not see an order for her code status. She indicated if resident coded, she would go and get the charge nurse. During an interview with the ED (Executive Director) on 8/8/23 at 10:40 a.m., she indicated there is a binder with all the residents and their code statuses. She indicated Resident 29 went out to the hospital and the order was not added to her records when she returned. The ED indicated she would educate QMA 10. On 8/9/23 at 2:45 p.m., the RNC (Regional Nurse Consultant) provided a copy of Resident 29's code status. The order was for a full code. The order was written on 8/8/23 at 10:27 a.m. A policy titled "Advance Directive Policy and Procedures" was provided by the RNC on 8/11/23 at 1:43 p.m. The policy indicated, " ...The resident choice of advance directive will be developed into the resident's plan of care ....". 3.1-4(d) 3.1-4(e) 3.1-38(f) 3.1-4(l) 3.1-4(4)		**practice** Resident #29's Advanced Directive Physician Order has been obtained and entered reflecting resident #29's wishes of a full code status. **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 that currently reside in the facility have the potential to be affected by the alleged deficient practice. The Director of Nursing completed a house wide Advance Directive Physician Order audit on August 18, 2023 in order to confirm all residents residing in facility has an active Advanced Directive Physician Order in place. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.** The Director of Nursing or designee completed education with Licensed nursing staff and the Social Services Director on 08/30/23 related to Advanced Directive and Physician Orders in the electronic medical record. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated The Director of Nursing or designee will complete an	

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			Advanced Directive Physician Order Audit on all admissions and readmissions Monday through Friday. **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** *Advance Directive Physician order audit tool will be completed on all new admissions and readmissions 5 days a week x 4 weeks,3 days a week, x 2 months, then weekly 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.** September 8, 2023	
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving			

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	treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to provide a home-like environment for 1 of 9 resident reviewed for	F 0584	It is the policy of the facility that the facility must provide a safe, clean, comfortable, home-like	09/08/2023

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	home-like environments (Resident 26). Findings include: On 8/7/23 at 12:24 p.m., an observation of Resident 26's room. There was a large bed stored in her room, perpendicular to her bed. It was the main object in her field of vision. The large mattress was askew, the upper corner was on the wall. The bed was unmade and dirty with white flakes on it. The bed controls and a wheelchair foot pedal were on the bed too. On 8/9/23 at 10:52 a.m., an observation of Resident 26's room. There was a large bed stored in her room, perpendicular to her bed. It was the main object in her field of vision. The large mattress was askew, the upper corner was on the wall. The bed was unmade and dirty with white flakes on it. The bed controls and a wheelchair foot pedal were on the bed too. On 8/8/23 at 12:08 p.m., an observation of Resident 26's room. There was a large bed stored in her room, perpendicular to her bed. It was the main object in her field of vision. The large mattress was askew, the upper corner was on the wall. The bed was unmade and dirty with white flakes on it. The bed controls and a wheelchair foot pedal were on the bed too. On 8/9/23 at 11:05 a.m., the Maintenance man (MM) 12 indicated he was working alone. He would have liked to get the extra bed out of Resident 26's room. The facility turned her bed for better nursing access. On 8/9/23 at 11:59 a.m., the MM 12 indicated the facility decided to remove the large mattress in Resident 26's room. They planned to put a regular		environment. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The identified mattress and frame have been removed from Resident 26's room. Additionally, foot pedals placed in proper storage in Resident 26's closet. 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 that currently reside in the facility have the potential to be affected by the alleged deficient practice. Housekeeping Director or designee complete a facility wide audit to verify resident rooms are safe, clean, comfortable, and are home-like environment per resident centered care by 8/25/2023. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not reoccur. Administrator educated Housekeeping Director and Housekeeping department on facility providing safe, clean, comfortable, home-like environment per resident centered care on 8/23/23. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or	

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	size mattress on the bed frame and make the bed. On 8/9/23 at 12:17 p.m., the Director of Nursing (DON) indicated Resident 26's room was not home-like because the mattress was partial up on the wall and equipment was stored on the unmade bed. On 8/8/23 at 10:12 a.m., Resident 26's record was reviewed. Her diagnoses included, but were not limited to, anoxic brain damage (damage to the brain due to lack of oxygen), tracheostomy status (opening in windpipe to relieve obstruction when breathing), seizures (sudden attack of illness, epileptic fit), altered mental status (this condition causes changes in consciousness), cognitive communication deficit, aphasia (loss of ability to understand or express speech due to brain damage), dyspnea (difficult or labored breathing), oropharyngeal dysphagia (impairment in the production of speech due to brain damage), and personal history of cardiac arrest. A long term care plan, dated 2/1/23, indicated Resident 26 will adjust to long term placement. An intervention was to encourage her family to bring in personal items. A current policy, titled, "Resident Rights," with no date, was provided by the ED, on 8/9/23 at 1:48 p.m. A review of the policy indicated, " ...The facility must care for you in a manner and environment that enhances or promotes your quality of life ...The facility must provide a safe, clean, comfortable, home-like environment ...." 3.1-19(f)(5)		progressively 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 “Home-like environment” audit tool will be completed 5 days a week x 4 weeks,3 days a week, x 2 months, then weekly 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. 9/8/2023	
F 0641 SS=B	483.20(g) Accuracy of Assessments			

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Bldg. 00	§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record reviews and interviews, the facility failed to update a resident's Minimum Data Set (MDS) information after an above the knee (AKA) amputation, accurately code level II assessments for residents with level IIs, and accurately code resident's who were receiving hospice and anticoagulant medication for 5 of 8 residents reviewed for MDS accuracy (Resident 6, 12,13, 16, and 53). Findings include: 1. A comprehensive record review was conducted for Resident 13 on 8/8/23 at 1:21 p.m. Here diagnoses included but were not limited to type 2 diabetes, major depressive disorder, hemiplegia (paralysis on one side of the body), cerebral infarction (stroke), hyperlipidemia (high cholesterol), essential hypertension (high blood pressure), anemia, aphasia (difficulty with speaking), and seizures. Resident 13 had an MDS (Minimum Data Set) assessment completed on 7/1/23. The MDS indicated Resident 13 was prescribed an anticoagulant. Resident was prescribed Plavix (an antiplatelet drug taken to prevent blood clots) 75mg 1 tablet one time daily for anticoagulant. Plavix was not an anticoagulant indicating the MDS was coded inaccurately. 2. A comprehensive record review was conducted for Resident 53. She had the following diagnoses but not limited to liver failure, cerebral infarction, hepatitis C, peripheral vascular disease, heart failure, hypertension, and nausea.	F 0641	**It is the policy of this facility for assessments to accurately reflect the residents status.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice** Resident #13 MDS dated 7/1/2023 was corrected to remove anticoagulant use. Resident #53 MDS assessment dated 5/31/2023 was corrected to indicate resident #53 was receiving Hospice Services. Resident #12 MDS assessment dated 07/23/2023 was corrected to indicate a Level II was required. Resident #16 MDS Assessment was corrected was corrected to indicate a Level II was required. Resident #6 MDS assessments dated 11/11/2022, 02/11/2023, and 05/14/2023 were corrected to indicate an Above the Knee Amputation. Resident #6 ADL care plan was corrected to show Above the Knee Amputation. **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 that receive Plavix, receive Hospice Services, require a Level II, and have an amputation that currently reside in the facility	09/08/2023

