STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	03/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00428815, IN00428292, IN00428033 and IN00427600 Complaint IN00428815 - Federal /state deficiencies related to the allegations are cited at F584. Complaint IN00428292 - Federal /state deficiencies related to the allegations are cited at F584 & F677. Complaint IN00428033 - Federal /state deficiencies related to the allegations are cited at F584 & F808. Complaint IN00427600 - Federal /state deficiencies related to the allegations are cited at F584, F677 & F804. Survey dates: February 25, 26, 27, 28, 29 and March 1, 2, 2024 Facility number: 000091 Provider number: 155689 AIM number: 100290080 Census Bed Type: SNF/NF: 115 Total: 115 Census Payor Type: Medicare: 5 Medicaid: 71 Private: 6 Other: 33 Total: 115 These deficiencies reflect State Findings cited in	F 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the low scope and severity of these findings we respectfully request a desk review in lieu of a traditional revisit.**	

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

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	accordance with 410 IAC 16.2-3.1. Quality review completed on 3/8/24.			
F 0584 SS=E 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 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;			

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	§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 ensure comfortable water temperatures were provided for showers and/or peri care, even after grievances had been filed, for 2 of 3 units observed. (Cedar and Birch units) Findings include: 1. On 2/29/24 at 9:25 A.M., Resident G was observed in his room, in bed. The resident was alert to self. The resident's bathroom was observed and the water facet would only dispense cold water, even after leaving it on for more than 3 minutes. Resident G made no comment when asked about the cold water, just covered his head with his blanket. During an interview, on 2/29/24 at 9:46 A.M., Resident G's wife indicated the facility had been without warm or hot water for a month. She had observed staff to continually use cold water on him, and when they cleaned him up around his private parts, he would cry out. The wife indicated once, a CNA (not named) told him she was sorry the water was so cold. He went without showers due to no hot water. She had filed a grievance and was told they were working on it, but the conditions went on and it disturbed her to watch them clean him up with cold water. On 2/29/24 at 9:46 A.M., a review of the clinical	F 0584	**F584 – Safe/Clean/Comfortable/Homelike Environment** It is the practice of this facility to ensure comfortable water temperatures were provided for showers and/or peri care, even after grievances had been filed, for 2 of 3 units observed. (Cedar and Birch units) **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident G – has been provided showers and/peri care with comfortable water temperatures. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who reside on Cedar and Birch units have the potential to be affected by this deficient practice. All residents residing on Cedar and Birch have been reviewed to ensure that showers and/or peri care have been	03/22/2024

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	record for Resident G was conducted. The resident's diagnoses included but were not limited to: Huntington's Disease, depression and dementia. An Activities of Daily Living (ADL) Care Plan indicated the resident required assistance with ADLs due to weakness and need for personal care assistance. The interventions included but were not limited to: showers on first shift every Tuesday/Friday, and resident was dependent on 1 staff member for incontinence care and personal hygiene. A Report of Concern (Grievance) form, dated 1/28/24 at 11:20 A.M., indicated the resident's wife had called to report her husband had his breakfast tray in his room when she arrived, and he had food on his face. She wanted to ensure sure staff were assisting with his meals. The wife complained her husband had been "cleaned up with cold washcloths". Corrective action indicated the resident was to be in the dining room and assisted with his meals. The form did not address the concern of being cleansed with cold washcloths. The form did not indicate the complainant was notified or if the concern had been resolved. The form was signed by the Executive Director on 1/28/24. An invoice from a contractor, dated 1/30/24, indicated he found leaks in both boiler rooms. In the small boiler room, he installed a clamp. In the main boiler room, he replaced a section of leaking pipe with new pipe and fittings. A Report of Concern (Grievance) form, dated 2/11/24, indicated Resident J's daughter had contacted the Executive Director (ED) via a text message. The daughter was asking why there		provided with comfortable water temperatures. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 3/22/24. This in-service will be conducted by the Executive Director or Designee and will include a review of safe water temperatures, resident showers, and ADL care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Maintenance Director/Designee will be responsible for completing the QAPI Audit tools labeled "Shower Temperatures" daily for 4 weeks and weekly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic**	

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	was still no hot water, and asking why it had not been fixed. The ED informed the daughter that the facility does have hot water, and only one boiler was not functioning and were waiting on parts. The ED informed the daughter the resident may shower on another unit and the Maintenance staff were monitoring water temperatures multiple times a day. A Report of Concern (Grievance) form, dated 2/12/24, indicated the Executive Director was notified all Cedar and Birch residents were being affected by a "...Partial interruption of hot water...Hot water is partially interrupted during the day. Boiler for building part completely out so water temps [temperatures] are up/down...parts ordered by vendor & facility maintenance..." The follow up indicated the part arrived on 2/15/24, however an additional part was needed to fix it completely, but the boiler was functioning properly and water temperatures were appropriate. A self-reported incident form, dated 2/12/24 at 8:01 A.M., indicated the facility had intermittent and partial hot water interruption. One boiler was being serviced and parts ordered. The form indicated the facility had been completing water temperatures throughout the facility, and offering showers on another unit to ensure residents were without interruption of showers. A Report of Concern (Grievance) form, dated 2/24/24, indicated Resident M complained of not getting a shower due to no hot water. The Department Finding section of the form indicated "...staff to be taking residents to alternate halls for showers. The Follow Up/Resolution section indicated "...Staff educated on hot water status and to take residents to alternative hall to complete showers." This grievance was signed by		**changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	

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	the ED on 2/26/24. On 2/29/24 at 3:18 P.M., an interview was conducted with the ED, Maintenance Director, Director of Nursing (DON) and Assistant Director of Nursing (ADON). The ED indicated she was first notified, by staff, on 1/28/24, there was no hot water. She notified the Maintenance Director and a contractor was called in. The facility had 2 boilers and the one used of the Cedar/Birch units, which consisted of room numbers in the 100, 200 and 300 range, were the rooms and shower rooms which were effected. The ED indicated daily temperatures were started on 1/28/24 and were constantly above 100. There were no temperatures taken on the 300 unit nor in the shower room. The highest water temperature was 112.7 degrees on 02/24/24 in room 125. Then, on 2/27/24, the ED indicated the boiler was turned off completely due to giving off hot water which was to hot and not consistent. The ED indicated the residents had been offered showers, on the units, with a functional boiler. The ED indicated warm water had been brought over to the Cedar/Birch units for bed baths and peri care. The ED confirmed residents were cleansed, during peri care with a wash cloth and water as the facility did not use packaged wipes for cleansing. The ADON indicated the CNAs were documenting on the shower sheets "refused" because the residents were being offered showers but were not willing to go to the other unit. The ED indicated staff were educated on hand sanitation-and provided hand sanitizer to use, since there was no hot water for washing hands, however there was no documented education indicating the staff were to offer showers on another unit, provide a warm bed bath and/or peri care by transferring warm water to the resident's room.			

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	An invoice from Mechanical Contractors, dated 2/27/24 at 8:52 A.M. was provided by the ED, which indicated the cost of boiler would be $18,927.36, with materials and installation at an additional cost. The ED did not indicate the boiler would be installed. Observations of the hallways on the Cedar/Birch units were conducted on 2/28/24, 2/29/24 and 3/1/24 during the survey process, from approximately 9:45 A.M. through 11:30 A.M., and again in the afternoons from approximately 1:45 P.M. through 3:15 P.M. At no time during these observations was a cart noted on the unit with a basin of warm water. During an interview, on 3/1/24 at 10:03 A.M., CNA 8 indicated the facility used wash clothes, not disposable wipes, to clean up residents after incontinent episodes. She indicated the DON came around and educated her to get warm water from another unit, as the cold water problem was going to be ongoing. She indicated she had to go to the other unit, fill a basin full of warm water, put the basin on a cart and push it over to the unit she was working. For residents' showers, they were told the residents would have to be taken to the other unit. CNA 8 indicated some residents were ok with that and some were not. During an interview, on 3/1/24 12:52 P.M., Hospice RN 11 indicated the only solution to cold water temperatures provided to her staff was to take an open basin of warm water from the kitchen to residents' rooms. They decided this was unacceptable and brought in an insulated jug with a lid with hopes the facility staff would use it throughout the day. RN 11 had personally witnessed facility staff using cold water to wash the residents and the residents yelled out			

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	objections to the cold water. A resident was also observed in the dining room and brought back and placed in bed, but no one came in to cleanse or change the brief while she had been in the room. On 3/01/24 at 1:18 P.M., CNA 12 was observed coming out of Resident K's room with a bagged brief, linens and had no basin with warm water. He indicated he had changed the resident's brief and had completed peri care with a wash cloth and cold water. 2. During observation of care, on 2/29/2024 and 3/1/2024 on the Cedar unit, from approximately 8:30 AM. - 11:00 A.M. and 1:30 P.M. - 3:00 P.M., there were no basins of warm water observed being brought over from the kitchen or the Dogwood unit. During an interview, on 2/27/2024 at 8:45 A.M., the Administrator indicated the hot water had been shut off to the Cedar unit as it was not functioning correctly, and staff were directed to obtain basins of warm water for resident care, and to offer to take residents from the Cedar unit to the Dogwood unit, which had warm water, for showers. During an interview with alert and oriented Resident N, on 3/1/24 at 9:16 A.M. she indicated she had not been offered warm water to clean herself up with in the bathroom. She indicated she would have washed her face at least, had she been offered warm water. During an observation of morning care for Resident D, on Cedar unit. on 3/1/24 at 9:17 A.M., CNA 12 used toilet paper to wipe the resident's rectum but did not provide any cleansing of the front of the resident's peri area, even though he had been incontinent of urine. After assisting the resident to redresss, the resident requested a			

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	wash cloth to wash his face. CNA 12 was heard reminding the resident there was only cold water. Resident D asked a second time for a washcloth to wash his face, and was provided with a wash cloth but no warm water. Resident D then washed his own face with cold water from the bathroom sink. The facility policy and procedure, titled, "Safe Water Temperatures,," provided by the Administrator as current on 2/26/2024 at 1:55 P.M. included the following: "...2. Staff will be educated on safe water temperatures upon employment and on a regular basis. 3. Thermometers will be available as needed for use by all staff. 4. Staff will report abnormal findings, such as complaints of water too cold or hot, burns, redness, or any problems with water temperatures. (ex. water is painful to touch or causes redness) to the supervisor and/or maintenance staff..." This citation relates to Complaints IN00428815, IN00428292, IN00428033 and IN00427600.			
F 0600 SS=G Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-			

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	§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observations, record reviews, and interviews, the facility failed to protect a resident's right to be free from verbal abuse from another resident, which resulted in emotional distress, and physical abuse by a staff member, for 3 of 4 residents reviewed for abuse. (Residents 68, 218 & 43) Findings include: 1. During a dining observation, on 2/25/2024 at 12:24 P.M., Residents 218 and 68 were sitting at the assisted dining table, and sitting side by side. Resident 218 was observed yelling at Resident 68. CNA 5 attempted to intervene verbally, but did not move Resident 218 from the table. Resident 218 continued yelling at Resident 68 to get up and walk so they could "get out of here". Resident 68 looked at the surveyor, and stated, "Can you at least tell her I can't walk so she will stop?" Resident 218 continued to escalate at yelling at Resident 68. This resulted in Resident 68 crying. During an interview, on 2/25/2024 at 2:01 P.M., Resident 68 indicated "that lady screamed at me," and it made her feel terrible. At 2:28 P.M., Resident 68 continued to cry. A record review for Resident 68 was completed on 2/27/2024 at 11:20 A.M. Diagnoses included, but were not limited to: dementia, major depressive disorder, and anxiety disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 2/14/24, indicated Resident 68 was cognitively intact. During the assessment	F 0600	**F600 – Free from Abuse and Neglect** It is the practice of this facility to ensure that all residents are free from verbal and physical abuse. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 43 – investigation was initiated upon notification, report sent to ISDH, and social services provided resident follow up. Resident 218 – resident was discharged from facility. Resident 68 – investigation was initiated, resident was provided follow up services by social services and declined any follow up from psych services. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. Interviews were completed with residents to assure they have no concerns with verbal or physical abuse with no concerns identified. **What measures will be put into**	03/22/2024

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	period, she did not display any mood or behavioral issues. Progress Notes, including notes from the nursing and social service departments, indicated no documentation of the incident for Resident 68, or follow-up with her for psychosocial wellbeing for this incident. A Social Service Note, dated 2/25/2024 at 2:26 P.M., indicated staff had reported to social services that Resident 218 went to the large dining room and did eat some of her meal. After lunch, the Social Service Assistant observed Resident 218 yelling and screaming. Resident 218 was observed yelling she wanted to leave to go to school. Resident 218 had agitation with verbal aggression when she realized the staff could not take her outside or accompany her outside of the building. A record review for Resident 218 was completed on 2/28/2024 at 10:03 A.M.. A Nursing Admission Evaluation, dated 2/15/2024, indicated Resident 218 had a memory problem. She had behavioral issues of wandering, exit seeking, and resisting care. An Admission Minimum Data Set (MDS) assessment was in progress. During an interview, on 3/1/2024 at 9:57 A.M., the Social Service Assistant indicated follow-up with a resident after a verbal altercation depends on the impact to the resident, including if the resident was distressed. She indicated she was unsure if she was aware of the dining room incident, but was informed Resident 218 was becoming disruptive, and unaware Resident 68 was crying.		**place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 3/22/24. This in-service will be conducted by the Executive Director or Designee and will include a review of abuse prevention and reporting, resident interviews and/or concerns to ensure all remain free from abuse, neglect, and exploitation; all staff educated that any concerns of abuse, neglect, and exploitation are reported immediately to the Executive Director. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for completing the QAPI Audit tools labeled “Abuse Prohibition and Investigation” weekly for 4 weeks and monthly for at least 6 months. The Executive Director/Designee will audit all resident interviews and/or concerns to ensure all residents remain free from abuse, neglect, and exploitation; all staff will	

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	She indicated no one followed up with Resident 68, and if a staff member had told her about Resident 68 crying, she did not recall. She indicated staff should inform Social Services of altercations. During an interview, on 3/1/2024 at 10:55 A.M., the Executive Director indicated Resident 68 was receiving psychosocial visits daily, and those should be documented in the progress notes. During an interview, on 3/1/2024 at 12:40 P.M., CNA 5 indicated Resident 218 was displaying signs of dementia and trying to get Resident 68 to go on a field trip. Resident 218 was getting upset since Resident 68 would not go. She indicated, when she was sitting at the table, Resident 218 grabbed Resident 68's wheelchair and shook it, and got mad at Resident 68 for not getting up from her wheelchair. CNA 5 indicated another CNA was able to separate the residents. Resident 68 was very upset and crying. CNA 5 took Resident 68 to her room, talked with her, and reported the altercation to a nurse. She was unable to identify to whom she reported the incident. 2. During an interview, on 2/25/2024 at 10:10 A.M., Resident 43 indicated she felt CNA 22 was unusually rough, and she could feel herself tensing up knowing she was her aide. When CNA 22 took her to the bathroom, CNA 22 would be complaining and "huffed and puffed." Resident 43 indicated this incident occurred 3-4 weeks ago, and she reminded CNA 22 of her colostomy bag so she wouldn't pull her pants down roughly. Resident 43 indicated during the toileting and roughness, she hit her head on the bathroom wall, and "that was the last straw that broke the camel's back."		ensure that any concerns of abuse, neglect, and exploitation are reported immediately to the Executive Director. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024 The facility will be submitting further documentation to request an IDR to this deficiency. The facility followed their policy, as the incident described in the 2567 does not reflect verbal abuse resulting in emotional distress towards resident Peggy Hollar as resident did not have a change in her activity, she did not report to the staff that she was upset about or even mention Mary's behavior. The facility requests that the citation for F tag 600 be removed from their record and/or reduced to a D level citation as no actual harm was caused from this alleged incident, and resident did not display any emotional distress from the resident asking her to go to school with her on a field trip,	

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	155689	A. BUILDING 00 B. WING	03/02/2024

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MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

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	During an interview, on 2/26/2024 at 9:12 A.M., Resident 43 indicated she discussed this allegation with the Social Service Director on February 6, 2024, and since that time, CNA 22 had not been taking care of her any more. A record review was completed on 2/27/2024 at 11:07 A.M. Diagnoses included, but were not limited to multiple sclerosis, muscle weakness, and difficulty walking. A Care Plan, dated 9/1/2017 and revised on 11/10/2022, indicated Resident 43 required assistance for activities of daily living related to, but not limited to: multiple sclerosis, muscle weakness, chronic obstructive pulmonary disease, and abnormalities of gait and mobility. An intervention, dated 9/1/2017 and revised on 10/16/2018, indicated Resident 43 to have extensive toileting assistance with one staff member, and to assist with emptying the colostomy every shift as needed while sitting on the commode. A Quarterly Minimum Data Set (MDS) assessment, dated 2/14/2024, indicated Resident 43 was cognitively intact. She required extensive assistance with toileting with on staff member assist. A Social Service Progress Review for Documentation, dated 2/7/2024, indicated Resident 43 was feeling good. There was no documentation in the Progress Notes of the allegation or follow-up documentation. During an interview, on 3/1/2024 at 1:14 P.M., the Social Service Director indicated that Resident 43		and does not rise to the level of a harm citation.	