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	Resident was receiving hospice services via a local hospice care company. Resident had an MDS completed on 5/31/23. The MDS did not indicate resident was receiving hospice services. Resident 53 had a care plan dated 5/23/23 indicating she received hospice services. 3. On 8/11/23 at 12:00 p.m., a comprehensive record review was conducted for Resident 12. His diagnoses included but were not limited to COPD (Chronic Obstructive Pulmonary Disease), major depression, coronary artery disease, major depression, BPH (Benign Prostatic Hypertrophy), GERD (Gastroesophageal Reflux Disease), dysphagia (difficulty swallowing), hyperlipidemia (high cholesterol) and MI (myocardial infarction). Resident 12 had a level II completed on 8/22/19 related to diagnosis of major depression. Resident 12 had an MDS assessment completed on 7/23/23. Section A 1500 indicated he did not require a level II assessment. Resident 12 had a care plan dated 7/7/23 indicating he required a level II assessment related to major depressive disorder. 4. On 8/11/23 at 2:05 p.m., a comprehensive record review was conducted for Resident 16. Her diagnoses included, but were not limited to chronic liver disease, cerebral infarction, peripheral vascular disease, heart failure, essential hypertension, schizophrenia, psychotic delusional disorder, PTSD (Post Traumatic Stress Disorder), and mood disorder. Resident 16 had a level II dated 11/3/22. Resident 16's MDS, section A 1500 did not		have the potential to be affected by the alleged deficient practice. The MDS Coordinator or desginee completed a facility wide audit on 8/28/23 on residents who receive Plavix, Hospice Services, require Level II and have amputations to verify MDS accuracy. **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.** MDS Consultant or designee completed education with MDS Coordinator on 8/28/23 related to accuracy of MDS assessments. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively 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** *MDS accuracy related to Plavix, Hospice Services, Level II and amputation audit tool will be completed daily weekly 6 months..* 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. BUILDING 00 B. WING	08/11/2023

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	indicate resident required a level II related to schizophrenia, psychotic delusional disorder, PTSD and mood disorder. Resident 16 had a care plan dated 4/24/23 indicating she required a level II related to paranoid schizophrenia without specialized services. During an interview, on 8/11/23 at 1:23 p.m., the RNC (Regional Nurse Consultant) indicated the facility referred to the RAI (Resident Assessment Instrument) for the accuracy of MDS assessments. 5. On 8/10/23 at 10:12 a.m., Resident 6's record was reviewed. His diagnoses included, but were not limited to, acquired absence of right leg below the knee (amputation), chronic obstructive pulmonary disease (COPD), peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs), intermittent asthma (spasms in in the bronchi of the lungs causing difficulty in breathing), and chronic pain syndrome. A review of Resident 6's Minimum Data Set (MDS) indicated on 11/11/22, 2/11/23, and 5/14/23, Resident 6's MDS' were inaccurate. He had his AKA amputation on 10/31 /23 and was still reported as a below the knee amputation (BKA) on those dates. All three indicated he had an, "acquired absence of right leg below knee." A nursing progress note, dated 11/3/22 at 11:03 p.m., Resident 6 returned from the hospital after an AKA of the left leg. He came by ambulance with 2 paramedics via a stretcher. A pain care plan, dated 9/26/22, indicated		Action Plan will be monitored by the Administrator weekly until resolved. **By what date the systemic changes for each deficient will be completed.** September 8, 2023	

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	Resident 6 had the potential for pain due to a right BKA. Interventions included pain medications as ordered, notify medical doctor of uncontrolled pain, and observe for effectiveness of the intervention. An Activities of Daily Living (ADL) care plan, dated 9/24/22, indicated Resident 6 required staff assistance with ADLs due to impaired balance and right BKA. An intervention indicated for the resident to complete as much as he was able to do. An amputation care plan, dated 10/20/22, indicated Resident 6 had a right below the knee (BKA) amputation. Monitor for signs and symptoms of infection. On 8/11/23 at 10:17 a.m., the Director of Nursing (DON) indicated Resident 6's diagnoses and care plans were resident centered and up-to-date as the resident changed. On 8/11/23 at 10:40 a.m., the DON indicated the MDS information should have been updated after Resident 6's 10/31/22 AKA amputation. On 08/11/23 at 11:23 a.m., the MDS Coordinator (MDSC) indicated she did not catch the change in condition for Resident 6 after his surgery. He left the facility on 10/31/22 for an above the knee amputation. She indicated the hospital notes and the admission assessment were available to her. Both indicated the resident experienced an above the knee amputation and she just missed it. She indicated it was human error. On 8/11/23 at 11:33 a.m., Resident 6's admission assessment, dated 11/3/22, indicated, Under Head to Toe Assessment that the resident had a			

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	surgical incision due to a right above the knee amputation (AKA amp). On 8/11/23 at 11:41 a.m., the Executive Director (ED) indicated her expectation was for the staff to follow the hospital discharge summary and correlation the new information with the resident's record. A current policy, titled, "Baseline Care Plan/Comprehensive Care Plans," dated 9/18/18, was provided by the DON, on 8/10/23 at 8:25 a.m. A review of the policy indicated, " ...The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues ...." During a review of CMS's Long-Term Care Facility Resident Assessment Instrument 3.0, Version 1.16, dated October 2018, indicated, " ...Federal regulations ...require that (1) the assessment accurately reflects the resident's status ...." 3.1-31(c)(1) 3.1-35(a) 3.1-35(c)(1)			
F 0657 SS=D 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.			

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	(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 record review and interviews, the facility failed to revise a care plan for a resident that did not smoke cigarettes for 1 of 6 residents reviewed for smoking (Resident 31). Findings include: During an interview with Resident 31 on 8/10/23 at 3:05 p.m., he indicated he did not smoke. He indicated the facility told him that for him to leave the building, he needed to have a smoking assessment. On 8/9/23 at 9:45 a.m., a comprehensive record review was conducted. His diagnoses included but were not limited to paraplegia, anemia, essential hypertension, unspecified injury at T2-T6, and pressure ulcers.	F 0657	It is the policy of the facility to ensure that residents care plan is revised as needed for residents who do not smoke. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #31 care plan was corrected to indicate resident is a non-smoker. 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 that smoke in the facility have the potential to be affected by the alleged deficient	09/08/2023

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	A smoking assessment was completed on 6/2/23. The assessment indicated he did not smoke. Resident 31 had a care plan dated 1/27/23 indicating he was a smoker. A policy titled "Baseline Care Plan Assessment/Comprehensive Care Plan" was provided by the RNC (Regional Nurse Consultant) on 8/11/23 at 2:37 p.m., it indicated, " ...The comprehensive care plan will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues ....". 3.1-35(c) 3.1-35(l)		practice. MDS Coordinator or designee completed a facility wide audit on 8/30/23 to compare residents smoking assessments are accurate with resident's care plans. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The Director of Nursing or designee completed education with MDS coordinator on 8/30/23 related to accuracy of smoking assessments and care plans related to smoking. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. The Director of Nursing or designee will complete a smoking assessment and care plan audit weekly to verify care plans are accurate with smoking assessments. 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 Smoking Assessment and Accurate Care plan Audit Tool will be comp It is the policy of the facility to ensure that residents care plan is revised as needed for residents who do not smoke. Completed *1x week x 6 months.* If the facility is within 95%	