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	complained CNA 22 was "gruff and rough". She indicated she spoke with the Executive Director after Resident 43 informed her of the incident. During an interview, on 3/1/2024 at 1:18 P.M., the Executive Director indicated she did not have an investigation of this allegation. She indicated it was just basically CNA's 22 personality and how she talks loudly. She indicated that CNA 22 can no longer care for Resident 43. On 3/2/2024 at 8:45 A.M., the Executive Director provided a policy titled, "Abuse, Neglect and Exploitation". The policy indicated, " ...It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property ...IV. Identification of Abuse, Neglect and Exploitation A. The facility will have written procedures to assist staff in identifying the different types of abuse - mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations ...B. Possible indicators of abuse includes, but are not limited to: 1. Resident, staff or family report of abuse ...VI. Protection of Resident ...The facility will make every effort to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: A. Responding immediately to protect the alleged victim and integrity of the investigation ...B. Examining the alleged victim for any sign of injury, including physical examination or psychosocial assessment if needed ...C. Increased supervision of the alleged victim and residents			

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	...." During an interview, on 3/2/2024 at 10:17 A.M., the Executive Director indicated she reported this incident to the Indiana State Department of Health on 3/1/2024. Resident 43's interview aligned with the allegation during the surveyor's interview. The Executive Director indicated Resident 43 indicated the incident was not intentful, but that CNA 22 was rough when pulling her pants up, and she toppled hitting her head on the wall. 3.1-27(a)(1) 3.1-27(b)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.			

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	§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, record review, and interview, the facility staff failed to report alleged abuse allegations immediately to the administrator for 3 of 4 residents reviewed for abuse. (Residents 43, 218 and 68) Findings include: 1. During a dining observation, on 2/25/2024 at 12:24 P.M., Residents 218 and 43 were sitting at the assisted dining table, and sitting side by side. Resident 218 was observed yelling at Resident 43. CNA 5 attempted to intervene verbally, but did not move Resident 218 from the table. Resident 218 kept yelling at Resident 43 to get up and walk so they could "get out of here". Resident 43 looked at Surveyor 11942, and stated, "Can you at least tell her I can't walk so she will stop?" Resident 218 continued to escalate at yelling at Resident 43. This resulted in Resident 43 crying. During an interview, on 2/25/2024 at 2:01 P.M., Resident 43 indicated "that lady screamed at me," and it made her feel terrible. At 2:28 P.M., Resident 43 continued to cry. A record review for Resident 43 was completed on 2/27/2024 at 11:20 A.M. Diagnoses included, but were not limited to: dementia, major depressive disorder, and anxiety disorder. A Quarterly Minimum Data Set (MDS) assessment	F 0609	**F609- Reporting of Alleged Violations** It is the practice of this facility to ensure that all alleged violations are reported in a timely manner. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 43 – investigation was initiated upon notification, report sent to ISDH, and social services provided resident follow up. Resident 218 – resident was discharged from facility. Resident 68 – investigation was initiated, resident was provided follow up services by social services and declined any follow up from psych services. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All resident, family, and	03/22/2024

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	indicated Resident 43 was cognitively intact. During the assessment period, she did not display any mood or behavioral issues. Progress Notes, including notes from the nursing and social service departments, indicated no documentation of the incident for Resident 43, or follow-up with her for psychosocial wellbeing for this incident. A Social Service Note, dated 2/25/2024 at 2:26 P.M., indicated that staff had reported to social services that Resident 218 went to the large dining room and did eat some of her meal. After lunch, the Social Service Assistant observed Resident 218 yelling and screaming. Resident 218 was observed yelling she wanted to leave to go to school. Resident 218 had agitation with verbal aggression when she realized the staff could not take her outside or accompany her outside of the building. A record review for Resident 218 was completed on 2/28/2024 at 10:03 A.M. A Nursing Admission Evaluation, dated 2/15/2024, indicated Resident 218 had a memory problem. She had behavioral issues of wandering, exit seeking, and resisting care. An Admission Minimum Data Set (MDS) was in progress. During an interview, on 3/1/2024 at 9:57 A.M., the Social Service Assistant indicated follow-up with a resident after a verbal altercation depends on the impact to the resident, including if the resident was distressed. She indicated she was unsure if she was aware of the dining room incident, but was informed Resident 218 was becoming		staff concerns have been reviewed to ensure appropriate and timely reporting if applicable. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 03/22/2024. This in-service will be conducted by the Executive Director or Designee and will include a review of abuse prevention and reporting. The Executive Director/Designee will audit all reportable and concerns weekly to ensure all have been reported and followed up in a timely manner. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for completing the QAPI Audit tools labeled “Abuse Prohibition and Investigation” weekly for 4 weeks and monthly for at least 6 months. The Executive Director/Designee will audit all reportable and concerns	

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	disruptive, and unaware Resident 43 was crying. She indicated no one followed up with Resident 43, and if a staff member had told her about Resident 43 crying, she did not recall. She indicated staff should inform social services of altercations. During an interview, on 3/1/2024 at 10:55 A.M., the Executive Director indicated had she known of this incident, it would have been reported to the Indiana Department of Health. During an interview, on 3/1/2024 at 12:40 P.M., CNA 5 indicated Resident 218 was displaying signs of dementia and trying to get Resident 43 to go on a field trip. Resident 218 was getting upset since Resident 43 would not go. She indicated when she was sitting at the table, Resident 218 grabbed Resident 43's wheelchair and shook it, and got mad at Resident 43 for not getting up from her wheelchair. CNA 5 indicated another CNA was able to separate the residents. She indicated Resident 43 was very upset and crying. CNA 5 indicated she took Resident 43 to her room, talked with her, and reported the altercation to a nurse. She was unable to identify to whom she reported the incident. During an interview on 3/1/2024 at 10:55 A.M., the Executive Director indicated had she known about the verbal altercation, she would have investigated the incident and reported the incident to the Indiana Department of Health. 2. During an interview, on 2/25/2024 at 10:10 A.M., Resident 68 indicated she felt CNA 22 was unusually rough, and she could feel herself tensing up knowing she was her aide. She indicated when CNA 22 took her to the bathroom, CNA 22 was complaining and huffed and puffed.		weekly to ensure all have been reported and followed up in a timely manner. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	

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	Resident 68 indicated this incident occurred 3-4 weeks ago, and she reminded CNA 22 of her colostomy bag so she wouldn't pull her pants down roughly. Resident 68 indicated during the toileting and roughness, she hit her head on the bathroom wall, and "that was the last straw that broke the camel's back." During an interview, on 2/26/2024 at 9:12 A.M., Resident 68 indicated she discussed this allegation with the Social Service Director on February 6, 2024, and since that time, CNA 22 had not been taking care of her anymore. A record review was completed, on 2/27/2024 at 11:07 A.M. Diagnoses included, but were not limited to multiple sclerosis, muscle weakness, and difficulty walking. A Care Plan, dated 9/1/2017, and revised on 11/10/2022, indicated Resident 68 required assistance for activities of daily living related to, but not limited to: multiple sclerosis, muscle weakness, chronic obstructive pulmonary disease, and abnormalities of gait and mobility. An intervention, dated 9/1/2017, and revised on 10/16/2018, indicated Resident 68 to have extensive toileting assistance with one staff member, and to assist with emptying the colostomy every shift as needed while sitting on the commode. A Quarterly Minimum Data Set (MDS) assessment, dated 2/14/2024, indicated Resident 68 was cognitively intact. She required extensive assistance with toileting with on staff member assist. A Social Service Progress Review for Documentation, dated 2/7/2024, indicated			

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	Resident 68 was feeling good. There was no documentation in the Progress Notes of the allegation or follow-up documentation. During an interview, on 3/1/2024 at 1:14 P.M., the Social Service Director indicated that Resident 68 complained CNA 22 was "gruff and rough". She indicated she spoke with the Executive Director after Resident 68 informed her of the incident. During an interview, on 3/1/2024 at 1:18 P.M., the Executive Director indicated she did not have an investigation of this allegation. She indicated it was just basically CNA's 22 personality and how she talks loudly. She indicated that CNA 22 can no longer care for Resident 68, and this was not a reportable incident to the Indiana Department of Health. On 3/2/2024 at 8:45 A.M., the Executive Director provided a policy titled, "Abuse, Neglect and Exploitation". The policy indicated, " ...It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property ...VII. Reporting/Response ...A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies [e.g. law enforcement when applicable] within specified timeframes: a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not			

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	involve abuse and do not result in serious bodily injury ...." During an interview, on 3/2/2024 at 10:17 A.M., the Executive Director indicated she reported this incident to the Indiana State Department of Health on 3/1/2024. She indicated Resident 68 interview aligned with the allegation. The Executive Director indicated Resident 68 indicated the incident was not intentful, but that the CNA 22 was rough when pulling her pants up, and she toppled hitting her head on the wall. A document titled, "Indiana State Department of Health Survey Report System", dated 3/1/2024 at 3:01 P.M., indicated, " ...During interview with ISDH [Indiana State Department of Health] surveyor resident indicated that a CNA had been rough with her. Upon interview of resident details obtained around a CNA who she indicated was rough while toileting and resident hit her head on the wall while CNA was attempting to assist with ADLs [activities of daily living]. Resident made statements to SS [social services] on 2/7/24 stating customer service issues with the CNA; at that time CNA was interviewed and educated due to resident with no concerns of safety or feeling that employee was intentionally rough. Employee has not worked with resident since this initial concern. Due to residents current statements; CNA was suspended pending investigation ...." 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:			

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	§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, record review, and interview, the facility failed to investigate allegations of abuse for 3 of 4 residents reviewed for abuse prevention. (Residents 43, 218 and 68) Findings include: 1. During a dining observation, on 2/25/2024 at 12:24 P.M., Residents 218 and 43 were sitting at the assisted dining table, and sitting side by side. Resident 218 was observed yelling at Resident 43. Certified Nursing Assistant (CNA) 5 attempted to intervene verbally, but did not move Resident 218 from the table. Resident 218 continued yelling at Resident 43 to get up and walk so they could "get out of here". Resident 43 looked at Surveyor 11942, and stated, "Can you at least tell her I can't walk so she will stop?" Resident 218 continued to escalate at yelling at Resident 43. This resulted in Resident 43 crying. During an interview, on 2/25/2024 at 2:01 P.M., Resident 43 indicated that lady screamed at me, and it made her feel terrible. As the interview continued at 2:28 P.M., Resident 43 continued to	F 0610	**F610- Investigate/Prevent/Correct Alleged Violation** It is the practice of this facility to investigate all allegations of abuse. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 43 – investigation was initiated upon notification, report sent to ISDH, and social services provided resident follow up. Resident 218 – resident was discharged from facility. Resident 68 – investigation was initiated, resident was provided follow up services by social services and declined any follow up from psych services.	03/22/2024

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	cry. A record review of Resident 43 was completed on 2/27/2024 at 11:20 A.M. Diagnoses included, but were not limited to: dementia, major depressive disorder, and anxiety disorder. A Quarterly Minimum Data Set (MDS) assessment indicated Resident 43 was cognitively intact. During the assessment period, she did not display any mood or behavioral issues. A review of the Progress Notes, that includes notes from the nursing and social service departments, indicated no documentation of the incident for Resident 43, or follow-up with her for psychosocial wellbeing for this incident. A Social Service Note, dated 2/25/2024 at 2:26 P.M., indicated that staff had reported to social services that Resident 218 went to the large dining room and did eat some of her meal. After lunch, the Social Service Assistant observed Resident 218 yelling and screaming. Resident 218 was observed yelling she wanted to leave to go to school. Resident 218 had agitation with verbal aggression when she realized the staff could not take her outside or accompany her outside of the building. A record review of Resident 218 was completed on 2/28/2024 at 10:03 A.M., a Nursing Admission Evaluation, dated 2/15/2024, indicated Resident 218 had a memory problem. She had behavioral issues of wandering, exit seeking, and resisting care. An Admission Minimum Data Set (MDS) assessment was in progress. During an interview, on 3/1/2024 at 9:57 A.M., the Social Service Assistant indicated follow-up with		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All resident, family, and staff concerns have been reviewed to ensure appropriate and timely investigation and reporting if applicable. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 03/22/2024. This in-service will be conducted by the Executive Director or Designee and will include a review of abuse prevention and reporting. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for completing the QAPI Audit tools labeled “Abuse Prohibition and Investigation”	

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	155689	A. BUILDING 00 B. WING	03/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	a resident after a verbal altercation depends on the impact to the resident, including if the resident was distressed. She indicated she was unsure if she was aware of the dining room incident, but was informed Resident 218 was becoming disruptive, and unaware Resident 43 was crying. She indicated no one followed up with Resident 43, and if a staff member had told her about Resident 43 crying, she did not recall. She indicated staff should inform social services of altercations. During an interview, on 3/1/2024 at 10:55 A.M., the Executive Director indicated that Resident 43 was receiving psychosocial visits daily, and those should be documented in the progress notes. During an interview, on 3/1/2024 at 12:40 P.M., CNA 5 indicated Resident 218 was displaying signs of dementia and trying to get Resident 43 to go on a field trip. Resident 218 was getting upset since Resident 43 would not go. She indicated when she was sitting at the table, Resident 218 grabbed Resident 43's wheelchair and shook it, and got mad at Resident 43 for not getting up from her wheelchair. CNA 5 indicated another CNA was able to separate the residents. She indicated Resident 43 was very upset and crying. CNA 5 indicated she took Resident 43 to her room, talked with her, and reported the altercation to a nurse. She was unable to identify whom she reported the incident to. During an interview on 3/1/2024 at 10:55 A.M., the Executive Director indicated had she known about the verbal altercation, she would have investigated the incident and reported the incident to the Indiana Department of Health. 2. During an interview, on 2/25/2024 at 10:10 A.M.,		weekly for 4 weeks and monthly for at least 6 months. The Executive Director/Designee will audit all reportable and concerns weekly to ensure all have been reported and followed up in a timely manner. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	

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	Resident 68 indicated she felt CNA 22 was unusually rough, and she could feel herself tensing up knowing she was her aide. She indicated when CNA 22 took her to the bathroom, CNA 22 was complaining and huffed and puffed. Resident 68 indicated this incident occurred 3-4 weeks ago, and she reminded CNA 22 of her colostomy bag so she wouldn't pull her pants down roughly. Resident 68 indicated during the toileting and roughness, she hit her head on the bathroom wall, and "that was the last straw that broke the camel's back." During an interview, on 2/26/2024 at 9:12 A.M., Resident 68 indicated she discussed this allegation with the Social Service Director on February 6, 2024, and since that time, CNA 22 had not been taking care of her anymore. A record review was completed on 2/27/2024 at 11:07 A.M. Diagnoses included, but were not limited to multiple sclerosis, muscle weakness, and difficulty walking. A Care Plan, dated 9/1/2017, and revised on 11/10/2022, indicated Resident 68 required assistance for activities of daily living related to, but not limited to: multiple sclerosis, muscle weakness, chronic obstructive pulmonary disease, and abnormalities of gait and mobility. An intervention, dated 9/1/2017, and revised on 10/16/2018, indicated Resident 68 to have extensive toileting assistance with one staff member, and to assist with emptying the colostomy every shift as needed while sitting on the commode. A Quarterly Minimum Data Set (MDS) assessment, dated 2/14/2024, indicated Resident 68 was cognitively intact. She required extensive			

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	assistance with toileting with on staff member assist. A Social Service Progress Review for Documentation, dated 2/7/2024, indicated Resident 68 was feeling good. There was no documentation in the Progress Notes of the allegation or follow-up documentation. During an interview, on 3/1/2024 at 1:14 P.M., the Social Service Director indicated that Resident 68 complained CNA 22 was "gruff and rough". She indicated she spoke with the Executive Director after Resident 68 informed her of the incident. During an interview, on 3/1/2024 at 1:18 P.M., the Executive Director indicated she did not have an investigation of this allegation. She indicated it was just basically CNA's 22 personality and how she talks loudly. She indicated that CNA 22 can no longer care for Resident 68. On 3/2/2024 at 8:45 A.M., the Executive Director provided a policy titled, "Abuse, Neglect and Exploitation". The policy indicated, " ...It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property ...V. Investigation of Alleged Abuse, Neglect and Exploitation A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur ...." During an interview, on 3/2/2024 at 10:17 A.M., the Executive Director indicated Resident 68's			

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	interview aligned with the allegation during the surveyor's interview. The Executive Director indicated Resident 68 indicated the incident was not intentful, but that CNA 22 was rough when pulling her pants up, and she toppled hitting her head on the wall. 3.1-28(d)			
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident			

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	only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.			