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			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. September 8, 2023	
F 0689 SS=E 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 observations, interviews and record reviews, the facility failed to ensure residents did not keep smoking materials independently against facility policy and without appropriate assessment or monitoring, and failed to ensure person-centered assessments and care plans revisions were implemented for 9 of 9 residents reviewed for accidents, (Residents 21, 29, 106, 43, 108, 34, 41, 6 and 105).	F 0689	It is the policy of the facility to ensure that the resident environment remains as free of accident hazards as is possible; and that each resident receives adequate supervision and assistance devices to prevent accidents. What corrective action will be	09/08/2023

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	Findings include: 1. On 8/7/23 at 10:14 a.m., Resident 21 was observed in her room on Hope Springs Hall, a secured memory care unit (SMC). She was reclined in her bed with the head of her bed (HOB) elevated. She wore a nasal canula connected to a concentrator which ran on 4 liters (L). There was a rolling bedside table next to her cluttered with several items which included, but was not limited to, a black lockbox with a key in the lock. The key had a green covering and a tag with her name. When asked about her box, Resident 21 indicated she kept her money, cigarettes, lighter and other valuable items such as some of her rings. On 8/8/23 at 9:32 a.m., Resident 21 was assisted to the SMC courtyard with her peers for a smoke break. Once outside, Resident 21 opened her lockbox, pulled out a pack of cigarettes and a lighter. The Activity Director (AD) walked over. Resident 21 handed her the lighter and the AD lit the cigarette for Resident 21, placed the lighter back in her box and continued to assist other residents. During an interview on 8/8/23 at 9:35 a.m., the AD indicated, Resident 21 was allowed to keep her own smoking material, because she preferred to. As the AD spoke, Resident 28 interrupted and indicated, "yea, she's allowed to keep her stuff but nobody else is." Resident 21 indicated back to Resident 28, it wasn't her business and to "shut her mouth." The AD changed the subject and the resident continued to smoke without incident. On 8/9/23 at 10:13 a.m., Resident 21 was observed. She laid on her bed with her eyes closed. Her lockbox was observed at the foot of her bed. The		accomplished for those residents found to have been affected by the deficient practice Resident 21, 29, 34, 43, 6, 41, 108, 105, and Resident 106 utilize leave of absence. **It is the practice of the facility that smoking paraphernalia be secured by facility staff. Furthermore, it is the policy of the facility to ensure substantial compliance regarding resident rights. Therefore, searching residents for paraphilia upon return from leave of absence is not facility practice. Facility has provided those residents who utilize LOA policy, secured locked boxes for residents to secure personal property in to ensure resident environment remains as free of accident hazards as is possible by 8/15/23, and as needed.** 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 that currently reside in the facility have the potential to be affected by the alleged deficient practice. Activity director or designee will complete a facility wide audit to verify residents that utilize leave of absence(s) have assigned, secured locked box and that (if) any paraphernalia is identified, resident will be educated on facility practice that	

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	key was inside the lock. Her bedroom door was open. During an interview on 8/10/23 at 9:47 a.m., the Executive Director (ED) indicated, Residents were not permitted to keep smoking materials in their rooms, and staff were responsible for storage of smoking materials, especially memory care residents. On 8/11/23 at 11:19 a.m., Resident 21 was observed. She was seated in her WC outside of her room with her lockbox on her lap. The ED was on the unit and Resident 21 asked if she could go to smoke because she missed the morning smoke break. The ED indicated she had been asleep when they went out for the first break and did not want to wake her. Resident 21 began tearful and asked if she could go out at that time. The ED indicated she would help her out to smoke, in just a few minutes. On 8/8/23 at 2:40 p.m., Resident 21's medical record was reviewed. She was a long-term care resident who resided on the HSMC unit. She had diagnoses which included, but were not limited to, dementia (a degenerative brain disease which affects memory), bipolar (a mental illness which can causes radial and unpredictable mood swings), and Schizophrenia (a chronic brain disorder that affects a person's ability to think, feel, and behave clearly). Resident 21 signed a Smoking Policy agreement on 6/30/22. The agreement indicated, "All smoking materials will be secured with the staff upon the resident's return ..." She had a comprehensive care plain initiated 7/25/22 which indicated she required supervision		smoking paraphernalia should be secured by facility staff. Additionally, care plan of resident will be updated to reflect non-compliance and resident preference to be honored as applicable, by 8/25/2023. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not reoccur Administrator educated Activity Director, activity department, and all staff on facility policy to ensure that the resident environment remains as free of accident hazards as is possible; and that each resident receives adequate supervision and assistance devices to prevent accidents on 8/23/23. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. Activity Director or designee will complete “Secured Safe for Personal Items” audit to ensure that the resident environment remains as free of accident hazards as is possible; and that each resident receives adequate supervision and assistance devices to prevent accidents weekly or more, as needed. How the corrective action will be monitored to ensure the deficient	

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	155717	A. BUILDING 00 B. WING	08/11/2023

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	to smoke. An intervention for this care plan included, but was not limited to, "residents and staff members are placing cigarettes, lighters, and all other smoking related materials securely at the nurses' station after each use." A nursing progress note dated 6/21/23 at 12:01 p.m., indicated, "Required secured lock unit related to little or no safety awareness." The record lacked documentation of assessment/s for her ability to hold smoking materials independently. 2. On 8/8/23 at 10:30 a.m., a comprehensive record review was conducted for Resident 29. She had the following diagnoses but not limited to chronic viral hepatitis C, atrial fibrillation (irregular heart rate), dysphagia (difficulty swallowing), generalized anxiety disorder, hearing loss, anemia, muscle weakness, depression, GERD (gastro-esophageal reflux), neuralgia (nerve pain), vitamin deficiency and heart failure. During an interview with Resident 29 on 8/7/23 at 10:32 a.m., she indicated she smoked cigarettes. She indicated she kept her cigarettes and lighter in a locked box in her room. Resident 29 had a smoking assessment completed on 7/11/23. The assessment determined she did not require any interventions to smoke; therefore, she was independent with smoking. Resident 29 had a care plan dated 9/21/22 indicating she smoked. The care plan was not individualized regarding locking her cigarettes and lighter in a box in her room. 3. A comprehensive record review was completed on 8/8/23 at 2:32 p.m. Resident 34 had the		practice will not recur, i.e what quality assurance program will be put into place “Secured Safe for Personal Items” audit tool will be completed 5 days a week x 4 weeks,3 days a week, x 2 months, then weekly 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. 9/8/23	

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	155717	A. BUILDING 00 B. WING	08/11/2023

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	following diagnoses, but not limited to COPD (Chronic Obstructive Pulmonary Disease, GERD (Gastroesophageal Reflux Disease), overactive bladder, essential hypertension, cognitive communication deficit, major depression disorder and insomnia. During an observation on 8/7/23 at 11:06 a.m., Resident 34 was observed to have a red lighter and Pall Mall menthol cigarettes on his bedside table. He indicated he always keeps his smoking material with him. Resident 34 had a smoking assessment completed on 6/6/23. The assessment determined he required a smoking apron when he smoked. Resident 34 had a care plan dated 11/24/21 indicating he was a "smoker." The care plan was not individualized regarding him keeping his smoking materials in his room unsecure. 4. During an observation on 8/7/22 at 10:40 a.m., Resident 43 was sitting on his bed. He had a white lighter and Pall Mall cigarettes sitting on his bedside table. He indicated he always keeps his cigarettes and lighter with him. A comprehensive record review was completed on 8/9/23 at 3:15 p.m. He had the following diagnoses, but not limited to nicotine dependence, COPD (Chronic Obstructive Pulmonary Disease)), unsteadiness on feet, generalized anxiety disorder, and major depression. Resident 43 had a smoking assessment completed on 6/22/23. The assessment indicated he was independent with smoking.			

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	He had a care plan dated 8/21/22 indicating he was a "smoker." The care plan was not individualized regarding having his cigarettes with him at bedside.5. On 8/7/23 at 10:25 a.m., a box of cigarettes and a lighter were observed on Resident 6's over the bed table. He was in bed with his eyes closed. On 8/10/23 at 12:03 p.m., Resident 6 was observed in the hallway with a cigarette behind one ear. The Maintenance man (MM) 12 was pushing him to his room. While in his room, the cigarette was still behind his ear. The Director of Nursing (DON) was in the room with Resident 6 and did not say anything to him about the cigarette behind his ear. On 8/10/23 at 10:12 a.m., Resident 6's record was reviewed. His diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs), intermittent asthma (spasms in in the bronchi of the lungs causing difficulty in breathing), acquired absence of right leg above the knee (amputation), and chronic pain syndrome. A current smoking care plan, dated 11/9/22, indicated he was a smoker who would be compliant with the facility smoking policy. He would be supervised during smoking. A current smoking care plan, dated 4/19/23, indicated he was in non-compliance with the facility smoking policy. If materials were found, the resident would receive a 30 day discharge notice and the smoking materials would be turned in immediately. Department manager would perform room inspections weekly. A current smoking care plan, dated 6/5/23,			

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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
	indicated Resident 6 met facility policy to be an independent smoker. A physician's order, dated 11/16/22, indicated Resident 6, "may smoke in accordance with the facility smoking policy." His smoking assessment, dated 6/22/23, indicated this evaluation was used to determine the resident's needs during supervised smoking. It indicated he used cigarettes, and was independent to hold and handle the cigarette, had a ability to dispose of ashes in the ashtray and extinguish the cigarette. The determination was the resident did not need a smoking apron, cigarette holder, someone to light or extinguish his cigarette, someone to retrieve it if dropped, and did not need one on one assistance. 6. On 8/8/23 at 12:47 p.m., Resident 41 was observed opening the exit door. He had used the codes to unlock the door. He indicated the knew the exit door codes and was an independent smoker. He kept his cigarettes and lighter in his room. On 8/9/23 at 11:16 a.m., Resident 41 indicated he was an independent smoker, that was why he had the door codes to get outside. His diagnoses included, but were not limited to, hemiplegia and hemiparesis following a stroke on his non-dominate side (paralysis and weakness on one side of the body), chronic congestive heart failure (weakness of the heart resulting in fluid buildup), COPD, intermittent asthma and angina pectoris (chest pain or discomfort due to coronary heart disease). A current smoking care plan, dated 4/13/23,			

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	155717	A. BUILDING 00 B. WING	08/11/2023

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	indicated he was a smoker who would be compliant with the facility smoking policy. He would be supervised during smoking. A physician's order, dated 7/21/23, indicated Resident 41, "may smoke in accordance with the facility smoking policy." His smoking assessment, dated 7/20/23, indicated this evaluation was used to determine the resident's needs during supervised smoking. It indicated he used cigarettes, and was independent to hold and handle the cigarette, had a ability to dispose of ashes in the ashtray and extinguish the cigarette. The determination was the resident did not need a smoking apron, cigarette holder, someone to light or extinguish his cigarette, someone to retrieve it if dropped, and did not need one on one assistance. 7. On 8/9/23 at 11:21 a.m., Resident 108 indicated she was an independent smoker and kept her cigarettes and lighter in her room. Her diagnoses included, but were not limited to, acute and chronic respiratory failure with hypercapnia (inability in breathe adequately resulting in increased carbon dioxide in the blood), COPD, chronic congestive heart failure. Her smoking care plan, dated 4/4/23, indicated she was a smoker who would be compliant with the facility smoking policy. She would be supervised during smoking. A physician's order, dated 4/25/23, indicated Resident 108, "may smoke in accordance with the facility smoking policy." Her smoking assessment, dated 4/26/23, indicated			

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	this evaluation was used to determine the resident's needs during supervised smoking. It indicated she used cigarettes, and was independent to hold and handle the cigarette, had a ability to dispose of ashes in the ashtray and extinguish the cigarette. The determination was the resident did not need a smoking apron, cigarette holder, someone to light or extinguish his cigarette, someone to retrieve it if dropped, and did not need one on one assistance. 8. On 8/7/23 at 11:05 a.m., Resident 105 indicated she kept her cigarettes and lighter in her rollator (walker with storage and seat) basket. On 8/9/23 at 11:27 a.m., Res 105 indicated she was an independent smoker. She had the door code to exit the building to smoking independently. She indicated her cigarettes and lighter were in the room. Her diagnoses included, but were not limited to, bipolar disorder (mental condition with alternating periods of elation and depression), opioid dependence, and attention-deficit hyperactivity (trouble paying attention, controlling impulsive behaviors and /or be overly active). Her smoking care plan, dated 8/7/23, indicated she was a smoker who would be compliant with the facility smoking policy. She would be supervised during smoking. A physician's order, dated 8/7/23, indicated Resident 108, "may smoke in accordance with the facility smoking policy." Her smoking assessment, dated 8/7/23, indicated this evaluation was used to determine the resident's needs during supervised smoking. It			

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	indicated she used cigarettes, and was independent to hold and handle the cigarette, had a ability to dispose of ashes in the ashtray and extinguish the cigarette. The determination was the resident did not need a smoking apron, cigarette holder, someone to light or extinguish his cigarette, someone to retrieve it if dropped, and did not need one on one assistance. 9. On 8/7/23 at 10:53 a.m., Resident 106 indicated she was an independent smoker and was able to keep her cigarettes and lighter in her room. On 8/11/23 at 12:17 p.m., Resident 106's record was reviewed. Her diagnoses included, but were not limited to, schizophrenia (mental disorder with a breakdown of thought, emotion and behavior, leading to faulty perception) encephalopathy (functioning of the brain is affected by some agent), dementia (mental process or loss of intellectual functioning, often with personality changes), seizures (sudden attack of illness epileptic fit)), COPD, atrial fibrillation (common type of heart arrhythmia), and shortness of breath. Her smoking care plan, dated 8/4/23, indicated she was a smoker who would be compliant with the facility smoking policy. She would be supervised during smoking. A physician's order, dated 8/5/23, indicated Resident 106, "may smoke in accordance with the facility smoking policy." Her smoking assessment, dated 8/4/23, indicated this evaluation was used to determine the resident's needs during supervised smoking. It indicated she used cigarettes, and was independent to hold and handle the cigarette, had a ability to dispose of ashes in the ashtray and			