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	(iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on interview and record review, the facility failed to provide required resident information to the receiving facility for 3 of 3 residents reviewed for hospitalizations. (Residents 96, 68, and 10) Findings include: 1. During an interview, on 2/25/2024 at 1:35 P.M., Resident 96 indicated she had been hospitalized for ketoacidosis, kidney failure due to diabetes, and two stents. A record review was completed on 2/27/2024 at 8:47 A.M. Diagnoses included, but were not limited to: hypoglycemia, diabetes mellitus type 1, chronic obstructive pulmonary disease, and chronic kidney disease. A Quarterly Minimum Data Set (MDS) assessment, dated 1/30/24, indicated Resident 96 was cognitively intact. A Nurse's Note, dated 8/3/2023 at 2:56 A.M.,	F 0622	**F622 Transfer and Discharge** It is the practice of this facility to provide required resident information to the receiving facility for all resident hospitalizations or discharges. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 96 – has had no further hospitalizations. Resident 68 – has had no further hospitalizations. Resident 10 – all appropriate resident information was sent to receiving facility upon resident hospitalization. **How other residents having the potential to be affected by the**	03/22/2024

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	indicated Resident 96 was persistent in needing to be transferred to the Emergency Room for dropping blood sugars, vomiting, severe abdominal pain, and right mouth pain. The Nurse Practitioner agreed to transfer to the Emergency Room. A call was placed to the hospital for report of Resident 96's condition. A Nurse's Note, dated 8/4/2023 at 1:10 P.M., indicated Resident 96 was transferred back to the hospital for nausea, vomiting, and stomach cramping. No resident discharge information/paperwork for the receiving provider could be found in the medical record. A Nurse's Note, dated 12/19/2023 at 10:37 P.M., indicated Resident 96 complained of body aches, headache, and cough/congestion. She requested to be sent to the hospital. No resident discharge information/paperwork for the receiving provider could be found in the medical record for the receiving provider. During an interview, on 3/1/2024 at 10:42 A.M., the Executive Director indicated a transfer assessment should be sent to the receiving provider. 2. During an interview, on 2/25/2024 at 2:14 P.M., Resident 68 indicated she had been hospitalized. "I almost died. I had sepsis." A record review was completed on 2/27/2024 at 11:20 A.M. Diagnoses included, but were not limited to: dementia, functional quadriplegia, and acute and chronic respiratory failure. A Nurse's Note, dated 11/6/2023 at 9:23 A.M., indicated Resident 68 was observed to be lethargic, and only responding when her name		**same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All resident discharges have been audited to ensure that all appropriate resident information was sent to receiving facility upon discharge or hospitalization. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 3/22/2024. This in-service will be conducted by the Director of Nursing or Designee and will include a review of the transfer/discharge assessment and bed hold policy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled "Resident Transfer/Discharge" weekly for 4 weeks and monthly	

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	was called. The Nurse Practitioner gave an order to be sent to the hospital for further evaluation. The Emergency Room staff was informed via telephone. No resident discharge information/paperwork for the receiving provider could be found in the medical record. A Nurse's Note, dated 12/22/2023 at 6:22 P.M., indicated Resident 68 was transferred to the hospital. No resident discharge information/paperwork for the receiving provider could be found in the medical record. During an interview, on 3/1/2024 at 10:42 A.M., the Executive Director indicated that a transfer assessment should be sent to the receiving provider. 3. A record review was completed on 2/27/2024 at 10:03 A.M. Diagnoses included, but were not limited to: dementia, atrial fibrillation, heart failure, and chronic kidney disease. An Admission Minimum Data Set (MDS) assessment, dated 1/15/2024, indicated Resident 10 had severe cognitive impairment and received an anticoagulant medication. A Nurse's Note on 2/25/2024 at 1:24 P.M., indicated Resident 10's Nurse Practitioner was updated on his status and INR. A new order was obtained to be sent to the Emergency Room for evaluation and treatment. A Nurse's Note, dated 2/25/2024 at 1:57 P.M., indicated report was called to the hospital. No resident discharge information/paperwork for the receiving provider could be found in the medical record for the receiving provider.		for at least 6 months. The Director of Nursing/Designee will audit all resident discharges daily to ensure all resident information was sent to receiving facility. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	

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	During an interview on 3/1/2024 at 10:42 A.M., the Executive Director indicated that a transfer assessment should be sent to the receiving provider. On 3/2/2024 at 8:45 A.M., the Executive Director provided a policy titled, "Bed Hold Notice Upon Transfer". The policy indicated, " ... The facility will provide the receiving provider the following: a. Contact information of the practitioner responsible for the care of the resident, b. Resident representative information including contact information, c. Advance Directive information, d. All special instructions or precautions for ongoing care, as appropriate, e. Comprehensive care plan goals, f. All other necessary information, including a copy of the resident's discharge summary, as applicable, and any other documentation to ensure a safe and effective transition of care ...." 483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.			
F 0623 SS=D Bldg. 00				

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	§483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and			

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	submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate			

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	relocation of the residents, as required at § 483.70(l). Based on interviews and record reviews, the facility failed to provide the required transfer and discharge form to the resident or resident representative for 3 of 3 residents reviewed for hospitalizations. (Residents 96, 68, and 10) Findings include: 1. During an interview, on 2/25/2024 at 1:35 P.M., Resident 96 indicated she had been hospitalized for ketoacidosis, kidney failure due to diabetes, and two stents. A record review was completed on 2/27/2024 at 8:47 A.M. Diagnoses included, but were not limited to: hypoglycemia, diabetes mellitus type 1, chronic obstructive pulmonary disease, and chronic kidney disease. A Quarterly Minimum Data Set (MDS) assessment, dated 1/30/24, indicated Resident 96 was cognitively intact. A Nurse's Note, dated 8/3/2023, 2:56 A.M., indicated Resident 96 was persistent to be transferred to the Emergency Room for dropping blood sugars, vomiting, severe abdominal pain, and right mouth pain. The Nurse Practitioner agreed to transfer to the Emergency Room. A call was placed to the hospital for report of Resident 96's condition. A Nurse's Note, dated 8/4/2023 at 1:10 P.M., indicated that Resident 96 was transferred back to the hospital for nausea, vomiting, and stomach cramping. No resident discharge information/paperwork for the receiving provider could be found in the medical record for the	F 0623	**F623 Notice of Requirements Before Transfer/Discharge** It is the practice of this facility to provide required transfer and discharge form to resident or resident representative for discharges or hospitalization. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 96 – has had no further hospitalizations. Resident 68 – has had no further hospitalizations. Resident 10 – all required transfer documentation was sent with resident and/or responsibly party upon resident hospitalization. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All resident discharges have been audited to ensure that the transfer and discharge forms were sent to the resident or to resident representative for discharge or hospitalization. **What measures will be put into place or what systemic**	03/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	03/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

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	receiving provider, including the State's Transfer and Discharge form. A Nurse's Note, dated 12/19/2023 at 10:37 P.M., indicated that Resident 96 complained of body aches, headache, and cough/congestion. She requested to be sent to the hospital. No resident discharge information/paperwork for the receiving provider could be found in the medical record for the receiving provider, including the State's Transfer and Discharge form. During an interview, on 3/1/2024 at 10:42 A.M., the Executive Director indicated that a Transfer/Discharge form should be provided to the resident or resident representative. 2. During an interview, on 2/25/2024 at 2:14 P.M., Resident 68 indicated she had been hospitalized. "I almost died. I had sepsis." A record review was completed on 2/27/2024 at 11:20 A.M. Diagnoses included, but were not limited to: dementia, functional quadriplegia, and acute and chronic respiratory failure. On 11/6/2023 at 9:23 A.M., a Nurse's Note indicated Resident 68 was observed to be lethargic, and only responding when her name was called. The Nurse Practitioner gave an order to be sent to the hospital for further evaluation. The Emergency Room staff was informed via telephone. No resident discharge information/paperwork for the receiving provider could be found in the medical record, including the State's Transfer and Discharge form. A Nurse's Note, dated 12/22/2023 at 6:22 P.M., indicated Resident 68 was transferred to the hospital. No resident discharge		**changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 3/22/2024. This in-service will be conducted by the Director of Nursing or Designee and will include a review of the transfer/discharge assessment and bed hold policy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled "Resident Transfer/Discharge" weekly for 4 weeks and monthly for at least 6 months. The Director of Nursing/Designee will audit all resident discharges daily to ensure the required transfer and discharge forms are sent to the resident upon hospitalization or discharge. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up.	

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	information/paperwork for the receiving provider could be found in the medical record, including the State's Transfer and Discharge form. During an interview, on 3/1/2024 at 10:42 A.M., the Executive Director indicated that a Transfer/Discharge form should be provided to the resident or resident representative. 3. A record review, was completed on 2/27/2024 at 10:03 A.M. Diagnoses included, but were not limited to: dementia, atrial fibrillation, heart failure, and chronic kidney disease. An Admission Minimum Data Set (MDS) assessment, dated 1/15/2024, indicated Resident 10 had severe cognitive impairment and received an anticoagulant medication. A Nurse's Note on 2/25/2024 at 1:24 P.M., indicated Resident 10's Nurse Practitioner was updated on his status and INR. A new order was obtained to be sent to the Emergency Room for evaluation and treatment. A Nurse's Note, dated 2/25/2024 at 1:57 P.M., indicated report was called to the hospital. No resident discharge information/paperwork for the receiving provider could be found in the medical record for the receiving provider, including the State's Transfer and Discharge form. During an interview on 3/1/2024 at 10:42 A.M., the Executive Director indicated that a Transfer/Discharge form should be provided to the resident or resident representative. On 3/2/2024 at 8:45 A.M., the Executive Director provided a policy titled, "Bed Hold Notice Upon Transfer". The policy indicated, " ...At the time of		**By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	

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	transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed ...3. The facility must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless: d. The health of the individuals in the facility would otherwise be endangered ...." 3.1-12(a)(6)(A)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for			

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	hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interviews and record reviews the facility failed to provide the required bed hold form to the resident or resident representative for 3 of 3 residents reviewed for hospitalizations. (Residents 96, 68, and 10) Findings include: 1. During an interview, on 2/25/2024 at 1:35 P.M., Resident 96 indicated she had been hospitalized for ketoacidosis, kidney failure due to diabetes, and two stents. A record review was completed on 2/27/2024 at 8:47 A.M. Diagnoses included, but were not limited to: hypoglycemia, diabetes mellitus type 1, chronic obstructive pulmonary disease, and chronic kidney disease. A Quarterly Minimum Data Set (MDS) assessment, dated 1/30/24, indicated Resident 96 was cognitively intact. A Nurse's Note, dated 8/3/2023, 2:56 A.M., indicated Resident 96 was persistent to be transferred to the Emergency Room for dropping blood sugars, vomiting, severe abdominal pain, and right mouth pain. The Nurse Practitioner agreed to transfer to the Emergency Room. A call was placed to the hospital for report of Resident 96's condition. A Nurse's Note, dated 8/4/2023 at 1:10 P.M., indicated that Resident 96 was transferred back to the hospital for nausea, vomiting, and stomach	F 0625	**F625 Notice of Bed Hold Policy Before/Upon Transfer** It is the practice of this facility to provide the required bed hold form to the resident or the resident representative upon discharge or hospitalization. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 96 – has had no further hospitalizations. Resident 68 – has had no further hospitalizations. Resident 10 – the required bed hold form was sent with resident upon hospitalization. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All resident discharges have been audited to ensure that the required bed hold form was sent with the resident or the resident representative upon discharge or hospitalization.	03/22/2024

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	cramping. No resident discharge information/paperwork for the receiving provider could be found in the medical record for the receiving provider, including a bed-hold policy form. A Nurse's Note, dated 12/19/2023 at 10:37 P.M., indicated that Resident 96 complained of body aches, headache, and cough/congestion. She requested to be sent to the hospital. No resident discharge information/paperwork for the receiving provider could be found in the medical record for the receiving provider, including a bed-hold policy form. During an interview, on 3/1/2024 at 10:42 A.M., the Executive Director indicated that a bed hold policy form should be provided to the resident and/or responsible party. 2. During an interview, on 2/25/2024 at 2:14 P.M., Resident 68 indicated she had been hospitalized. "I almost died. I had sepsis." A record review was completed on 2/27/2024 at 11:20 A.M. Diagnoses included, but were not limited to: dementia, functional quadriplegia, and acute and chronic respiratory failure. On 11/6/2023 at 9:23 A.M., a Nurse's Note indicated Resident 68 was observed to be lethargic, and only responding when her name was called. The Nurse Practitioner gave an order to be sent to the hospital for further evaluation. The Emergency Room staff was informed via telephone. No resident discharge information/paperwork for the receiving provider could be found in the medical record, including a bed hold policy form.		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 3/22/2024. This in-service will be conducted by the Director of Nursing or Designee and will include a review of the transfer/discharge assessment and bed hold policy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled "Resident Transfer/Discharge" weekly for 4 weeks and monthly for at least 6 months. Director of Nursing/Designee will audit all resident discharges daily to ensure required bed hold form was sent to resident or responsible party upon discharge or hospitalization. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance	

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	A Nurse's Note, dated 12/22/2023 at 6:22 P.M., indicated Resident 68 was transferred to the hospital. No resident discharge information/paperwork for the receiving provider could be found in the medical record, including a bed hold policy form. During an interview, on 3/1/2024 at 10:42 A.M., the Executive Director indicated that a bed-hold policy form should be provided to the resident and/or resident representative. 3. A record review was completed on 2/27/2024 at 10:03 A.M. Diagnoses included, but were not limited to: dementia, atrial fibrillation, heart failure, and chronic kidney disease. An Admission Minimum Data Set (MDS) assessment, dated 1/15/2024, indicated Resident 10 had severe cognitive impairment and received an anticoagulant medication. A Nurse's Note on 2/25/2024 at 1:24 P.M., indicated Resident 10's Nurse Practitioner was updated on his status and INR. A new order was obtained to be sent to the Emergency Room for evaluation and treatment. A Nurse's Note, dated 2/25/2024 at 1:57 P.M., indicated report was called to the hospital. No resident discharge information/paperwork for the receiving provider could be found in the medical record for the receiving provider, including a bed-hold policy form. During an interview, on 3/1/2024 at 10:42 A.M., the Executive Director indicated that a bed-hold policy form should be provided to the resident and/or resident representative.		Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	

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	On 3/2/2024 at 8:45 A.M., the Executive Director provided a policy titled, "Bed Hold Notice Upon Transfer". The policy indicated, " ...At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed ...1. Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and/or resident representative written information that specifies: a. The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility. B. The reserve bed payment policy in the state plan policy, if any. C. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed ...2. In the event of an emergency transfers of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold polices, as stipulated in the State's plan ...." 3.1-12(a)(25)A)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately completed, related to PASARR (Pre-Admission Screening and Resident Review) coded incorrectly, for 1 of 27 MDS assessments reviewed. (Resident 7) Finding includes:	F 0641	**F641 – Accuracy of Assessments** It is the practice of this facility to ensure MDS assessments are accurately completed for all residents related to PASARR. **What corrective action(s) will**	03/22/2024

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	A record review was completed on 2/28/2024 at 12:26 P.M. Resident 7's diagnoses included, but were not limited to: Major depressive disorder, dementia without behavioral, psychotic mood and anxiety, delusional disorder, aphasia, anxiety disorder, expressive language disorder, pseudobulbar affect, hydrocephalus, and mild cognitive impairment. A Quarterly MDS (Minimum Data Set) assessment, dated 12/15/2023 indicated Resident 7 had intact cognition. The Admission MDS assessment, dated 8/30/2022, indicated the section for PASARR Level 2 needed was checked no. On 9/25/2019, Resident 7 had a PASARR Level 1 completed, and it determined Resident 7 had a serious mental illness and/or intellectual disability and required a Level II PASARR to be completed. During an interview, on 2/29/24 at 2:47 P.M., the MDS Coordinator indicated it should have been marked yes for PASARR Level 2 needed due to Resident 7's diagnoses and Level 1 results. A policy titled, "Conducting an Accurate Resident Assessment" was provided by the Administrator on 3/1/2024 and indicated it was the policy currently being used. The policy indicated, "...6. The physical, mental and psychosocial condition of the resident determines the appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, medical social workers, dietitians, and other professionals, such as development disabilities specialist, in assessing the resident, and in correcting resident assessments...."		**be accomplished for those residents found to have been affected by the deficient practice:** Resident 7 – MDS has been modified to ensure accuracy with PASARR. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents with a PASARR determining a level 2 have been reviewed. All MDS assessments for residents with a PASARR determining level 2 have been reviewed and modified as appropriate. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All MDS staff will be in-serviced on or before 03/22/2024. This in-service will be conducted by the Executive Director or Designee and will include a review of MDS coding accuracy and conducting an accurate resident assessment. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

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	3.1-31(7)		Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The MDS Coordinator/Designee will be responsible for completing the QAPI Audit tools labeled “MDS Accuracy” weekly for 4 weeks and monthly for at least 6 months. The MDS Coordinator/Designee will audit all resident MDS assessments in window weekly to ensure MDS accuracy related to PASARR. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -			

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	(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review, and interview, the facility failed to ensure an individualized comprehensive care plan was developed for 2 of 2 residents reviewed for bowel	F 0656	**F656 –Develop/Implement Comprehensive Care Plan** It is the practice of this facility to ensure that all residents have	03/22/2024

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	and bladder incontinence (Residents D and 90) and failed to ensure fall care plans were followed for 1 of 4 residents reviewed for falls. (Resident 267) Findings include: 1. During an observation and interview with alert and oriented Resident 90, on 2/26/2024, she indicated she used to get out of bed and go to the bathroom, but now, due to pain in her legs, she was incontinent. She indicated sometimes the aides brought her a bed pan. The record for Resident 90 was reviewed on 2/27/2024 at 11:11 A.M. Diagnoses included, but were not limited to: morbid obesity, cirrhosis of the liver, chronic kidney disease, stage 4, muscle weakness, major depressive disorder and overactive bladder. The Admission Minimum Data Set (MDS) assessment, dated 3/2/2023, indicated she required only supervision for in room ambulation and transfers, and was frequently incontinent of bowel and bladder. A Significant Change MDS assessment, dated 2/13/2024, indicated the resident required moderate assistance for transfers and ambulation up to 50 feet, and required substantial assistance for toileting and transferring needs. The current Care Plans for Resident 90 included a plan to address the resident's assistance needs with activities of daily living, including interventions for toileting and transferring indicating the resident required extensive assistance of one staff.		individualized comprehensive care plans developed related to bowel and bladder incontinence/ It is the practice of this facility to ensure that all resident care plans are followed related to falls. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident D – all residents care plans reviewed and updated as appropriate. Resident 90 – all resident care plans reviewed and updated as appropriate. Resident 267 – all resident care plans reviewed and updated as appropriate, and education provided to staff on following care plans. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. Residents with bowel and bladder incontinence and fall care plans were reviewed to assure they are comprehensive and individualized with residents. Care plans to be reviewed and updated in conjunction with resident MDS assessments or as needed.	