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	extinguish the cigarette. The determination was the resident did not need a smoking apron, cigarette holder, someone to light or extinguish his cigarette, someone to retrieve it if dropped, and did not need one on one assistance. A current policy, titled, "Smoking Policy," with no date, was provided by the facility. A review of the policy indicated, " ...All residents' smoking materials will be kept by the facility in a secure location ...all residents will be under supervision while smoking ...Smoking monitors will hold lighters for ignition of cigarettes ...Smoking materials will be kept in a safe/secure location within the facility under staff control ...Residents will have no smoking materials in their possession. This includes lighters ...Smoking materials may be accepted by the Administrator/SSD (Social Services Director)/Charge Nurse ...All smoking materials will be held in the facility smoking cart/receptacle (secured) ... Smoking materials will be labeled so as to keep an accurate inventory of each resident's supplies ...The facility will determine designated smoking locations and times ...Smoking areas/times are to be posted ...Residents who go out to smoke must sign out and sign back in with the assistance of the person supervising their smoking ...." 3.1-45(a)(1) 3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a			

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	resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observations, interview and record review, the facility failed to ensure a resident, (Resident 44) with a history of weight loss, was provided with an upgraded diet as prescribed by his physician, weekly weights were obtained as ordered and failed to provide adaptive or alternative snacks/hydration during the scheduled snack activities for 1 of 2 residents reviewed for hydration/nutrition. Findings include: On 8/7/23 the Hope Spring Memory Care (HSMC) unit activity calendar indicated the activity scheduled for 10:30 a.m. every morning from 8/7/23 - 8/10/23, was "Hydration Cart/Snacks." On 8/7/23 at 10:40 a.m., Resident 44 was observed. He paced up and down the hall, and in and out of the dining room. At that time, an Activity Assistant entered the unit with a rolling cart. The cart was observed to have insulated pitchers of coffee and ice pitchers of juice. There were also a	F 0692	**F 692** It is the policy of the facility to ensure residents received prescribed diet, weekly weights as ordered, and are provided alternative snacks/hydration during scheduled snack activities. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice** Resident #44's tray ticket was updated to indicate the correct diet orders. Weekly weights were obtained on 8/9/2023 and weekly thereafter. Weekly weights to continue per physician order. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**	09/08/2023

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	variety of individually wrapped snacks. There were no puree and/or mechanical soft options. Resident 44 was not offered a snack or drink. On 8/8/23at 9:32 a.m., Resident 44 was observed as he finished his breakfast tray. The divided plate was observed to have pureed contents. On 8/8/23 at 10:53 a.m., several residents were observed as they finished a snack activity. Resident 44 paced up and down the hall. An Activity Assistant, seated by the snack cart indicated, Resident 44 had not gotten a snack because he kept walking up and down the hall. When asked if there were diabetic options and/or options for residents on a puree or mechanical soft diet, the Activity Assistant indicated she did not know, she would have to ask the nurse. On 8/8/23 at 12:26 p.m., Resident 44 was given a divided lunch plate with puree food. His plate and portions were observed to be identical to a peer's plate which was also purree. He was not observed to have double portions as his ticket indicated. On 8/9/23 at 12:26 p.mm., Resident 44 received a divided plate with puree lunch. Double portions were not observed. On 8/11/23 at 10:34 a.m., An Activity Assistant entered the unit with the snack/hydration cart. Resident 44 was observed as he paced throughout the unit, per his baseline observed during the survey period. There were no puree and/or mechanical soft options. Resident 44 was not offered a snack or drink. On 8/10/23 at 2:00 p.m., Resident 44's medical record was reviewed. He was a long-term care resident who resided on the Hope Spring Memory		All residents that currently reside in the facility have the potential to be affected by the alleged deficient practice. The Director of Nursing or designee will complete a facility wide Individual weight order audit, following physician diet order audit, and providing alternative snacks audit on all residents to identify residents who have orders for weekly weights and alternative diets on 8/30/23 **What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.** The Director of Nursing or designee completed education with activity staff on 8/30/23 related to altered diets and providing altered diet snacks to residents who have physician orders for altered diets. The Director of Nursing or designee completed education with nursing staff on 8/30/23 related to obtaining weekly weights per physician orders. The Executive Director or designee completed education with dietary staff on 8/30/23 related to reviewing tray tickets and providing double portions per physician orders. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. **How the corrective action will**	

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	Care (HSMC) secured unit. He had diagnoses which included, but were not limited to, Alzheimer's disease, (a degenerative brain disease that affects memory), generalized anxiety and insomnia. He had current physician's orders which included, but were not limited to; a. Weekly weights, for 4 weeks, started on 7/5/23. b. General diet, mechanical soft, ground meat texture, thin liquids with double portions at all meals. His weights were reviewed in his vital set log. a. On 7/5/23 at 10:50 a.m., he weighted 128 pounds. b. the record lacked documentation of a weekly weight on 7/12/23. c. the record lacked documentation of a weekly weight on 7/19/23. d. On 7/26/23 at 11:14 a.m., he weighed 133 pounds. e. On 8/2/23 at 1:10 p.m., he weighed 133 pounds f. On 8/9/23 at 11:09 a.m., he weighted 128 pounds, (a 5 pound weight loss in one week). He had a comprehensive care plan, initiated 10/14/22, which indicated, Resident 44's nutritional status was compromised secondary to his diagnoses of Alzheimer's, depression, vitamin deficiency. He had a history of significant weight loss. Interventions for the care plan included, but were not limited to, prepare and serve the resident's nutritional diet as ordered, determine food preferences through one-to-one interview and or family interview and weight the resident as ordered. A therapy progress note dated, 7/3/2023 at 4:30 p.m., indicated, Resident 44's daughter inquired		**be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place.** *Weekly Weight Audit Tool, Following Physician Order Related to Diet Audit Tool, and Providing Alternative Diet Snacks Audit Tool will be completed on all weekly weight orders 5 days a week x 4 weeks,3 days a week, x 4 weeks,, then weekly 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.** September 8, 2023	

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	about his puree diet. It was explained, the goal was to continue to trial mechanical soft food with resident and upgrade as appropriate. A Speech Therapy Communication Form, dated 7/5/23 indicated, "upgrade to mechanical soft, ground meat diet, remain on thin liquids, still double portions for all three meals." A Diet progress note dated, 8/10/2023 at 3:20 p.m., indicated, he was being reviewed for weight loss. He had a history of weight fluctuations. He had a good appetite but did a lot of walking throughout the day. On 8/10/23 at 8:25 a.m., the Director of Nursing (DON) provided a copy of current, but undated facility policy titled, "S.W.A.T. Program, Skin and Weight Assessment Team). The policy indicated, "It is the policy of the facility to assess the nutritional status of each resident. SWAT is designed to aggressively review and address those residents exhibiting significant weight change or skin breakdown ...." 3.1-46			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			