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	A Care Plan addressing the resident's risk for skin breakdown included interventions to assist the resident with routine toileting, and to check for incontinence and provide incontinence care as needed. There was no other, more specific care plan to address the resident's bladder and bowel incontinence. During an interview with CNA 3, on 3/1/2024 at 1:36 P.M., he indicated Resident 90 used to use a stand lift to transfer out of bed, but now required a full mechanical lift to get out of bed. The resident was now either incontinent of her bowel and bladder in her brief, or sometimes would ask for a bedpan. He indicated there was no specific toiileting plan, and she was either checked for incontinence and changed every two hours, or changed and/or given a bed pan when she put her call light on and requested to be assisted. During an interview on 3/1/2024 at 3:45 P.M., CNA 13 indicated Resident 90 did not get out of bed, did not use a bed pan and was totally incontinent of her bowel and bladder. The resident was checked and changed. After looking at her assignment sheet, "x1 extensive assist" was the instruction given, but CNA 13 then reiterated the resident did not get out of bed and was not toileted. During an interview with the MDS coordinator, on 3/1/2024 at 3:05 P.M., she indicated the care plan denoted Resident 90 as "extensive assist of 1," which could refer to toilet use and/or bed pan use. She indicated she was unaware Resident 90 was not getting out of bed, or had previously utilized a stand up lift but was currently requiring a total mechanical lift.		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 3/22/2024. This in-service will be conducted by the Director of Nursing or Designee and will include a review of resident comprehensive care planning, fall prevention program, and following resident care plans. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The MDS Coordinator/Designee will be responsible for completing the QAPI Audit tools labeled “Comprehensive Care Plan Review” weekly for 4 weeks and monthly for at least 6 months. The MDS Coordinator/Designee will audit all resident care plans with incontinence of bowel and bladder and falls weekly to ensure all care plans are accurate, person centered, and being followed by direct care staff. If 100% is not	

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	The current care plans for Resident 90 did not include interventions pertaining to bed pan use, and indicated the resident was still getting out of bed to utilize a toilet, and did not have any type of individualized routine toileting plan for the resident. 2. During an interview with Resident D, on 2/27/24 at 1:53 P.M., he indicated staff never offered to assist him to the toilet. He toileted himself, even though he knew he was supposed to have help and was afraid of falling. He indicated he does put his light on for help but does not wait for help because he does not want to "S---" in his pants. The record for Resident D was reviewed on 2/27/24 at 9:13 A.M. Resident D was admitted to the facility with diagnosis, including but not limited to: Parkinson's disease with dyskinesia, Alzheimer's disease, overactive bladder, history of falls and muscle weakness. A Quarterly Minimum Data Set (MDS) assessment, dated 1/26/2024, indicated the resident had impaired range of motion on one side, was moderately cognitively impaired, required extensive assistance of staff for toileting needs and was frequently incontinent of his bowels and bladder. A Functional Abilities Assessment, dated 2/12/2024, indicated the resident required substantial staff assistance for toileting needs. The current Care Plans for Resident D included a plan to address the resident's needs for assistance with activities of daily living. The plan included an intervention to provide extensive staff		achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	

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	assistance of 2 for toileting needs and assistance with incontinence care as needed. A plan to prevent urinary tract infections included an intervention to provide routine toileting assistance. A plan to address falls had an intervention to assist the resident to toilet after the evening meal at 6:00 P.M. There were no other more specific plans to address incontinence. During an interview, on 2/28/2024 at 2:16 P.M., CNA 3 indicated he attempted to check on the resident (and offer toileting assistance) before and after meals, and every two hours in between times. The resident often took himself to the bathroom, and CNA 3 was unaware of any specific toileting schedule/needs for Resident D. During an interview, on 2/29/2024 at 3:00 P.M., CNA 4 indicated she tried to check (and offer toileting assistance) on Resident D every two hours, but did not know of any set toileting planned schedule for Resident D. The care plan for Resident D was not individualized to address what the resident routine toileting needs and staff were unaware of the only specific toileting time for Resident D.3. During an observation, on 2/29/24 at 11:13 A.M., Resident 267 was sitting near the Nurses' Station in a wheelchair, with black socks, no shoes on his feet and both feet resting on the ground. The wheelchair had an anti-tilt back device, but no fall indicator was noted on the resident's wheel chair. At 11:15 A.M., a staff member placed the resident's feet on the foot rests of the wheel chair, and propelled him towards the dining room. On 2/29/24 at 1:47 P.M., Resident 267 was observed walking quickly past the facility entrance with CNA 21 following him with his			

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	wheel chair. The resident had a gait belt on and his black socks as he approached the Nurses' Station. Another staff member came along side the resident, and both were encouraging him to sit in the wheelchair. Then resident took off at a quick pace down the middle of the hallway, and a nurse came along on other side of resident, encouraging him to have a seat. He then turned around and headed back up the hallway. And then headed down the 100 hallway and at the end of the hallway he was persuaded to have a seat in his wheel chair and then propelled himself up hallway and towards the entrance. On 3/1/24 at 9:27 A.M., the resident was observed in a wheel chair near the Nurses' Station, leaning forward with one foot rest off to side and other in front of him. Both feet had black socks on them and both feet were resting on the floor. Staff approached the resident and offered activities of music, or something in the activity room. During an observation of the resident, on 3/1/24 at 1:03 P.M., CNA 21 was observed propelling the resident from dining room to the Nurses' Station. She placed a gait belt on the resident and explained the resident had taken off away from her yesterday after lunch. CNA 21 indicated at that time, to prevent falls, the resident had his bed left in the low position with a padded mat on floor. The black socks the resident wore were not non-skid socks and he probably should not have them on. On 2/29/24 at 11:18 A.M. a review of the clinical record for Resident 267 was conducted. The record indicated the resident was admitted on 2/16/24. The resident's diagnoses included, but were not limited to: history of falling, multiple sclerosis, Parkinson's Disease and severe			

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	dementia. On 2/20/24, a Fall Risk Assessment indicated the resident was at high risk for a fall. A Progress Note, dated 2/22/24 3:04 P.M., indicated in a hour, the resident had attempted 3 times to get out of his wheel chair. When assisted by staff to be seated, he began to yell and became combative. Distraction was used as a means to calm the resident down, but had been not effective. A Progress Note, dated 2/22/24 at 3:07 P.M., indicated the resident was currently on 1 to 1 attention at this time. Staff were wheeling the resident in the hallway and talking to him. The wheel chair feet had been removed to help prevent against tripping and falling, should the resident attempt to get up again. A Progress Note, dated 2/22/24 at 4:30 P.M., indicated the resident had been found next to his wheelchair in the hallway, with both he and his wheelchair toppled over. A Care Plan, dated 2/16/24, indicated the resident was at risk for falls and a fall related injury due to a history of falls, dementia with behaviors, multiple sclerosis and Parkinson's Disease. The interventions included, but were not limited to: anti-roll back device on wheel chair, encourage resident to lie down in bed when visibly tired and encourage & assist to wear non-skid footwear. On 3/1/24 at 1:22 P.M., the Executive Director provided a current policy titled, "Fall Prevention Program, dated 2023 and reviewed on 1/15/24. The policy indicated "...Each resident will be assessed for fall risk and will receive care and services in			

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	accordance with their individualized level of risk to minimize the likelihood of falls...d. Encourage residents to wear shoes or slippers with non-slip soles when ambulating...6. High Risk Protocols...Place Fall Prevention Indicator on the resident's wheel chair...Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status...." 3.1-35(a)(b)(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. (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.			

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	(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to include or invite residents' family members or responsible parties to participate in Care Plan conferences and failed to revise Care Plans timely for 5 of 5 residents reviewed for care planning. (Residents 95, C, 30, 64 and 27). Findings include: 1. During an interview, on 2/25/2024 at 11:17 A.M., Resident 95's daughter indicated she has not had a care planning meeting since her mother was admitted. A record review was completed on 2/26/2024 at 10:23 A.M. Resident 95's diagnoses included, but were not limited to: metabolic encephalopathy, chronic obstructive pulmonary disease, dementia, hypertensive heart disease, heart failure and hyperlipidemia. An Admission MDS (Minimum Data Set) assessment, dated 1/5/2024, indicated Resident 95 had severe impaired cognition. During an interview, on 2/28/2024 at 9:16 A.M., the Assistant Social Service Director (ASSD) indicated Resident 95 had not had a care conference with the family and she should have had one. 2. During an interview, on 2/25/2024 at 2:01 P.M., Resident C indicated she has not had a care planning meeting. A record review was completed on 2/27/2024 at	F 0657	**F657 – Care Plan Timing and Revision** It is the practice of this facility to ensure that all residents are provided care plan meetings. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 95 – care plan meeting has been offered and scheduled for resident. Resident C – was not identified on sample. Resident 30 – care plan meeting has been offered and scheduled for resident. Resident 64 – care plan meeting has been offered and scheduled for resident. Resident 27 – care plan meeting has been offered and scheduled for resident. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All residents have been audited, and meetings scheduled for any resident that has not	03/22/2024

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	10:22 A.M. Resident C's diagnoses included, but were not limited to: Type 2 diabetes, major depressive disorder, chronic obstructive pulmonary disease, fibromyalgia, malignant neoplasm of colon, mild cognitive impairment and multisystem inflammatory syndrome. A Quarterly MDS (Minimum Data Set) assessment, dated 1/12/2024, indicated Resident C had intact cognition. During an interview, on 2/28/2024 at 2:11 P.M., the Assistant Social Service Director indicated Resident C had not had a care conference, and they were running behind on them. 3. During an interview, on 2/27/2024 at 2:17 P.M., Resident 30's daughter and POA (Power of Attorney) indicated she has not had a care planning meeting for over 6 months. A record review was completed on 2/27/2024 at 2:49 P.M. Resident 30's diagnoses included, but were not limited to: Cognitive communication deficit, hypertensive heart disease, Hyperlipidemia and Osteoarthritis. A Quarterly MDS (Minimum Data Set) assessment, dated 11/27/2023, indicated Resident 30 had moderately impaired cognition. During an interview, on 2/28/2024 at 2:19 P.M., the Assistant Social Service Director indicated Resident 30 had not had a care conference, and they were running behind on them. 4. During an interview with Resident 64, on 2/26/2024 at 9:59 A.M., she indicated she had only had one care planning meeting since she was admitted to the facility.		received a timely care plan meeting. Care plan meetings are being conducted in conjunction with quarterly MDS assessments or as necessary. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All IDT staff will be in-serviced on or before 3/22/2024. This in-service will be conducted by the Executive Director or Designee and will include a review of resident comprehensive care planning. The Social Services Director/Designee will audit all resident assessment schedules weekly to ensure all resident care plan meetings are being offered and completed in a timely manner. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Social Services Director/Designee will be responsible for completing the QAPI Audit tools labeled “Care Plan Meeting Tracking” weekly for 4 weeks and monthly for at least 6	

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	The record for Resident 64 was reviewed on 2/27/2024 at 12:02 P.M. Diagnoses included, but were not limited to: chronic lymphocytic leukemia of B-Cell type, parkinsonism, atrial fibrillation,anemia and atrial flutter. The Admission Minimum Data Set (MDS) assessment was completed on 5/22/2023, a Quarterly MDS assessment was completed on 10/5/2023, and the most recent Quarterly MDS assessment was completed on 1/2/2024. Care Plan Conference documentation and an interview with the Social Service Director (SSD), on 2/29/2024 at 11:00 A.M., indicated there had been a care plan meeting with the resident on 5/17/2023 and another care plan conference on 11/24/2023. The resident's family had requested a meeting on 11/8/2023 and 12/13/2023 but the meetings had not involved the resident. The SSD indicated there was also an August 31, 2023 meeting, but no documentation was completed. 5. The record for Resident 27 was reviewed on 2/27/2024 at 10:33 A.M. Diagnoses, included but were not limited to: cerebral infarction, hemiplegia and hemiparesis, pseudobulbar affect, unspecific dementia and vascular dementia. Resident 27 was observed on 2/25/2024, 2/26/2024, 2/27/2024,, 2/28/2024, 2/29/2024 and 3/1/2024 lying in her bed for a majority of the day time hours, except during the meal time, when she was placed in a reclining wheelchair and taken to the dining room. After meals, she was placed in the hallway across from the Nurses' Station, until she was pushed to her room and placed in her bed. There was no television or music playing in her room and no activity staff were observed to go into her room to provide any type of 1:1 activity with		months. The Social Services Director/Designee will audit all resident assessment schedules weekly to ensure all resident care plan meetings are being offered and completed in a timely manner. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	

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	Resident 27., A Significant Change Minimum Data Set (MDS) assessment, completed on 1/15/2024, indicated the resident was severely cognitively impaired, had impaired mobility on one side both upper and lower extremity, had experienced a significant, unplanned weight loss and had two stage 3 pressure ulcers. The preferences section indicated the resident liked religious activities, outdoor activities, doing activities with groups of people and liked music. A Significant Change Activity Review, completed on 1/29/2024, indicated the resident attended some church and some small groups on the unit, and had very little family involvement. The activity care plan was not to be changed. The Activity Care Plan for Resident 27 indicated she benefited for being involved in small groups with activity staff. The goal was to involve her in small groups, such as music, exercise, reading and/or talking three times a week. A second plan, addressing the resident's strengths, lifestyle and background, indicated the resident received support from her family, enjoyed music, especially jazz music, drew strength from religious activities. The plan had interventions to place the resident in common areas with groups of people when awake, offer tea and cranberry juice and indicated the resident liked chocolate. During an observation of wound care, on 2/28/2024 in the morning, the wound nurse indicated the resident was to be placed in her bed after meals due to her pressure ulcers. Review of the activity participation log for			

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	Resident 27, on 2/29/2024 at 12:30 P.M. with the Activity Director, indicated the resident was marked as having attended a music activity daily. The Activity Director indicated music played during meals. During the interview, which occurred in the dining room during the noon meal, the background music playing was very faint and hard to hear over the noise of the meal time. Besides the daily background music during meals, the resident was only marked as having attended a nail care/beauty/spa activity during the week. Regarding why the care plan still indicated the resident was to attend small group activities when she was being placed in bed after meals due to her wounds, the Activity Director indicated sometimes things just "fell through the crack." The facility policy and procedure, titled, "Activities" provided by the Administrator as current on 3/2/2024 at 8:45 A.M. included the following: "...Policy: It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment..." A current facility policy, revised on 6/2018, titled "Care Planning-Interdisciplinary Team," provided by the Executive Director on 3/1/2024 at 1:40 P.M., indicated the following: "...1. A comprehensive care plan for each resident is developed within 7 days of completion of the resident assessment (MDS). 2. The care plan is based on the residents comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team which includes, but is not necessarily limited to the following personnel: a. Residents Attending Physician b. The Registered Nurse who has responsibility for the resident c. The Dietary Manager/Dietician			

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MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

(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
	d. The social worker e. The Activity Director/Coord f. Therapists g. Consultants h. The Director of Nursing i. The charge nurse responsible for the resident j. Nursing Assistants k. Others as appropriate 3. The resident, resident family and/or legal guardian/representative are encouraged to participate in the development of and revisions to the residents careplan. 4. Every effort will be made to schedule care plan meetings at the best time of day for the resident and family. 5. When a resident has no family, the ombudsman will be invited to attend the careplan meeting if desired by the resident...." 3.1-35 (d)(2)(B) 3.1-35(e)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure 5 of 5 dependent residents reviewed for Activities of Daily Living received needed assistance related to AM care, showers, and shaving. (Residents E, D, B, C, & G) Findings include: 1. During an interview with alert and oriented Resident E on 2/26/24 at 9:17 A.M., he indicated	F 0677	**F677- ADL Care Provided for Dependent Residents** It is the practice of this facility to ensure that all residents receive AM care, showers, and shaving per their preference. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	03/22/2024

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	the staff did not bring him any water or washcloths and towels to wash his face and hands in the mornings. Resident E indicated he could not walk or go into the bathroom, but could wash his face and hands with assistance if he was brought the proper supplies. The record for Resident E was reviewed on 2/27/2024 at 9:46 A.M. Diagnoses included, but were not limited to: paraplegia, thyrotoxicosis with diffuse goiter, history of multiple injuries, chronic pain and hypothyroidism. A Quarterly Minimum Data Set (MDS) assessment, dated 1/30/2024, indicated the resident was alert and oriented, had limited range of motion for both lower extremities, and required extensive staff assistance for dressing, bathing and personal hygiene needs. Resident E was observed daily on 2/25/2024 - 2/29/2024 seated on the edge of his bed. The resident was interviewed daily regarding his morning care and indicated he was not offered any water, soap or washcloths to wash his face, hands or upper extremities/torso. He indicated he only had hand sanitizer available to clean his hands. Resident E was observed on 3/1/2024 at 8:45 A.M. seated on the side of his bed eating breakfast. He indicated no one had offered him any care or assisted him to change clothes. At 9:15 A.M., during wound care, CNA 12 changed Resident E's shirt prior to the wound care and changed Resident E's outside pants after wound care. The resident was not offered any water, soap or linens. During an interview with the Assistant Director of Nursing (ADON), on 3/1/2024 at 3:00 P.M., she		**practice:** Resident E– residents AM care and bathing preferences reviewed and updated Resident D – residents AM care and bathing preferences reviewed and updated Resident B – residents AM care and bathing preferences reviewed and updated Resident C – residents AM care and bathing preferences reviewed and updated Resident G – residents AM care and bathing preferences reviewed and updated **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All residents AM care, bathing preferences, and shaving preferences reviewed and updated. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 03/22/2024. This in-service will be conducted by the Director of Nursing or Designee and will include a review of resident ADLs related to shower	

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	indicated daily morning care should include face washing, hair brushing, shaving for men, and dressing. There was no specific policy and procedure describing what was to be included with morning care. 2. During an interview, on 2/27/2024 at 1:27 P.M., Resident D and a family member indicated the resident was not routinely receiving his showers as scheduled. The resident's family member indicated part of the issue was there had not been hot water on the unit for the past two months. The record for Resident D was reviewed on 2/27/24 at 9:13 A.M. Diagnoses included, but were not limited to: Parkinson's disease with dyskinesia and Alzheimer's disease. A Quarterly MDS assessment, dated 1/26/2024, indicated the resident had range of motion impairment on one side, was moderately cognitively impaired, was frequently incontinent of bowels and bladder, and required substantial staff assistance for bathing and personal hygiene needs. The current care plans for Resident D included a plan to address Activities of Daily Living needs, with an intervention to provide bathing/showering care on Monday and Thursday on the second shift. The Shower Records in the resident's electronic chart and written Shower Sheets indicated the resident had received a shower on 1/18/2024, 1/25/2024, 1/30/2024, 2/4/2024, 2/12/2024, 2/21/2024 and 2/27/2024. The resident had missed a scheduled shower on 1/22/2024, 2/1/2024, 2/8/2024, 2/15/2024, 2/19/2024. The resident had received 7 showers in the past 6 weeks and had		preferences, AM care, and shaving. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled "Resident Shower Schedules" weekly for 4 weeks and monthly for at least 6 months. The Director of Nursing/Designee will audit all resident shower schedules daily to ensure that all residents are receiving showers, AM care, and shaving per preference. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	

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	missed 5 bathing/shower opportunities. 3. During an interview, on 2/25/2024 at 1:50 P.M., Resident B indicated the facility has had no hot water and he had not been receiving showers. He had reported the issue to the state at the beginning January. A record review was completed on 2/28/2024 at 9:56 A.M. Resident B's diagnoses included, but were not limited to: Hypertension, benign prostatic hyperplasia, type 2 diabetes, acute and chronic respiratory failure, hypertensive heart disease and adjustment disorder with mixed anxiety and depressed mood. An Admission MDS (Minimum Data Set) assessment, dated 12/21/2023, indicated Resident B had intact cognition and required substantial maximum assistance with bathing Resident B's Shower Schedule indicated he was to be showered on Tuesday and Friday every week. Resident B's Shower Sheets indicated, between the dates of 2/2/2024 and 2/27/2024, Resident B had only 3 showers documented. During an interview, on 2/29/24 at 9:57 A.M., the MDS Coordinator indicated residents should be getting at least 2 showers every week. 4. During an interview, on 2/25/2024 at 2:01 P.M., Resident C indicated she had hardly had any showers for a month. The facility would document that she had refused, but the water was ice cold. A record review was completed on 2/27/2024 at 10:22 A.M. Resident C's diagnoses included, but were not limited to: Type 2 diabetes, major			

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	depressive disorder, chronic obstructive pulmonary disease, fibromyalgia, malignant neoplasm of colon, mild cognitive impairment and multisystem inflammatory syndrome. A Quarterly MDS (Minimum Data Set) assessment, dated 1/12/2024, indicated Resident C had intact cognition and required one assist for bathing. Resident C's shower schedule indicated she was to be showered on Tuesday and Friday every week. Resident C's shower sheets indicated, between the dates of 1/30/2024 and 2/23/2024, Resident C had 4 showers documented. During an interview, on 2/29/24 at 11:13 A.M., the MDS Coordinator indicated residents should be getting at least 2 showers every week. 5. On 2/29/24 at 9:25 A.M., Resident G was observed in bed and alert to self. He had no beard, but whiskers on his face indicated he had not been recently shaven. During an interview, on 2/29/24 at 9:46 A.M., the resident's wife indicated the facility had been without warm or hot water for a month. He was not getting shaved and therefore food got caught in his beard. He also went without showers due to no hot water. She had filed a grievance the end of January, and was told they were working on it. The wife indicated she had finally shaved him herself. On 2/29/24 at 9:46 A.M., a review of the clinical record for Resident G was conducted. The resident's diagnoses included but were not limited to: Huntington's Disease, depression and			

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	dementia. An Activities of Daily Living (ADL) Care Plan indicated the resident required assistance with ADLs due to weakness and need for personal care assistance. The interventions included, but were not limited to: showers on first shift every Tuesday/Friday and resident was dependent on 1 staff member for incontinence care and personal hygiene, which included shaving. A Shower Sheet, dated January 2024, indicated a shower or bed bath was not completed on the following dates: 1/2/24, 1/12/24, 1/16/24 and 1/26/24. A Shower Sheet, dated February 2024, indicated a shower or bed bath was not completed on the following dates: 2/2/24, 2/6/24, 2/20/24, 2/23/24 and 2/27/24. All shower sheets for January and February did not indicate the resident had been shaven. During an interview, on 3/1/24 at 9:35 A.M., CNA 10 indicated if a resident had been shaven on their bathing day, it would be documented on the shower sheets. On 3/1/24 at 1:39 P.M., the Executive Director provided a policy titled, " Activities of Daily Living (ADLs), dated 2023 and revised on 1/15/24, and indicated the policy was the one currently used by the facility. The policy indicated "...3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene...." This citation relates to Complaints IN00427600			

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	and IN00428292. 3.1-38(a)(3)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to provide an individualized activity program for 1 of 2 residents reviewed for activities. (Resident 27) Finding includes: The record for Resident 27 was reviewed on 2/27/2024 at 10:33 A.M. Diagnoses included, but were not limited to: cerebral infarction, hemiplegia and hemiparesis, pseudobulbar affect, , unspecific dementia and vascular dementia. Resident 27 was observed on 2/25/2024, 2/26/2024, 2/27/2024,, 2/28/2024, 2/29/2024 and 3/1/2024 lying in her bed for a majority of the day time hours, except during the meal time, when she was placed in a reclining wheelchair and taken to the dining room. After meals, she was placed in the hallway across from the nurse's station until she was pushed to her room and placed in her bed. There was no television or music playing in her room	F 0679	**F679- Activities Meet Interest/Needs Each Resident** It is the practice of this facility to ensure that all residents are provided an individualized activity program. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 27 – resident has been discharged from facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient	03/22/2024

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	and no activity staff were observed to go into her room to provide any type of activity with Resident 27. A Significant Change Minimum Data Set (MDS) assessment, completed on 1/15/2024, indicated the resident was severely cognitively impaired, had impaired mobility on one side both upper and lower extremity, had experienced a significant, unplanned weight loss and had two stage 3 pressure ulcers. The preferences section indicated the resident liked religious activities, outdoor activities, doing activities with groups of people and liked music. A Significant Change Activity Review, completed on 1/29/2024, indicated the resident attended some church and some small groups on the unit and had very little family involvement. The assessment indicated the activity care plan was not to be changed. The Activity Care Plan for Resident 27 indicated she benefited for being involved in small groups with activity staff. The goal was to involve her in small groups, such as music, exercise, reading and/or talking three times a week. A second plan, addressing the resident's strengths, lifestyle and background indicated the resident received support from her family, enjoyed music, especially jazz music, drew strength from religious activities. The plan had interventions to place the resident in common areas with groups of people when awake, offer tea and cranberry juice and indicated the resident liked chocolate. During an observation of wound care, on 2/28/2024 in the morning, the wound nurse indicated the resident was to be placed in her bed		practice. All residents reviewed to ensure that activities offered are individualized to resident needs and interests. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All activity staff will be in-serviced on or before 3/22/2024. This in-service will be conducted by the Executive Director or Designee and will include a review of Individual Activities. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Activity Director/Designee will be responsible for completing the QAPI Audit tools labeled "Activities" weekly for 4 weeks and monthly for at least 6 months. The Activity Director/Designee will audit all resident Activity Care Plans to ensure accuracy and that facility is providing appropriate individualized activities to all residents. If 100% is not achieved an action plan will be	

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	after meals due to her pressure ulcers During an interview with Activity Aide (AA) 6, on 2/29/2024 at 11:00 A.M., she indicated Resident 27 usually went to a small group in the morning on her unit. The resident sometimes attended Bingo and a memory activity one time a week in the afternoon. AA 6 confirmed the resident had not attended those activities this week. AA 6 also indicated Resident 27 was not being provided any individual 1:1 activities. Review of the activity participation log for Resident 27, on 2/29/2024 at 12:30 P.M. with the Activity Director, indicated the resident was marked as having attended a music activity daily. The Activity Director indicated the music played during meals. During the interview, which occurred in the dining room during the noon meal, the background music playing was very faint and hard to hear over the noise of the meal time. Besides the daily background music during meals, the resident was only marked as having attended a nail care/beauty/spa activity during the week. The facility policy and procedure, titled, "Activities" provided by the Administrator as current on 3/2/2024 at 8:45 A.M. included the following: "...Policy: It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessments, care plans, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental , and psychosocial well-being...." 3.1-33(a)		developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	

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F 0684 SS=G Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview, record review, and observation, the facility failed to identify and manage an acute change in condition of worsening respiratory symptoms, irregular blood sugar levels, and abnormal laboratory results not addressed. The deficient practice resulted in a delayed hospital evaluation, and hospitalization for pneumonia, acute kidney injury on chronic kidney disease, and cardiac disease (Resident 96). The facility failed to notify the physician of blood sugars outside of ordered parameters (Resident 109), to assess and treat a scabbed skin area (Resident 27), and to identify and notify the physician of bruising and swelling in a resident who received an anticoagulant medication (Resident 64) for 4 of 5 residents reviewed for quality of care. Findings include: 1. During an interview, on 2/25/2024 at 1:35 P.M., Resident 96 indicated she had been hospitalized for ketoacidosis, kidney failure due to diabetes, and two heart stents. A record review was completed on 2/27/2024 at 8:47 A.M. Diagnoses included, but were not limited to: hypoglycemia, diabetes mellitus type 1,	F 0684	**F684 – Quality of Care** It is the practice of this facility to identify and accurately manage all acute changes of condition. It is the practice of this facility to identify and address bowel habits for all residents. It is the practice of this facility to inform the physician of any vitals out of the specified parameter range. It is the practice of this facility to assess skin abnormalities for residents on anticoagulant medications. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 96 – all current labs reviewed by NP and plan of care updated as needed. Resident 68 – all resident outputs have been reviewed by NP and plan of care updated as needed. Resident 109 – all vitals have been	03/22/2024

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	chronic obstructive pulmonary disease, and chronic kidney disease. A Quarterly Minimum Data Set (MDS) assessment, dated 1/30/24, indicated Resident 96 was cognitively intact. A Nurse's Note, dated 12/1/2023 at 7:23 A.M., indicated Resident 96 was at the nursing station requesting medication, and was observed to be short of breath. Her lungs were diminished, and wheezes were heard. Resident 96 indicated to the nursing staff that the primary care physician told her if she wasn't better by Monday (12/4/2023), he would admit her to the hospital. She refused a chest x-ray at that time. A Nurse's Note, dated 12/1/2023 at 11:35 P.M., indicated the physician ordered a new cough medication. A Nurse Practitioner (NP) Note, dated 12/8/2023, indicated Resident 96 had finished a course of antibiotic therapy of Levaquin and doxycycline from her physician, and continued to have yellowish-tan mucus with a productive cough. Resident 96's lung sounds were course, she had a stuffy nose, and green drainage. The NP gave diagnoses of sinusitis, with prescriptions for Flonase and Linezolid, and pneumonia, with prescriptions for guaifenesin with codeine and a chest x-ray. He also adjusted her insulin medications. No new orders were given for monitoring of Resident 96's condition. A Nurse's Note, dated 12/9/2024 at 6:09 P.M., indicated Resident 96 was on day two of antibiotic therapy due to a diagnosis of pneumonia. She reported being in mild discomfort but requested no pain medication.		reviewed by NP and plan of care updated as needed. Resident 64 – resident bruising and anticoagulation use have been reviewed by NP and plan of care updated as needed. Resident 27 – resident has been discharged from facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All residents with an acute change in condition, abnormal labs, vitals out of range, and anticoagulation medication have been reviewed by IDT and NP to ensure appropriate plan of care is in place, with timely follow up with physician. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 03/22/2024. This in-service will be conducted by the Director of Nursing or Designee and will include a review of change of condition, blood glucose monitoring, abnormal labs, anticoagulation mediation and skin conditions, bowel elimination protocol, and notification to NP.	

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	A Nurse's Note, dated 12/12/2024 at 6:28 A.M., Resident 96 complained of being short of breath. Her vital signs and blood sugar were within normal limits. A Nurse's Note, dated 12/13/2024 at 7:14 A.M., indicated Resident 96's blood sugar measured 60 mg/dl (milligrams per deciliter). The resident refused orange juice, but drank a cola, and stated she didn't feel well. Her blood sugar dropped further to 45 mg/dl after 20 minutes. Resident 96 drank another cola, and her blood sugar increased after an hour to 90 mg/dl. A Nurse's Note, dated 12/15/2024 at 7:07 A.M., indicated Resident 96 was observed in her room snoring loudly and salivating. Her blood sugar was checked and was 47 mg/dl. An as needed Baqsimi (glucagon nasal spray for emergency hypoglycemia) medication was administered, and the Nurse Practitioner notified. After 15 minutes, Resident 96's blood sugar was 43 mg/dl. A second dose of Baqsimi was administered, and as Resident 96 was able to talk, a glass of orange juice was provided. Resident 96's blood sugar was rechecked and recorded as 67 mg/dl. A Nurse's Note, dated 12/16/2024 at 1:03 P.M., indicated Resident 98 was having fatigue and required more assistance with activities of daily living (ADLs). A chest x-ray was ordered and an order for antibiotic therapy received. On 12/17/2024, a chest x-ray indicated, " ...interval development of platelike atelectatic changes int eh right perihilar middle lung zone and bilateral lower lung fields, and was signed by the nurse practitioner on 12/18/2024.		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled “Change of Condition” daily for 1 week, weekly for 4 weeks, and monthly for at least 6 months. The Director or Nursing/Designee will audit all facility 24-hour report daily to ensure all changes of condition are appropriately managed, all vitals out of range are communicated to NP, all abnormal labs are communicated to NP, all skin conditions related to medication use are communicated to NP, and bowel elimination protocol is followed appropriately for all residents. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	

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	155689	A. BUILDING 00 B. WING	03/02/2024

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	A Nurse's Note, dated 12/17/2024 at 7:49 A.M., indicated Resident 96 complained of not feeling well and nauseated. She was encouraged to drink water and to eat small frequent meals. At 12:35 P.M., Resident 96 indicated she was still not feeling well, and had a stomachache with nausea, and indicated no appetite and coughing. Resident 96 requested to be sent to the hospital. A video call with Resident 96 and a physician occurred and the physician ordered medications, STAT (with no delay) labs, and a chest x-ray. The medication ordered was famotidine. Laboratory results were received in the electronic medical record on 12/17/2023 at 10.23 P.M. The results included a white blood cell count of 10.4 (normal 3.4-15.5), neutrophils 90.2 H (normal 45.0-75.0), lymphocytes 5.3 L (normal 17.0-43.0), bun urea nitrogen (BUN) 2.78 H (normal 0.6-1.1), creatinine 2.278 H (normal 0.6-1.1), and sodium 134 (normal 134-146). The Nurse Practitioner (NP) reviewed the labs on 12/18/2024 at 10:16 A.M. Prior lab results, dated 11/28/2023, indicated a BUN of 19 (normal 7-25), and creatinine 1.38 (normal 0.5-1.03). There was no documentation indicating the NP was notified timely of the STAT test results. An NP Note, dated 12/18/2023, indicated Resident 96 was seen for follow-up of cough and congestion. The NP indicated the chest x-ray showed containment in her right lung and likely aspiration. Her sinusitis could possibly be gastroparesis, and ordered a chest x-ray, computerized tomography scan, and speech therapy. He did not address her STAT laboratory results, which were not within normal levels. A Nurse's Note, dated 12/19/2023 at 10:37 P.M., indicated Resident 96 was complaining of body		The facility will be providing additional documentation to respectfully IDR this deficiency. The facility respectfully denies and disputes the allegation that it was deficient regarding F684 and requests that the deficiency identified as F684 be decreased to a D level for the reasons set forth herein.	