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	A. Based on observation, interview, and record review, the facility failed to ensure respiratory equipment was properly replaced, stored and placed on a residents for 3 of 4 residents reviewed for respiratory care (Residents 21, 34, and 2). B. Based on observation, interview, and record review, facility failed to clean the filter of a specialized oxygen concentrator and ensure an ambu-bag was readily accessible at bedside for a resident, who was dependent on respiratory and tracheostomy for 1 of 1 resident reviewed for tracheostomy care (Resident 26). Findings include: A1. On 8/7/23 at 10:14 a.m., Resident 21 was observed in her room on Hope Springs Hall, a secured memory care unit. She was reclined in her bed with the head of her bed (HOB) elevated. She wore a nasal canula connected to a concentrator which ran on 4 liters (L). There was a rolling bedside table next to her. The table was cluttered with several items which included, but was not limited to: a small, personal nebulizer with an attached nebulizer mask. The mask and tubing were dated 5/12/23 and was not bagged. The mask rested on the wood of the table. There was a portable oxygen tank on the back of a wheelchair (WC) which was observed at the foot of her bed. The oxygen tubing/nasal cannula from the portable tank was observed coiled and unbagged, on the floor. The tubing was dated 7/7/23. On 8/7/23 at 10:38 a.m., an unidentified nursing staff member was observed as she replaced and dated the oxygen concentrator tubing. The date read 8/3/23. When asked why it was dated for the previous week, she indicated, that was when it had been changed, but they must have forgotten	F 0695	It is the policy of the facility to ensure respiratory equipment is properly replaced and stored. It is the policy of the facility to ensure the oxygen concentrator filters are cleaned per manufacturers guidelines and that ambu-bags are readily accessible at bedside for residents with tracheostomies. What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident #26 Oxygen concentrator filter was cleaned and ambu-bag was placed at bedside. Resident #21 nebulizer mask, Nebulizer Tubing, and Oxygen tubing were replaced and bagged. Resident #34 Nebulizer Mask was replaced, dated and bagged, Resident #2 Oxygen Supply bag was replaced. 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 that currently reside in the facility and utilize respiratory equipment have the potential to be affected by the alleged deficient practice. Director of Nursing or designee completed audit on 8/30/23 for all residents that currently utilize respiratory supplies and equipment for proper dating, storage and cleaning. What measures will be put in place and what systemic changes	09/08/2023

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	to date it. At that time, Resident 21 was observed seated in her WC, and wore the nasal cannula attached to her portable tank. The tubing from the portable tank was dated still dated 7/7/23. During an interview on 8/7/23 at 10:40 a.m., Registered Nurse (RN) 45 observed the portable tank and tubing. She indicated it was out of date and needed to be replaced. She indicated staff were supposed to replace oxygen tubing and equipment as needed and at least weekly on Thursdays on the evening shift. On 8/8/23 at 9:32 a.m., Resident 21 was assisted to the courtyard with her peers for a smoke break. The Activity Director (AD) stopped Resident 21 at the door, helped her remove her NC and portable oxygen tank, and placed it on the floor by the door so that the tubing and nosepiece touched the floor. On 8/8/23 at 9:48 a.m., Resident 21 finished her smoke break and was assisted back inside by the AD. Inside the door, she replaced the portable oxygen tank on the back of the WC, and replaced the tubing, which had been on the floor, back into Resident 21's nose. On 8/8/23 at 2:40 p.m., Resident 21's medical record was reviewed. She was a long-term care resident. She had diagnoses which included, but were not limited to, dementia (a degenerative brain disease which affects memory), COPD (a group of diseases that cause airflow blockage and breathing-related problems, often making it difficult to breath). She had current physician's orders, which included, but were not limited to: a. Change oxygen tubing and bottle, clean filter		will be made to ensure that the deficient practice does not recur. The Director of Nursing or designee completed education with nursing staff 8/30/23 related to respiratory equipment including dating, storage, and cleaning of equipment. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively 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, *Respiratory equipment dating, storage, and cleaning audit toolwill be completed 5 days/week on 5 random residents x4 weeks, 3 days/week on 3 random residents x 4 weeks, then random residents weekly for 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	

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	weekly on Thursdays b. Nebulizer mask and tubing- change weekly on Tuesdays A nursing progress note, dated 6/2/23 at 12:39 p.m., indicated Resident 21 had a change in her condition. She was unresponsive and short of breath. Her oxygen saturation level was only 91% even though her oxygen was increased to 6 liters per minute. She was sent to the Emergency Room (ER). A (late entry) physician's progress note dated, 6/14/23 at 10:38 p.m., indicated Resident 21 had been seen for readmission after a hospital stay where she was diagnosed with pneumonia, and COPD exacerbation.A2. A comprehensive record review was completed on 8/8/23 at 2:32 p.m. Resident 34 had the following diagnoses, but not limited to COPD (Chronic Obstructive Pulmonary Disease, GERD (Gastroesophageal Reflux Disease), overactive bladder, essential hypertension, cognitive communication deficit, major depression disorder and insomnia. During and observation on 8/7/23 at 10:32 a.m., Resident 34 had his nebulizer mask propped up on the drawer of his nightstand. The mask was not bagged. Resident 34 had a care plan dated 10/11/22 indicating he was noncompliant with nebulizer treatments, refusal of medications. He also had a care plan, dated 7/25/22, indicating he refuses smoking cessation interventions such as lozenges and nebulizer treatment for COPD. A3. A comprehensive record review was completed on 8/8/23 at 2:00 p.m. for Resident 2. She had the following diagnoses, but not limited		completed. September 8, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. BUILDING 00 B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALPHA HOME - A WATERS COMMUNITY	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

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	to type II diabetes, neuropathy, essential hypertension, mild cognitive impairment, peripheral vascular disease, depression, and hyperlipidemia. During an observation on 8/7/23 at 11:05 a.m., Resident 2 had an oxygen supply bag attached to her oxygen concentrator. The bag was dated 7/22/23. Resident 2's medical record lacked a care plan related to oxygen usage. She had an order for oxygen at 2 liters per minute per nasal cannula. A policy titled, "Oxygen Administration," was provided by the ED (Executive Director) on 8/8/23 at 3:05 p.m. It indicated, " ...At regular intervals, check and clean oxygen equipment, masks, tubing, and cannula ...."B. On 8/7/23 at 10:20 a.m., Resident 26 was observed in her bed with her eyes closed. She did not respond to vocal questions. Her oxygen concentrator was observed, the filter had a very thick layer of dust, it was set to provide 28% oxygen to the tracheal opening in her neck. Several boxes of oxygen and tracheal supplies were observed in the corner of her room. On top of an open box, farthest from the resident, was an ambu-bag (hand held device commonly used to provide positive pressure ventilation to patients who are not breathing), still in its original packaging. On 8/7/23 at 10:25 a.m., Licensed Practical Nurse (LPN) 8 indicated Resident 26's oxygen concentrator was set to deliver 28% oxygen. On 8/8/23 at 10:31 a.m., Resident 26's oxygen concentrator filter was observed to have a very thick layer of dust. Her ambu-bag was not at her bedside. It was still in the corner of the room, on			