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	aches, headache, and cough with congestion. Resident 96 requested to go to the hospital. The facility obtained a Physician's Order to send her to the Emergency Department for evaluation and treatment. A Hospital Health Summary, dated 12/26/2023, indicated Resident 96 presented to the emergency department for complaints of shortness of breath. She had an elevated creatinine reflecting acute on chronic kidney injury and had an elevated troponin. Resident 96 was admitted for further workup. Cardiology felt Resident 96 needed further care for her renal dysfunction before attempting further treatment of the cardiac issues. Diagnoses of non-ST elevation MI (heart attack), and acute kidney injury superimposed on chronic kidney disease were given. During an interview, on 3/1/2024 at 10:51 A.M., the Assistant Director Nursing indicated practitioners have the ability to review lab results via the electronic medical record, and the record indicated the STAT labs had been viewed by the Nurse Practitioner on 12/18/2024 at 10:16 A.M. There was no documentation that the nursing staff had notified the Nurse Practitioner of the abnormal STAT labs. On 3/2/2024 at 10:13 A.M., the Assistant Director of Nursing Services indicated the staff nurses should be reviewing labs also, and indicated the nurses and the nurse practitioner should have addressed the abnormal labs. 2. During an interview, on 2/28/2024 at 9:01 A.M., Resident 109 indicated she received insulin injections. A record review was completed on 2/28/2024 at			

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	9:01 A.M. Diagnoses included, but were not limited to: chronic respiratory failure, diabetes mellitus, type 2, chronic kidney disease, and dependence on renal dialysis. A Quarterly Minimum Data Set (MDS) assessment, dated 2/9/2024, indicated Resident 109 was cognitively intact, and received insulin. Physician Order's, dated 1/2/2024, indicated to call the physician for a blood sugar less than 70 and greater than 400. A Care Plan, dated 1/8/2024, indicated Resident 109 was at risk for complications and symptoms of hypoglycemia or hyperglycemia due to a diagnosis of diabetes with an intervention of to document abnormal findings and notify the physician. Blood sugar documentation for January 2024 and February 2024 indicated the following: - 1/2/2024 11:57 A.M. 412 - 1/10/2024 8:19 A.M. 58 - 1/12/2024 7:39 A.M. 48 - 2/13/2024 12:46 P.M. 412 The medical record did not have any documentation of the Physician being informed of the abnormal blood sugars. During an interview, on 3/1/2024 at 10:29 A.M., the Assistant Director of Nursing indicated Resident 109 had parameters to notify the physician if the blood sugar result was below 60 and above 400. At 10:34 A.M. on 3/1/24, the Executive Director indicated there was no documentation of the physician or nurse practitioner being notified of			

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	the blood sugars out of range. A policy was provided on 3/2/2024 at 8:45 A.M. by the Executive Director. The policy titled, " Blood Glucose Monitoring", indicated, " ...It is the policy of this facility to perform blood glucose monitoring to diabetic residents as per physician's orders ...." The policy does not address notification of the medical professional for blood sugars outside the ordered blood sugar range.3. Resident 27 was observed on 2/25/2024 at 2:10 P.M., lying in her bed awake. The resident was noted to have a dark colored scabbed area, approximately the size of a thumb nail, on the side of her right nares. The top 2/3 of the scab was very dark and dry and the bottom 1/3 was a lighter dark red color and moist. The record for Resident 27 was reviewed on 2/27/2024 at 10:33 A.M. Diagnoses included, but were not limited to: cerebral infarction, hemiplegia and hemiparesis, unspecific dementia, seizures, generalized anxiety disorder, vascular dementia and muscle weakness. A Significant Change Minimum Data Set (MDS) assessment, dated 1/15/2024, indicated the resident was severely cognitively impaired, had impaired mobility of her upper and lower extremity on one side and had two stage 3 pressure ulcers. The Care Plans for Resident 27 did not mention a large scabbed area on her nose. The care plans did include a plan addressing the resident's risk for altered skin integrity with an intervention to inspect the skin weekly, document and notify the MD of abnormal findings and the resident was at risk for impaired skin integrity related to aspirin use and decreased mobility.			

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	A late entry required Physician's Note, dated 1/29/2024, did not mention any skin issues, including the large scabbed area on the resident's nose. A Wound Nurse Practitioner's note, dated 2/12/2024, mentioned the resident's pressure areas on her left ischium, left buttocks and coccyx and assessed the resident's skin as "dry", but there was no documentation of the large scab to the resident's nose. There was no documentation or mention of the scabbed nose in the Nursing Progress Notes for February 2024. A Weekly Nursing Summary form, dated 2/7/2024, did not mention any large scabbed area on the section of the assessment to address skin issues. During an interview with CNAs 7 and 8, on 2/27/24 at 11:24 A.M., both CNAs indicated the resident had the spot on her nose since she was admitted, and at times would pick at it and make it bleed. During an interview with LPN 9, on 2/28/24 at 10:17 A.M. .she indicated the area on the resident's nose was a scab. LPN 9 indicated she did not know how long the resident had had the scab on her nose. The scab was "nothing new," but she did not document herself about the scab because she was focused on pressure ulcers on her wound documentation. During an interview with RN 2, on 2/28/2024 at 11:00 A.M. she indicated impaired skin should be documented and the NP (nurse practitioner) notified of the areas. RN 2 indicated she thought the resident had had the large scab for at least the			

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	past 5 months. Although RN 2 was aware of the large scabbed area to Resident 27's nose, she could not explain where documentation regarding impaired skin would be located in the clinical record. During an interview on 2/28/2024 at 2:00 P.M., RN 2 indicated there was no documentation of the scabbed area for Resident 27's nose. The facility policy, titled "Skin Assessment" provided by the Administrator and indicated as current, on 3/2/2024 at 8:45 A.M. included the following: "...h. Note any skin conditions such as redness, bruising, rashes, blisters, skin tears, open areas, ulcers, and lesions...7. Documentation of skin assessment:...b. Document observations (e.g. skin conditions...) c. Document type of wound. d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain)...." 4. During the initial tour of the facility, conducted on 2/25/2024 between 9:30 A.M. - 11:00 A.M., Resident 64 was observed seated in her room in a wheelchair. The resident was noted to have bruising around each antecubital (inner elbow) area, and extensive bruising and slight swelling of the top of her left hand. During an observation and interview with Resident 64, on 2/26/24 at 10:02 A.M. the resident's left hand was again noted to have extensive bruising and was swollen. The resident indicated she thinks she ran into the bathroom doorframe when she was toileting herself and she thought the nursing staff was aware of the bruises. The record for Resident 64 was reviewed on			

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	2/27/2024 at 12:02 P.M. Diagnoses included, but were not limited to: chronic lymphocytic leukemia of B-Cell type, parkinsonism, atrial fibrillation, anemia and atrial flutter. The Physician's Orders for Resident 64 included orders for the medication Apixaban (anticoagulant - a medication to thin the blood). The Care Plans for Resident 64 included a plan to address the resident's use of anticoagulant therapy, which increased the resident's risk for abnormal bleeding. Interventions included inspecting the skin during care for bruising or increased bruising and notify the nurse of abnormal findings and observing the resident for signs of abnormal bleeding including increased frequency of bruising and increased size of bruising, documenting the findings and notifying the physician of abnormal findings. There was no documentation of the bruising or swelling to the resident's hand in the clinical record. During an interview on 2/28/2024 at 1:58 P.M., RN 2 indicated she had noticed the resident's left hand and notified the NP (nurse practitioner) to look at her today. RN 2 indicated she was planning to put the documentation in the nursing progress notes. A Nursing Progress Note, dated 2/28/24 at 2:13 P.M., documented increased swelling left (unable to decipher charting) NP notified and no new orders. The facility policy, titled "Skin Assessment" provided by the Administrator and indicated as current, on 3/2/2024 at 8:45 A.M. included the			

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	following: "...h. Note any skin conditions such as redness, bruising, rashes, blisters, skin tears, open areas, ulcers, and lesions...7. Documentation of skin assessment:...b. Document observations (e.g. skin conditions...) c. Document type of wound. d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain)...." 3.1-37			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on observation, record review, and interview, the facility failed to ensure 1 of 3 residents reviewed for vision needs received timely assistance to address visual impairment needs. (Resident 64) Finding includes: During the initial tour of the facility, conducted on 2/25/2024 between 9:30 - 11:00 A.M., Resident 64 was observed seated in her wheelchair in her room. The resident was noted to wear eyeglasses.	F 0685	**F685 – Treatment/Devices to Maintain Hearing/Vison** It is the practice of this facility to ensure residents receive vision services in a timely manner. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 64 – vision services have been scheduled for resident.	03/22/2024

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	During an interview with Resident 64, on 2/26/24 at 10:01 A.M., the resident indicated her current glasses were not strong enough and she needed new glasses. She had not seen an eye doctor since she had been admitted to the facility. The record for Resident 64 was reviewed on 2/27/2024 at 12:02 P.M. Diagnoses included, but were not limited to: chronic lymphocytic leukemia of B-Cell type, parkinsonism, atrial fibrillation, anemia, atrial flutter, presence of right and left artificial knee joint. The Admission Minimum Data Set (MDS) assessment, dated 5/22/2023, indicated the resident's vision was adequate without any corrective lenses. A Quarterly MDS assessment, dated 1/2/2024, indicated the resident's vision was adequate with corrective lenses. There was no care plan to address any impaired vision and/or visual needs for Resident 64. There was no documentation in the clinical record of any consents for optometry services being signed on admission, and there was no documentation of any eye care services being received. During an interview with the Social Services Director (SSD), on 2/29/2024 at 2:30 P.M., she indicated a previous staff member had failed to obtain consents for ancillary services for Resident 64. She was unaware Resident 64 needed to see an eye doctor, and confirmed there was no documentation the resident had been seen by an eye doctor since her admission.		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the deficient practice. All residents needing assistance with vision services and/or who have consented to vision services have been reviewed and appointment scheduling has been initiated. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 03/22/2024. This in-service will be conducted by the Social Services Director or Designee and will include a review of vision services and communication to social services on resident needs. The Social Services Director/Designee will review all residents with consents for vision services and/or dental needs and initiate appointment scheduling. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

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	The facility policy and procedure, titled, "Hearing and Vision Services" provided as current by the Administrator on 3/2/2024 at 8:45 A.M. included the following: "...1. The facility will utilize the comprehensive assessment process for identifying and assessing a resident's vision and hearing abilities in order to provide person-centered care...." 3.1-39(a)(1)		Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Social Services/Designee will be responsible for completing the QAPI Audit tools labeled “Vision Services” weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			

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	Based on observation, interview, and record review, the facility failed to ensure appropriate interventions were in place to ensure an area for a resident with a previous pressure ulcer remained closed and/or healed, for 1 of 4 residents reviewed for pressure ulcers. (Resident 17) Finding includes: On 2/28/24 at 1:54 P.M., an observation of a pressure wound dressing change for Resident 17 was conducted with LPN 9. The LPN washed her hands and then removed the left off-loading boot. She then sanitized her hands, donned gloves, and removed a dressing dated 2/28/24. The Stage III pressure wound was observed on the left lateral heel. The wound had serous drainage with granulation tissue, no odor, and the resident indicated "it hurts a little when changing the dressing". LPN 9 removed her gloves and sanitized her hands, then applied new gloves. The wound was measured as 5.0 x 5.0 x 0.2 cm. The wound was cleansed with wound cleanser, then collagen and calcium algenate was applied to the wound bed, an abdominal dressing was placed over the wound area, and then wrapped in kerlix gauze and secured with tape. LPN 9 indicated the wound was acquired at the facility and the resident had a history of wounds in the same area. The resident had a low air loss mattress in use. On 2/29/24 at 4:00 P.M., a review of the clinical record for Resident 17 was conducted. The resident's diagnoses included but were not limited to: diabetes, heart disease, heart failure and cerebrovascular accident. The Quarterly Minimum Data Set (MDS) Assessment, dated 1/2/24, indicated the resident was a maximum assist with turning in bed, was	F 0686	**F686- Treatment/Svcs to Prevent/Heal Pressure Ulcer** It is the practice of this facility to ensure appropriate interventions are in place to ensure areas for residents with previous pressure ulcers remain closed or healed. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 17 – resident skin and wound interventions reviewed and updated as appropriate. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents with previous pressure areas or at risk for pressure areas have the potential to be affected by this deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 03/22/2024. This in-service will be conducted by the Director of Nursing or Designee and will include a review of the skin management program, pressure injury prevention	03/22/2024

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	always incontinent of bowel/bladder and had one Stage III pressure ulcer. A Braden scale for predicting pressure sore risk was conducted on 7/19/23, and indicated the resident was at mild risk for developing a pressure ulcer. An Impaired Skin Integrity Care Plan, dated 12/18/23, indicated the resident had a right left heel opening (Stage III Pressure Injury) due to not keeping his heels elevated. The interventions included, but were not limited to: assess/document skin condition, notify MD of signs & symptoms of infection, assess for pain, assist with bed mobility, wound treatment as ordered, and notify MD if worsening or not improving. Another Care Plan for Impaired Skin Integrity, dated 10/22/20 with revision on 2/21/24, had interventions which included, but were not limited to: Heel-medix boots to bilateral feet while in bed. A Wound Evaluation, dated 1/25/23, indicated the resident had a left heel, unstageable pressure ulcer, acquired on 1/11/23. The wound bed was 100% slough and measured 2.59 x 3.43 cm. Treatment had been to do dressing changes daily and apply betadine, kerlix dressing, float heels and apply soft loading heel boats. A Wound Assessment Report, dated 9/8/23, indicated the resident had an in-house acquired Stage III pressure ulcer which was discovered on 1/11/23. The wound measured 4.0 x 4.50 x 0.10 cm. The wound had moderate amount of exudate and was worsening. The treatment consisted of wound cleanser, application of collagen, then calcium alginate, an ABD (abdominal dressing)		guidelines, and following plan of care. The Director or Nursing/Designee will audit all residents with current or closed pressure areas to ensure that appropriate interventions are in place and being carried out. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled “Skin Management” weekly for 4 weeks, and monthly for at least 6 months. The Director of Nursing/Designee will audit all residents with current or closed pressure areas to ensure that appropriate interventions are in place and being carried out. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	

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	155689	A. BUILDING 00 B. WING	03/02/2024

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	and rolled gauze. A Wound Assessment Report, dated 11/6/23, indicated the wound had resolved. A Pressure Ulcer - Weekly Observation form, dated 12/4/23, indicated the left heel had a DTI (deep tissue injury) that had been discovered, which measured 1.5 x 2.5 cm. Treatment included skin prep and wrap to protect. The form indicated the resident had continued to wear the off-loading boats and had a low air loss mattress. A Wound Assessment Report, dated 12/27/23, indicated the resident had a Stage III left heel pressure ulcer which measured 3.0 x 3.4 x 0.20 cm. Treatment included wound cleanser, calcium alginate and rolled gauze. A Wound Assessment Report, dated 1/3/24, indicated the Stage III, left heel pressure ulcer was worsening and measured 3.8 x 4.4 x 0.20 cm. No change in the treatment. A Wound Assessment Report, dated 1/8/24, indicated worsening Stage III, left heel pressure ulcer, which measured 5.5 x 7.0 x 0.20 cm with slough, eschar and granulation tissue. Treatment changed to cleanse with wound cleanser, apply Santyl, then moistened fluffed gauze, an ABD and rolled kerlix. A Wound Assessment Report, dated 1/29/24, indicated improving Stage III left heel pressure ulcer, which measured 5.0 x 4.2 x 0.20 cm. Treatment changed to wound cleanser, collagen, calcium alginate, ABD and rolled gauze. A Wound Assessment Report, dated 2/26/24, indicated there had been improvement of Stage III,			

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	left heel pressure ulcer, which measured 4.3 x 4.0 x 0.20 cm with 100% granulation tissue. On 3/1/24 at 12:48 P.M., the resident was observed sitting in her wheelchair, propelling herself and the left soft boot was dragging along the floor. On 3/1/24 at 2:20 P.M., the resident was passing the Nurses' Station, where there were several staff walking past, while the resident was observed digging her left heel boot into the floor to propel herself while sitting in her wheelchair. On 3/1/24 at 1:40 P.M., the Executive Director provided a policy titled, "Pressure Injury Prevention Guidelines:, dated 2023 with a revision date of 1/15/24 and indicated the policy was the one currently used by the facility. The policy indicated "...Policy: To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present...3. Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them...5. Prevention devices will be utilized in accordance with manufacturer recommendations (e.g., heel flotation devices, cushions, mattresses)...7. Interventions will be documented in the care plan and communicated to all relevant staff...." 3.1-40 (1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that			

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	resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, record review, and interview, the facility failed to ensure 1 of 2 residents reviewed for bladder incontinence received timely care to prevent and treat a urinary tract infection. (Resident D) Finding includes:	F 0690	**F690 – Bowel, Bladder Incontinence, Catheter, UTI** It is the practice of this facility to ensure timely care is received to prevent and treat urinary tract infections.	03/22/2024

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	The record for Resident D was reviewed on 2/27/24 at 9:13 A.M. Diagnoses included, but were not limited to: Parkinson's disease with dyskinesia, Alzheimer's disease, anxiety disorder, overactive bladder and male erectile dysfunction. The Quarterly Minimum Data Set (MDS) assessment, dated 1/26/2024, indicated the resident had impaired Range of Motion on one side, was moderately cognitively impaired, required extensive staff assistance for toileting needs and was frequently incontinent of his bladder. A Functional Abilities Assessment, dated 2/19/2024, indicated the resident required substantial staff assistance for toileting needs. During an interview with the resident and a family member, on 2/27/2024 at 1:53 P.M. the resident indicated staff do not offer to assist him to the toilet and he often toilets himself, even though he knows he is supposed to have staff assistance. He is afraid of getting another infection (urinary tract infection). His family member indicated the resident was very delirious with the most recent urinary tract infection, and there were issues with the amount of time it took to get a urine test ordered, the results obtained, and actually start the resident on an antibiotic. A Nursing Progress Note, dated 1/28/2024, indicated an order was received to obtain a urine analysis with a culture and sensitivity. There was no documentation of any symptoms or explanation as to why the test was ordered. The previous Nursing Note, dated 1/24/2024, indicated a PICC (Peripherally inserted central catheter) was removed per order.		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident D – orders from NP were obtained and followed for resident. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents receiving physician orders for lab have the potential to be affected by this deficient practice. All residents with orders to obtain urine cultures were reviewed to ensure timely response from NP, timely processing from lab, and timely communication of any new orders from NP. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 3/22/2024 This in-service will be conducted by the Director of Nursing or Designee and will include a review of lab monitoring process and physician notification of lab results. The Director or Nursing/Designee will review lab orders daily to ensure timeliness in lab provider and communication with NP on	