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	top of an open box of oxygen and tracheal supplies. On 8/9/23 at 10:52 a.m., Resident 26's oxygen concentrator filter was observed to have a very thick layer of dust. Her ambu-bag was not at her bedside. It was still in the corner of the room, on top of an open box of oxygen and tracheal supplies. On 8/9/23 at 11:05 a.m., the Maintenance Technician 12 indicated he did not service her oxygen concentrator. On 8/9/23 at 12:10 p.m., the Director of Nursing (DON) indicated Resident 26's oxygen filter was dirty and should have been cleaned. She was observed to scrape away some of the thick layer of dust with her fingernail, exposing the black filter under it. She indicated the ambu-bag was in the room, but should have been at the resident's bedside. On 8/10/23 at 12:02 p.m., the DON indicated the resident did not need tracheal suctioning everyday and it was unnecessary to put the resident through it. On 8/8/23 at 10:12 a.m., Resident 26's record was reviewed. Her diagnoses included, but were not limited to, anoxic brain damage (damage to the brain due to lack of oxygen), tracheostomy status (opening in windpipe to relieve obstruction when breathing), seizures (sudden attack of illness, epileptic fit), altered mental status (this condition causes changes in consciousness), cognitive communication deficit, aphasia (loss of ability to understand or express speech due to brain damage), dyspnea (difficult or labored breathing), oropharyngeal dysphagia (impairment in the			

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	production of speech due to brain damage), and personal history of cardiac arrest. Her physician order's indicated to: a. Suction trachea every shift and as needed for oxygen care. b. Clean her oxygen concentrator filter once weekly, every Thursday, during the night shift and as needed. c. Keep an ambu-bag at the resident's bedside, in case of emergency. d. Keep call light in reach. A care plan, dated 8/30/22 with revisions, indicated Resident 26's potential for ineffective airway clearance due to building of trachea-laryngeal secretions in the tracheostomy tube indicated to perform tracheostomy care every day and as needed and perform frequent pulmonary toileting (suctioning of the airways, changing body position and vigorous coughing) to main the airway. Assess for signs and symptoms of dyspnea, stridor (harsh or grating sound when breathing caused by obstruction), and cyanosis (bluish discoloration of the skin due to inadequate oxygenation of the blood). Suction the resident's tracheostomy tube and mouth as indicated, every shift and as needed. A care plan, dated 8/30/22 with revisions, indicated Resident 26 had a tracheostomy related to anoxic brain injury. She will have no signs and symptoms of infection through the review date. Using universal precaution, suction as necessary. On 8/10/23 at 11:33 a.m., the DON indicated the manufacturer's manual was the policy for Resident 26's oxygen concentrator and her machine also provided humidity to the oxygen she received.			

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	A current operator's manual, titled, "Drive Model 18450 Heavy Duty 50 PSI Compressor Operator's Manual, with no date, was provided by the DON, on 8/9/23 at 2:05 p.m. A review of the operator's manual indicated, " ...Replacing cabinet filter ...Perform this procedure as needed. Replace every 12 months or as needed. Frequency will depend upon environmental conditions ...The rear filter may be periodicaly [sic] rinsed with water to remove any debris or dust. Let air dry before replacing ...." 3.1-47(a) 3.1-47(a)(4) 3.1-47(a)(5) 3.1-47(a)(6)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to ensure a resident with a diagnosis of dementia was provided alternative or adaptive activities for 1 of 2 residents reviewed for dementia care (Resident 40). Findings include: On 8/7/23 the Hope Spring Memory Care (HSMC) unit activity calendar indicated the activity scheduled for 10:30 a.m. was "Hydration Cart/Snacks." On 8/7/23 at 10:37 a.m., Resident 40 was observed	F 0744	It is the policy of the facility to ensure a resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. What corrective action will be accomplished for those residents found to have been affected by the deficient practice Resident 40 person centered care plan updated to reflect current	09/08/2023

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	in her room. She laid in her bed with her eyes closed. There was no music or radio. Her T.V was off and unplugged from the power outlet. At that time, an Activity Assistant entered the unit with a rolling cart. The cart was observed to have insulated pitchers of coffee and ice pitchers of juice. There were also a variety of individually wrapped snacks. On 8/7/23 the HSMC activity calendar indicated the activity scheduled for 11:00 a.m. was "Residents Choice." During a continuous observation on 8/7/23 from 11:00 a.m. until 12:25 p.m., no group activities or one-to-one activities were observed on HSMC, and Resident 40 remained in her room with no music and her T.V. remained unplugged. On 8/7/23 at 12:25 p.m., an Activity Assistant entered HSMC with a rolling cart of various board and card games. Resident 40 was not invited to participate. During an interview on 8/7/23 at 12:30 p.m. the Medical Records (MR) Coordinator indicated Resident 40 could not participate any activities which involved snacks because she was unable to eat or drink anything by mouth. She had a short attention span as well, so she did not participate in many activities, but the MR Coordinator thought the Activity Staff were still coming back to do one-to-one activities with her. On 8/8/23 at 10:30 a.m., Resident 40 was observed. She walked up and down the hall by herself. During a continuous observation on 8/9/23 from 11:30 a.m. until 11:50 a.m., Resident 40 was observed as she received a nutritional tube		alternative/adaptive activities per resident preference. 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 diagnosis of dementia in facility have the potential to be affected by the alleged deficient practice. Activity Director or designee will complete facility wide audit to verify residents with dementia diagnosis are provided alternate or adaptive activities, as needed, per resident preference on 8/28/23 What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not reoccur Administrator educated Activity Director and activity department on facility policy to ensure a resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being in regards to alternate or adaptive activities, as needed, per resident preference on 8/23/23. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated.	