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	A Nursing Progress Note, dated 2/1/2024 at 4:57 P.M., indicated the urine was collected. A laboratory test result for Resident D indicated the lab received the urine on 2/3/2024. The test results were completed and reported on 2/5/2024 at 8:18 A.M. The test results indicated the resident had a urinary tract infection. A Nursing Progress Note, dated 2/7/2024 at 9:37 A.M., indicated the Nurse Practitioner had reviewed the laboratory results and ordered an antibiotic, Cipro to be given to address the resident's infection. During an interview with RN 2, on 2/28/2024, she indicated the lab came to the facility routinely on Mondays, Wednesdays and Fridays, and would need to be called if there were labs or pick ups on other days of the week. The Nurse Practitioners could access the lab results for themselves electronically, but if they did not give a needed order, then the nursing staff would call to obtain treatment. Treatment results should be obtained the same day the laboratory results were received. During an interview with the Assistant Director of Nursing, on 3/2/2024 at 11:30 A.M., she indicated it sometimes took 2 - 5 days to get urine cultures back from the laboratory. There was no other explanation as to why there was a delay of 4 days in obtaining the urine test, 2 days getting it to the laboratory, and then 2 additional days obtaining treatment once the results were reported. The facility policy and procedure, titled "Provision of Physician Ordered Services" provided as current by the Administrator on 3/2/2024 at 8:40 A.M. included the following: "...2.		abnormal labs. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled “Lab Monitoring” weekly for 4 weeks and monthly for at least 6 months. The Director of Nursing/Designee will review urine orders daily to ensure timeliness in lab provider and communication with NP on abnormal labs. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	

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	Qualified nursing personnel will submit timely requests for physician ordered services (laboratory, radiology, consultations) to the appropriate entity. 3. Qualified nursing personnel will receive and review the diagnostic test reports or consults and communicate the results to the ordering Physician, physician assistant, nurse practitioner or clinical nurse specialist within 24 hours of receipt unless the reports fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's order. Ordering Provider will be notified of results upon receipt if deemed 'critical' and/or require immediate attention...." The facility policy and procedure, titled "Laboratory Services and Reporting" provided as current by the Administrator on 3/2/2024 at 10:38 A.M. included the following: "...2. The facility is responsible for the timeliness of the services...7. Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside the clinical reference range..." 3.1-41(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 resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as			

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	usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure 1 of 1 residents observed for hydration was offered sufficient fluids to maintain proper hydration and health. (Resident 27) Finding includes: The room for Resident 27 was observed daily from 2/25/2024 - 3/1/2024. There was no large water cup for ice water observed in the resident's room. On 2/25/2024 there was a small Styrofoam cup 1/3 full of a thick brown liquid and on 3/1/2024 there was a store brand water bottle 1/2 full of water on her nightstand. The record for Resident 27 was reviewed on 2/27/2024 at 10;33 A.M. Diagnoses included, but were not limited to: cerebral infarction, hemiplegia and hemiparesis and unspecific dementia. A Significant Change Minimum Data Set (MDS) assessment, dated 1/15/2024, indicated the resident was severely cognitively impaired, had impaired upper and lower extremity mobility on one side, had a recent unplanned significant weight loss and had two stage 3 pressure ulcers.	F 0692	**F692 – Nutrition/Hydration Status Maintenance** It is the practice of this facility to ensure residents are offered sufficient fluids to maintain proper hydration and health. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 27 – has been discharged from facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents at risk for hydration have the potential to be affected by the deficient practice. Resident rooms reviewed to ensure they have appropriate hydration in place per physician orders with care plans reviewed and updated as needed, and	03/22/2024

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	A Hydration Risk Assessment, dated 2/19/2024, scored the resident as a low or not at risk for dehydration. However, some of the scoring was inaccurately added and the resident should have been scored as a moderate risk for dehydration. A Nutritional Needs Assessment, completed on 10/18/2024 by the Registered Dietician due to the Significant Change MDS assessment, indicated the resident required 1705-1989 ml (milliliters) of fluid needs per day. There was no specific care plan to address the resident's hydration needs. A care plan to address the resident's eating needs indicated she required the limited assistance of one staff. A general plan to address the resident's nutritional needs included interventions to document food/fluid intakes, encourage fluids, and honor food/fluid preferences. Laboratory testing for Resident 27, completed on 10/16/2023, indicated the resident's Blood Urea Nitrogen/Creatinine ratio (assessing kidney function) was slightly elevated at 20.55. (Normal range 9 - 20) On 3/1/2023 at 8:23 A.M., Resident 27 was observed being fed breakfast. There was one juice size glass of clear red liquid noted with the resident's meal. The resident was observed during the lunch meal on 3/1/2024 at 12:56 P.M. The staff member feeding the resident indicated she had drunk two cartons of chocolate milk, a small can of shasta soda and ate an Italian ice dessert. Review of the liquid intake records for Resident		interventions in place to provide additional hydration. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 03/22/2024. This in-service will be conducted by the Director of Nursing or Designee and will include a review of hydration program. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled "Intakes/Hydration" weekly for 4 weeks and monthly for at least 6 months. The Director of Nursing/Designee will review all intakes weekly to ensure that any resident with hydration risk are being provided sufficient fluids to maintain hydration needs and in residents room. If 100% is not achieved an action plan will be developed. Findings will be	

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	27, from 2/18/2024 through 3/1/2024, indicated there was no day the resident received anywhere close to the required 1705 ml minimum of liquids. The facility policy and procedure, titled "Hydration" provided by the Administrator as current on 3/1/2024 at 8:45 A.M. indicated the risk assessment and dietician's assessments should clarify the resident's fluid needs. The care plan implementation was to include individualized interventions to address the specific needs of the resident. Examples included the following: "...i. Offer the resident a variety of fluids during and between meals. ii. Promote assistance with dining..." 3.1-46		submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to provide sanitary nebulizer equipment for 1 of 2 residents reviewed for respiratory care. (Resident 68) Finding includes: During an observation, on 2/25/2024 at 11:05 A.M., Resident 68's nebulizer mask was observed	F 0695	**F695 – Respiratory/Tracheostomy Care and Suctioning** It is the practice of this facility to provide sanitary nebulizer equipment to all residents. **What corrective action(s) will be accomplished for those**	03/22/2024

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	sitting on the bedside table. On 2/26/2024 at 8:54 A.M., Resident 68's nebulizer mask was observed to be hanging from the call light outlet on the wall. A record review was completed on 2/27/2024 at 11:20 A.M. Diagnoses included, but were not limited to: sleep apnea, chronic respiratory failure, and pneumonia. A Quarterly Minimum Data Set (MDS) assessment, dated 2/17/2024, indicated Resident 68 was cognitively intact. She special treatments of oxygen use and non-invasive mechanical ventilation. A Physician's Order, dated 2/12/2024, indicated Resident 68 received Albuterol Sulfate inhalation nebulizer solution 2.5 milligram per 3 milliliters via nebulizer every 6 hours as needed for shortness of breath. A Care Plan, dated 10/16/2023 and revised on 11/15/2023, indicated Resident 68 was at risk for respiratory distress related to chronic respiratory failure, C-Pap (continuous positive airway pressure) use, morbid obesity with excess calories, and nebulizer treatments. During an observation, on 2/29/2024 at 11:53 A.M., Resident 68's nebulizer mask was observed on the floor by the bedside table with the tubing over the call light outlet. During an interview, on 3/1/2024 at 10:43 A.M., the Assistant Director of Nursing indicated the nebulizer mask should be stored in a respiratory bag when not in use.		**residents found to have been affected by the deficient practice:** Resident 68 – nebulizer equipment properly stored, resident and husband educated **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents utilizing respiratory devices have the potential to be affected by the deficient practice. All residents with nebulizer devices have been reviewed for proper labeling, dating, and storage of tubing. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 03/22/2024. This in-service will be conducted by the Director of Nursing or Designee and will include a review of residents receiving nebulizer treatments to ensure they are dated, labeled, and stored properly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	On 3/2/2024 at 8:45 A.M., the Executive Director provided a policy titled, "Nebulizer Therapy". The policy indicated, " ...It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions ...Care of the Equipment ...7. Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag ...." 3.1-47(a)(6)		**into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled "Respiratory" weekly for 4 weeks and monthly for at least 6 months. The Director of Nursing/Designee will review all residents with orders for nebulizer devices to ensure all accessories are labeled/dated, stored, and cleaned appropriately. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to provide ongoing assessment for a 1 of 1 resident reviewed for dialysis. (Resident 109)	F 0698	**F698 – Dialysis** It is the practice of this facility to provide ongoing assessment for all	03/22/2024

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	Finding includes: During an interview, on 2/26/2024 at 9:32 A.M., Resident 109 indicated she received dialysis on Mondays, Wednesdays, and Fridays. A record review was completed on 2/28/2024 at 9:01 A.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, chronic kidney disease, and dependence on renal dialysis. A Care Plan, dated 1/2/2024, indicated Resident 109 had end-stage renal disease (ESRD), and required hemodialysis on Monday, Wednesday, and Friday with a chair time of 12:45 P.M. Interventions, dated 1/2/2024, included, observe for signs of infection to access site: redness, swelling, warmth or drainage; observe for signs of the following: bleeding, hemorrhage, bacteremia, septic shock; observe for symptoms of fluid volume deficit such as hypotension, postural changes in blood pressure, dizziness, thirst, dry oral mucosa, weight loss, nausea or muscle cramps; and, observe for symptoms of fluid volume excess such as edema, shortness of breath, crackles in lungs, weight gain or hypertension. A Physician's Order, dated 1/29/2024, indicated Resident 109 was to receive hemo-dialysis three times a week on Monday, Wednesday, and Friday with a pick-up time of 11:30 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 2/9/2024, indicated Resident 109 was cognitively intact. A review of the Pre/Post Dialysis Assessments indicated Resident 109 should have attended		residents receiving dialysis. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 109 – Dialysis assessments reviewed and updated as appropriate. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents receiving dialysis have the potential to be affected by the deficient practice. All residents receiving dialysis have been reviewed for ongoing assessment accuracy and completion. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All licensed nursing staff will be in-serviced on or before 03/22/2024. This in-service will be conducted by the Director of Nursing or Designee and will include a review of hemodialysis and pre and post dialysis assessments. **How the corrective action(s) will be monitored to ensure the**	

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	dialysis on the following dates, with Pre/Post assessments completed: - 1/8/2024 Refused dialysis. - 1/10/2024 Pre & Post Assessment completed. - 1/12/2024 Pre & Post Assessment completed. - 1/15/2024 Refused dialysis. - 1/17/2024 Sent to hospital from dialysis center recommendation. - 1/19/2024 Pre & Post Assessment completed. - 1/22/2024 Pre & Post Assessment completed. - 1/24/2024 No Pre & Post Assessment completed. - 1/26/2024 No Pre & Post Assessment completed. - 1/29/2024 Hospitalized. - 1/31/2024 Hospitalized. - 2/2/2024 Hospitalized. - 2/5/2024 Pre & Post Assessment completed. - 2/7/2024 No Pre & Post Assessment completed. - 2/9/2024 No Pre & Post Assessment completed. - 2/12/2024 No Pre & Post Assessment completed. - 2/14/2024 No Pre & Post Assessment completed. - 2/16/2024 Pre & Post Assessment completed. - 2/19/2024 Pre & Post Assessment completed. - 2/21/2024 Pre-Assessment completed. - 2/23/2024 Pre & Post Assessment completed. - 2/26/2024 Pre & Post Assessment completed. - 2/28/2024 Pre & Post Assessment completed. During an interview, on 3/1/2024 at 10:38 A.M., the Assistant Director of Nursing Services indicated dialysis residents should have a Pre and Post Dialysis Assessment completed, and these assessments should be completed every time a dialysis appointment occurs. All refusals of dialysis appointments should be documented in the medical record. On 3/2/2024 at 8:45 A.M., the Executive Director provided a policy titled, "Hemodialysis". The policy indicated, " ...The facility will provide the necessary care and treatment, consistent with		**deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled “Dialysis QAPI” weekly for 4 weeks and monthly for at least 6 months. The Director or Nursing/Designee will review all residents receiving dialysis daily to ensure that ongoing assessments are being completed. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	

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	professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing , mental, and psychosocial needs of residents receiving hemodialysis ...The facility will ensure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. This will include: The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility ...." 3.1-37(a)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.			

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	(ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure the daily staff posting was current for 1 of 7 survey days observed. This had the potential to affect all residents in the facility. Finding includes: On 2/25/2024 at 9:32 A.M., upon entering the building, the posted staffing was for Thursday 2/19/2024. The posting remained inaccurate until later in the day after Administrative staff had arrived in the building. During an interview with Receptionist 24, on 2/25/2024 at 9:35 A.M., she indicated she was a fairly new employee and did not know about the staff posting information. A policy regarding staff posting was requested on 2/28/2024 and not received.	F 0732	**F732 – Posted Nurse Staffing Information** It is the practice of this facility to ensure the daily staff posting is current each day. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All residents – daily staff posting checked each day. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the deficient practice. Daily staff posting will be current and posted each day.	03/22/2024

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			What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All IDT will be in-serviced on or before 03/22/2024. This in-service will be conducted by the Executive Director or Designee and will include a review of staff posting. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled “Posted Staffing” weekly for 4 weeks and monthly for at least 6 months. The Executive Director/Designee ensure that daily staff posting is current and posted each day. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 03/22/2024**	

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			Compliance Date = 03/22/2024	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to monitor for the use of a thyroid medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 17) Finding includes: On 2/29/24 at 4:00 P.M., a review of the clinical record for Resident 17 was conducted. The resident's diagnoses included but were not limited to: diabetes, heart disease, heart failure,	F 0757	**F757 – Drug Regimen is Free from Unnecessary Drugs** It is the practice of this facility to ensure that residents are monitored for the use of thyroid medications for unnecessary medications. **What corrective action(s) will be accomplished for those residents found to have been**	03/22/2024

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	cerebrovascular accident and hypothyroidism. The Medication Administration Record (MAR) indicated the resident had been administered Levothyroxine (a thyroid replacing hormone) 150 milligrams daily, for hypothyroidism. The start date for this medication was 9/3/22. A Care Plan, dated 10/22/22 and revised on 2/21/24, indicated the resident had a diagnosis of hyperthyroidism and required medication. The interventions indicated for the facility to administer the thyroid replacement medication, monitor for effectiveness, watch for signs & symptoms of hyperthyroidism and obtain lab work as ordered. Lab work results indicated the resident's TSH (Thyroid Stimulating Hormone) levels were completed on 10/11/22 and level was within the normal range. No other results were found in the resident's record. During an interview, on 2/29/24 at 3:30 p.m., the Assistant Director of Nursing (ADON) indicated there were no other TSH levels completed on the resident since 2022 and no current order for TSH lab work to monitor the medication. The 2015 Edition Nurse's Drug Handbook, provided by the Director of Nursing (DON) indicated the handbook was used by the facility. The handbook indicated "...In adults with primary hypothyroidism, perform periodic monitoring of serum TSH levels...." On 3/2/24 at 11:28 A.M., the DON provided a policy titled, "Medication Monitoring", dated 2023, and indicated the policy was the one currently used by the facility. The policy		**affected by the deficient practice:** Resident 17 – resident thyroid levels have been obtained via lab, reported to NP, and no new orders received. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the deficient practice. All residents receiving thyroid medications will be reviewed for needed lab monitoring and lab results to be communicated to NP for further plan of care. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All licensed nursing staff will be in-serviced on or before 3/22/24. This in-service will be conducted by the Director of Nursing or Designee and will include a review of Medication Monitoring. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this	

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	indicated "...Policy: This facility takes a collaborative, systematic approach to medication management, including the monitoring of medications for efficacy and adverse consequences..."Indications for use" refers to the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and is consistent with manufacturer's recommendations and/or clinical practice guidelines...." 3.1-48(a)(3)		corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled "Pharmacy Review" monthly for at least 6 months. The Director or Nursing/Designee will review all residents with orders for a thyroid medication will be monitored appropriately. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---			

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	§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, that facility failed to limit as needed (PRN) psychotropic medication to 14 days for 1 of 5 residents reviewed for unnecessary medications. (Resident 18)	F 0758	**F758 – Free from Unnecessary Psychotropic Meds/PRN Use** It is the practice of this facility to ensure all residents that receive psychotropic medications as needed limit to 14 days ordered.	03/22/2024

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	Finding includes: A record review was completed for Resident 18 on 2/27/2024 at 3:19 P.M. Diagnoses included, but were not limited to: major depressive disorder, post-traumatic stress disorder, palliative care, and adjustment disorder with mixed anxiety and depressed mood. A Quarterly Minimum Data Set (MDS) assessment, dated 11/27/2023, indicated Resident 18 had moderate cognitive impairment. She received anti-anxiety, antidepressant, and antipsychotic medications. No gradual dose reductions or documentation had been completed for the use of the antipsychotic, haloperidol. A Physician's Order, dated 4/18/2023, indicated haloperidol 2 milligrams mouth every 8 hours as needed for Psychosis. This order was discontinued on 5/12/2023. A Pharmacy Recommendation, dated 5/4/2023, indicated, " ...Per CMS [Centers for Medicare and Medicaid] regulations, orders must include a 14-day stop date. If use is continued, the resident must be evaluated by MD [medical doctor] and a new 14-day PRN [as needed] order should be written ...." A Physician's Order, dated 6/6/2023, indicated haloperidol 1 milligram by mouth every 6 hours as needed for agitation. This order was discontinued on 6/26/2023. A Medication Administration Record (MAR), dated 6/2024, indicated haloperidol was administered on 6/23/2023 at 7:10 P.M.		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 18 – medication use reviewed by NP and hospice provider and changed to a routine administration. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents utilizing antipsychotic medications have the potential to be affected by the deficient practice. All residents utilizing antipsychotic medications have been reviewed to ensure a limit of 14 days was assigned if being used as needed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 3/22/24. This in-service will be conducted by the Director of Nursing or Designee and will include a review of psychotropic medication management and antipsychotic medication use. **How the corrective action(s)**	

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	During an interview, on 3/1/2024 at 10:39 A.M., the Assistant Director of Nursing indicated as needed psychotropic medications usually have a stop date of 14 days, and a reevaluation needed to be completed for resumption. The family had pressured the hospice company for Resident 18's medications. On 3/2/2024 at 8:45 A.M., the Executive Director provided a policy titled, "Use of Psychotropic Medications". The policy indicated, " ...Residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s) ...9. PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration [i.e. 14 days] ...a. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order ...." 3.1-48(a)(2)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled "Antipsychotic Medication Care Audit" weekly for 4 weeks and monthly for at least 6 months. The Director or Nursing/Designee will review all residents receiving antipsychotic medications to ensure that any as needed medications have a limit of 14 days of administration. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.			