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	feeding with Registered Nurse, (RN) 14. During the observation Resident 40 remained in her bed with her door closed as RN 14 administered the feeding. During the observation, RN 14 indicated, she had not been on HSMC very long, so she was still getting to know most of the residents. Resident 40 was "NPO," which meant she could not eat or drink anything by mouth. Because of that, RN 14 tried to schedule her feedings around snack activities and lunch times so that Resident 40 would not be left out. While in Resident 40's room at that time, her T.V. was observed still unplugged from the power outlet. On 8/10/23 the Hope Spring Memory Care (HSMC) unit activity calendar indicated the activity scheduled for 1:00 p.m. was "Balloon game." Resident 40 was not invited. Throughout the survey period, there were two main activity calendars posted. One in the main population hallway outside of the Activity Room, and the second was posted in the HSMC dining room. The calendars were identical. On 8/11/23 at 10:34 a.m., Resident 40 was observed pacing through the unit. She wandered up and down the hall, and in/out of the activity/dining room area. An Activity Assistant entered the unit with a snack cart, and Resident 40 was assisted out of the dining room as she could not participate. No alternative activity was observed available. On 8/11/23 at 11:18 a.m., Resident 40's nails were observed with the Executive Director, (ED). Although her nails were observed to be neatly trimmed, the polish was faded, chipped, and almost peeled completely away on some of her fingers. The ED indicate it appeared that her nails		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. “Alternate/Adaptive Activities audit tool will be completed 5 days a week x 4 weeks,3 days a week, x 4 weeks, then weekly 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. 9/08/2023	

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	had been trimmed but not repolished. When asked if there were additional activities or sensory experiences for Resident 40 due to her being NPO and that she could not participate in many of the scheduled activities because of her NPO status, the ED indicated, it was her expectation that person-centered adaptations for activities should be implemented for Resident 40. On 8/8/23 at 12:00 p.m., Resident 40's medical record was reviewed. She was a long-term care resident who resided on the secured memory care unit. She had diagnoses which included, but were not limited to, vascular dementia (a degenerative brain disease that causes irreversible memory loss), aphasia (a language disorder that affects a person's ability to communicate) and dysphagia (a difficultly or inability to swallow) following a cerebral infarction (a stroke). She had current physician's orders to remain NPO (not to eat or drink anything by mouth) and to receive enteral feeding through a gastrostomy tube (also called a G-tube, which is a tube inserted through the belly that brings nutrition directly to the stomach). The most recent comprehensive assessment was an annual Minimum Data Set (MDS) assessment dated 7/1/23. The MDS indicated Resident 40 was severely cognitively impaired. An interview for her daily routines and activity preferences was conducted and the majority of the answers indicated, items were important to her but that she could not do or had no choice. An admission Activity Resident Interview, dated 2/25/23, (completed upon her return from an extended therapeutic leave with family) indicated she had participated in "music: activities in the			

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previous 7 days," and to "continue with activities of interest," but no additional activities of interest were noted.

A quarterly Activity Resident Interview, dated, 5/25/23, indicated she had participated in "aromatherapy" in the previous 7 days, and to "continue with activities of interest," but no additional activities of interest were noted, except for music.

On 8/10/23 at 10:45 a.m., the Activity Director (AD) provided a copy of Resident 40's activity participation logs and one-to-one activity log. The AD indicated, Resident 40 was no longer on one-to-one activity programming because she was invited or participated in group activities. The participation log for 8/9/23 indicated Resident 40 had received/participated in the 11:00 a.m. activity for "Nail Care," even though she had been observed throughout the activity period alone in her room as she received a g-tube feeding with RN 14.

A comprehensive care plan, initiated 7/21/22, indicated Resident 40 was non-verbal and enjoyed coloring activities, watching T.V. and listening to music. The care plan indicated she received one-to-one activity engagement at least 3 times a week. The interventions for the care plan were to reassess as needed and quarterly, staff to assist Resident as needed and to provide her with materials for coloring and reminders for music groups.

A comprehensive care plan, initiated 1/25/23, indicated Resident 40 was cognitively impaired, "low functioning," and non-verbal. She enjoyed music and dancing. Interventions for the care plan were to encourage and assist her with one-to-one

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	activities, provide individual-focused one-to-one sessions with an emphasis on sensory and environmental awareness, integration and stimulation, and to provide "low-functioning" activity programming. The comprehensive care plan lacked person-centered revision to indicated Resident 40 had been removed from one-to-one activities and/or what her additional preferences and interventions were. On 8/11/23 at 2:45 p.m., the Regional Director of Operations, (RDO), provided a copy of the facility memory care program description. The RDO indicated, although there was no specific Memory Care Unit or Activity policy, it was the facilities expectation, that structured, individualized, and adaptive activities/environment should be implemented as outlined in the program description. The documented was current, but undated, and titled, "Hope Springs Special Care Unit." The program included, but was not limited to, the following highlights, " ...Objectives: to provide a structured and therapeutic environment that can help to better cope with the cognitive decline and progression of Alzheimer's disease, or the dementia made present by other physiological causes ... Hope Springs provides activities structured specifically for functionally limited residents ... offers rich sensory stimulation ... Philosophy: we believe that activity serves as a powerful coping mechanism in times of fear and stress and provides a sense of connectedness and familiarity for our residents ... Activity programming: life enrichment programming built of strengths, NOT activity programming. Use a 24 hours plan and not a 30-day calendar ...." 3.1-37(a)			

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	155717	A. BUILDING 00 B. WING	08/11/2023

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F 0805 SS=D Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observations, record review and interviews, the facility failed to ensure that a resident received thicken liquids as ordered related to dysphagia for 1 of 7 Residents reviewed to appropriate dietary requirements (Resident 3). Findings include: During an observation on 8/11/23 at 11:23 a.m., a water pitcher was observed on Resident 3's nightstand and out of reach of the resident. It contained regular water. During an observation and interview on 8/11/23 at 11:33 a.m., the RNC (Regional Nurse Consultant) and DON (Director of Nursing) observed the water inside the water pitcher to be regular water. It was not NTL (Nectar Thickened Liquid). On 8/11/23 at 12:00 p.m., Resident 3's record review was conducted. She had the following diagnoses, but not limited to major depression, unsteadiness on feet, dysphagia, cognitive communication deficit, psychotic disorder with hallucinations, generalized anxiety disorder, dementia, essential hypertension, PTSD (Post Traumatic Stress Disorder), schizoaffective disorder bipolar type, and hyperlipidemia. Resident 3 had a diet order, dated 12/12/22, for a general diet, mechanical soft texture, and nectar consistency fluid.	F 0805	**It is the policy of the facility to ensure that residents receive thicken fluids as ordered** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice.** **The water pitcher containing regular water was immediately removed from Resident #3's room. Resident #3's order for Ensure was discontinued. Thickened liquids provided immediately.** **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 thickened liquid orders that currently reside in the facility have the potential to be affected by the alleged deficient practice. Director of Nursing or designee completed a facility wide audit on 8/28/2023 to verify residents who have thickened liquid orders have the correct fluid consistency at bedside. **What measures will be put in place and what systemic**	09/08/2023

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	155717	A. BUILDING 00 B. WING	08/11/2023

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	She had an order for ensure two times daily for a supplement. Resident 3 had a care plan, dated 10/12/22, indicating she had signs posted in room related to food and drink consistency. Mechanical soft diet and nectar thick liquids due to family preferences. The goal, dated 10/12/22, indicated Resident 3 would comply with food and drink consistency through review date of 9/5/23. During an 8/11/23 at 2:30 p.m., the RNC indicated ensure supplement was not considered nectar thick and will discontinue it and place an order for something appropriate for Resident 3. A fluid consistency policy was not provided by the end of the survey. 3.1-21(a)(3)		**changes will be made to ensure that the deficient practice does not recur.** The Director of Nursing or designee completed education with nursing staff related to thickened liquid orders on 8/30/23 Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively 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** *Thickened Liquid Audit tool will be daily 5 days a week x 4 weeks,3 days a week, x 4 weeks, then weekly 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.** September 9, 2023	