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	155689	A. BUILDING 00 B. WING	03/02/2024

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	Based on observation, record review, and interview, the facility failed to ensure 1 of 2 residents reviewed for dental services received timely assistance. (Resident 90) Finding includes: During the initial tour of the facility, conducted on 2/25/2024 between 9:30 A.M. - 11:00 A.M., Resident 90 was observed lying in her bed. She was noted to be edentulous (without any teeth). During an interview with Resident 90, on 2/26/24 at 10:15 A.M., she indicated she had dentures but she did not wear them because they did not fit correctly. She had not seen a dentist since she was admitted to the facility. The record for Resident 90 was reviewed on 2/27/2024 at 11:11 A.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, type 2 diabetes, morbid obesity, cirrhosis of the liver, obstructive sleep apnea, hypertensive heart and chronic kidney disease and celiac disease. The Admission Minimum Data Set (MDS) assessment, dated 3/2/2023, indicated the resident had no natural teeth. There was a care plan to address the resident's oral health issue of lingua villosa nigra (black tongue) with interventions including coordinating arrangements for dental care as needed. The resident signed a consent on 2/27/2023 to receive in house dental services During an interview, on 2/28/2024 at 10:30 A.M., the Social Service Director (SSD) indicated	F 0791	**F791 – Routine/Emergency Dental Services** It is the practice of this facility to ensure residents receive dental services in a timely manner. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 90 – dental services have been scheduled. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the deficient practice. All residents needing assistance with dental services and/or who have consented to dental services have been reviewed and appointment scheduling has been initiated. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 03/22/2024. This in-service will be conducted by the Social Services Director or Designee and will include a review of dental services and communication to social services	03/22/2024

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	Resident 90 had not been seen by dental services since she was admitted. The dental provider had recently notified the facility about residents who were now going to be able to been seen, and Resident 90 was scheduled to be seen on 3/15/2024. A Communication form, dated 2/1/2024, indicated the dental provider was now able to bill a government funded source for residents who did not have any social security liability funds. Resident 90's name was on the list. There was no explanation as to why Resident 90 had not been assisted earlier to make a dental appointment to begin the process of aligning her ill fitting dentures. A policy regarding providing routine dental services was requested on 2/28/2024 and not received. 3.1-24(a)(1)		on resident needs. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Social Services/Designee will be responsible for completing the QAPI Audit tools labeled “Dental Services” weekly for 4 weeks and monthly for at least 6 months. The Social Services Director/Designee will review all residents with consents for dental services and/or dental needs and initiate appointment scheduling. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility			

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	provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review, and , the facility failed to ensure food was served at a palatable temperature on 2 of 3 nursing units. (Cedar & Dogwood units) Findings include: 1. During observation of the noon meal, on 2/28/2024 at 11:10 A.M., stacks of warmed pallet plate cover bottoms were noted stacked on the outside shelf of the steam table. The hot food temperatures were checked by the FSS (Food Services Supervisor) at 11:20 A.M., and were as follows: Fried chicken - 172 F, Mashed potatoes - 178 F, Gravy - 160 F, Malibu mixed vegetables -184 F, Mechanical ground chicken made from cooked diced chicken pieces - 152 F, Pureed chicken made from cooked diced chicken - 155 F, Baked chicken breast (only made a few) - 144 F - the FSS put back in the oven and later temped at 169 F, Pureed vegetable blend- 143 F, precooked hamburger patties - 147 F, hot dogs - 106 F - put back in the oven and retempted at 163 F. 2. The first meal cart was sent to the Cedar unit at 11:44 A.M. The second meal cart was sent to the Cedar unit at 11:54 A.M. The temperature from a meal tray was assessed at 12:00 P.M. as follows: Chicken: 142.9 F	F 0804	**F804 – Nutritive Value/Appear, Palatable/Prefer Temp** It is the practice of this facility to ensure food is served at a palatable temperature. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Cedar unit – food being served on unit has been monitored and holds appropriate temperature. Dogwood unit – food being served on unit has been monitored and holds appropriate temperature. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the deficient practice. All food on units to continue being monitored to ensure appropriate and palatable temperatures. **What measures will be put into**	03/22/2024

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	Mashed Potatoes: 133.5 F There were no vegetables on the plate to temp. 3. The first cart to was sent to the Dogwood unit at 12:08 P.M. The second cart, three shelf open type, was sent to Dogwood unit at 12:13 P.M. The temperature from a meal tray from the Dogwood cart was assessed at 12:25 P.M. as follows: Chicken: 121 F Mashed Potatoes: 131 F Vegetable blend: 100 F During the initial survey process, interviews with multiple alert and oriented residents on the Cedar unit (Residents D, E, & P) indicated the food was often cold when served. During an interview with the FSS (Food Services Supervisor), on 2/28/2024, after she had checked the temperatures of the meal trays on both Dogwood and Cedar units, she declined to comment on the target temperature for hot food served on the units. The facility policy and procedure, titled, "Record of Food Temperatures" provided as current by the Administrator on 3/1/2024 at 8:45 A.M. included the following: "...2. Hot food will be held at 135 degrees Fahrenheit or greater...." This citation relates to Complaint IN00427600. 3.1-21(a)(2)		**place or what systemic changes will be made to ensure that the deficient practice does not recur:** All dietary staff will be in-serviced on or before 3/22/2024. This in-service will be conducted by the Executive Director or Designee and will include a review of food temperature requirements and processes. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for completing the QAPI Audit tools labeled “Hot Holding Temperature” weekly for 4 weeks and monthly for at least 6 months. The Executive Director/Designee will audit all food being delivered to the units and in the main kitchen to ensure food is provided at palatable temperatures. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up.	

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			By what date the systemic changes will be completed: 03/22/2024 Compliance Date = 03/22/2024	
F 0808 SS=E Bldg. 00	483.60(e)(1)(2) Therapeutic Diet Prescribed by Physician §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. Based observation, record review, and interview, the facility failed to ensure the menu for therapeutic diets was prepared and offered. This deficient practice had the potential to affect residents receiving therapeutic diets from the kitchen. Finding includes: During an observation of the meal service, on 2/26/2024 at 11:14 A.M., there were large amounts of fried chicken pieces prepared, only one type of gravy, regular mashed potatoes, a vegetable blend, a small pan of green beans, regular dinner rolls, mechanically ground chicken, pureed chicken, pureed vegetable blend and a small pan with a few pieces of baked chicken prepared. During an interview with Cook 23, on 2/26/2024 after the meal had been served and review of the Modified Diet Spreadsheet for the meal was completed, she indicated she had not prepared enough backed chicken breast as was menued for	F 0808	**F808 – Therapeutic Diet Prescribed by Physician** It is the practice of this facility to ensure the menu for therapeutic diets are prepared and offered. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** All residents receiving therapeutic diets – no negative outcomes, resident diet orders reviewed and updated as needed, dietary staff educated on preparing therapeutic diets. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:**	03/22/2024

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	the reduced carbohydrate, heart healthy, and renal diet residents. She had prepared only a few pieces. Additionally, she indicated she had prepared a packaged gravy from the store room, and did not know if is was salt free. Review of the packaging from the gravy mix indicated it contained 17 percent of the daily allowance of sodium in one serving. Cook 23 indicated she had not prepared pureed bread/rolls, nor had she prepared mashed cauliflower for the one resident on a renal diet. The one resident on a gluten free diet did not receive any gravy. Review of the list of residents with therapeutic diet orders indicated the following: 16 residents had orders for a "Heart Healthy" diet 12 residents had orders for a "No Added Salt" diet 1 resident had orders for "No nuts, skins, seeds." 26 residents had orders for "Reduced carbohydrate" diet 1 resident had orders for "Renal" diet 5 residents had orders for "Pureed" diet The facility policy and procedure, titled, "Standardized Menus" provided as current by the Administrator on 3/1/2024 at 8:45 A.M. included the following: "...3. The cycle menus are planned to incorporate routinely served diets. The Dietary Manager should consult the Registered Dietitian when a diet not addressed on the menu is ordered by a physician...." This citation relates to Complaint IN00428033 3.1-21(b)		All residents receiving a therapeutic diet have the potential to be affected by the deficient practice. Dietary staff will ensure to prepare and offer therapeutic diets as ordered. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All dietary will be in-serviced on or before 3/22/24. This in-service will be conducted by the Executive Director or Designee and will include a review of therapeutic diets and preparing menu per resident orders/diets. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for completing the QAPI Audit tools labeled “Meal Preparation” weekly for 4 weeks and monthly for at least 6 months. The Executive Director/Designee will audit menus to ensure appropriate preparation for all diets is occurring. If 100%	

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			is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review and interviews, the facility failed to ensure food was stored, prepared and served in a sanitary manner in 1 of 1 kitchens observed. (Main Kitchen) This	F 0812	**F812 – Food Procurement, Store/Prepare/Serve - Sanitary** It is the practice of this facility to ensure food is stored, prepared,	03/22/2024

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	had the potential to affect 113 residents who received food from the kitchen. Finding includes: 1. During a tour of the kitchen, conducted on 2/25/2024 at 1:40 P.M. and accompanied by the Food Service Supervisor (FSS) the following was noted: a. There was a large accumulation of debris, food items and dust underneath the food storage shelving in the dry storage room. There was a wall air conditioner unit above an open cart utilized to store bread items, with a heavy accumulation of dark gray dust. b. Two buckets of sanitizing water were noted in use. The first bucket had not been changed since before the breakfast meal. The second bucket had just been changed, but Employee 17 had not placed the sanitizing tablet in the water and it did not test properly. The FSS indicated the automatic chemical system was not functioning and staff were supposed to use the chemical tablets for the water and she was trying to inform her staff. c. Multiple large sheet pans, used to bake, and store food items and dinnerware had a large build up of dark black grime around the edges. d. There was a large amount of a dark, slimy substance, water and debris underneath the dishwasher. e. There was a build up of food crumbs noted around the edges of several storage cabinets. f. There was a kitchen drawer, used to store serving utensils, with a dried orange liquid spilled		and served in a sanitary manner. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** A Dry storage room has been clean and sanitized; free of debris and dust. B Sanitizing water has been changed and testing properly. C Sheet pans have been deep cleaned and replaced as needed. D Water/debris under dishwasher has been cleaned. E Storage cabinets have been deep cleaned. F Kitchen drawers have been deep cleaned. G Refrigerator leaks have been fixed. H Education has been provided to all dietary staff on glove use. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the deficient practice. Main kitchen has been cleaned and sanitized and ongoing education provided. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

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	down the side and bottom of the drawer. The substance had spilled and dried on a serving utensil stored in the drawer. g. One of two reach in refrigerators had water pooling on the bottom. A cardboard carton of heavy whipping cream was noted sitting in the pooled water. The FSS indicated they had been having trouble with water pooling on the bottom and it was supposed to be getting fixed soon. 2. During an observation of the meal service, on 2/25/2024 at 11:31 A.M. , Dietary Employee 18 had donned gloves and was touching the outside of bread wrappers, plates, tongs and then directly touching cheese to place on sandwiches. She then removed her gloves, washed her hands, donned another pair of gloves, opened plastic wrapping from around a package of pancakes then with the same gloves hands directly handled the pancakes to place them on a plate. 3. During observation of the meal service, on 2/26/2024 at 11:18 A.M., Dietary Employee 19 had donned gloves, placed a hamburger patty onto a bun with tongs, then opened wrapped cheese slices and with his contaminated gloved hands, reached in to directly touch the cheese slice and then touched the bun several times before placing the plated sandwich into the microwave to melt the cheese. After removing his gloves and washing his hands, Employee 19 donned a new pair of gloves, handled the outside package of a loaf of bread, reached in and directly touched a slice of bread, placed the slice of bread in his left hand while he brushed butter onto the bread with a pastry brush. 4. During observation of the meal service on 2/28/2024 at 11:10 A.M., Dietary employee 20		**practice does not recur:** All dietary staff will be in-serviced on or before 3/22/2024. This in-service will be conducted by the Dietary Manager or Designee and will include a review of kitchen sanitation and glove use. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for completing the QAPI Audit tools labeled “Kitchen Sanitation” weekly for 4 weeks and monthly for at least 6 months. The Executive Director/Designee will audit kitchen sanitation weekly to ensure all items remain in compliance. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	

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	donned gloves, reached into the refrigerator and retrieved a saran wrapped package of pancakes, unwrapped the pancakes with her gloved hands and then directly touched two pancakes and placed them on a plate with her contaminated gloved hands. The facility policy, titled, "Sanitation Inspection" provided by the Administrator as current on 3/1/2024 at 8:45 A.M. indicated the following: "...1. All food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents..." The policy did not have any procedures regarding direct food handling. 3.1-23(i)(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement			

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	based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.			

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	155689	A. BUILDING 00 B. WING	03/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

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	§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to follow infection control standards during incontinence care, for 2 of 7 residents reviewed for activities of daily living. (Residents D and 27) The facility also failed to ensure transmission based precautions were implemented appropriately for 1 of 3 residents reviewed for infections. (Resident 11) Findings include: 1. During an observation of incontinence care for Resident 27, on 2/27/24 at 11:25 A.M., CNAs 7 and 8 were assisting the resident back into bed. The resident's incontinence brief was noted to be wet. CNA 8 donned gloves and removed the soiled brief from Resident 27. Next, without changing her gloves, CNA 8 took a premoistened washcloth and wiped both sides of the front of the resident's groin, however, CNA 8 did not wipe the middle of the resident's peri area or back side of the resident's peri area. After performing incontinence care, CNA 8 left her contaminated gloves on to remove the hoyer pad from underneath the resident, and pull up her outside pants. The resident was then assisted to roll towards CNA 8, who held her with her contaminated gloves hands, while CNA 7 finished removing the hoyer lift pad and completed pulling up the resident's outside pants.	F 0880	**F880 – Infection Prevention & Control** It is the practice of this facility to follow infection control standards during incontinence care. It is the practice of this facility to ensure transmission-based precautions are implemented appropriately. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident D – no negative outcomes, staff education provided. Resident 27 – resident has been discharged from facility. Resident 11 – all orders have been placed to ensure appropriate transmission based precautions in place. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to	03/22/2024

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	2. During an observation of toileting and hygiene assistance, on 3/1/24 at 9:17 A.M., CNA 12 was observed assisting Resident D with toileting and personal hygiene needs. Resident D was seated on the toilet and CNA 12 was noted stripping the bed linens and placing them in a plastic bag. A small plastic bag with a slightly wet brief was noted on the floor just outside the resident's bathroom door. When the resident indicated he was finished, CNA 12 put new outside pants on and left them around Resident D's ankles, he also put a new brief on Resident D. CNA 12 then assisted the resident to stand up from the toilet and hang onto the handrail beside the toilet. CNA 12 then took toilet paper and wiped Resident D's rectum and buttocks. CNA 12 did not provide any cleansing to Resident D's front peri area. After wiping his buttocks with toilet paper, CNA 12 then, without changing his gloves, proceeded to pull up the incontinence brief and outside pants. 3. During an observation, on 2/25/2024 at 9:52 A.M., Resident 11 was observed in her bed, door open, no precaution sign on the door, and no personal protective equipment (PPE) available for staff. During an interview, on 2/25/2024 at 10:23 A.M., Resident 11 indicated she was at another facility when her infection started. Her MD had diagnosed her with "a superbug in her urine" and had her transfer from the other facility to here. She indicated her MD told her it was gone, but could come back at any time. During an observation, on 2/25/2024 at 10:16 A.M., CNA 14 entered Resident 11's room and provided care. CNA 14 wore gloves only when providing care for Resident 11. During an interview, on 2/25/2024 at 10:34 A.M.,		be affected by the deficient practice. All residents reviewed to ensure appropriate transmission-based precautions in place as needed. Audits completed with direct care staff providing incontinence care to ensure gloves are changed and hands washed with care and perineal care process is followed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 3/22/2024. This in-service will be conducted by the Director of Nursing or Designee and will include a review of the infection prevention and control policy, peri care, and transmission-based precautions. The Director of Nursing/Designee will audit all residents to ensure appropriate transmission-based precautions are in place. The Director of Nursing/Designee will complete staff observations related to peri care to ensure proper handwashing, glove use, and cleaning are being met. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:**	

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	RN 16 indicated the resident was not on isolation at this time because her infection was dormant. During an observation, on 2/25/2024 at 11:31 A.M., CNA 14 entered Resident 11's room and provided care. CNA 14 wore gloves only when providing care for Resident 11. During an observation, on 2/27/2024 at 9:09 A.M., CNA 10 exited Resident 11's room and indicated she had changed Resident 11's brief, washed her up, and changed her top. CNA 10 indicated she did not wear PPE (Personal Protective Equipment) while in the room, and wore only gloves, and indicated Resident 11 was not in isolation. During an interview, on 2/27/2024 at 9:23 A.M., RN 15 indicated Resident 11 was not in isolation, and did not require special treatment to enter her room. During an interview, on 2/27/2024 at 11:13 A.M., the Executive Director indicated Resident 11 had colonized MRSA in her urine. During an observation, on 2/27/2024 at 1:02 P.M., CNA 10 was observed in Resident 11's room providing care, CNA 10 was observed not wearing PPE while in room. During an observation, on 2/28/2024 at 6:10 A.M., CNA 25 was observed in Resident 11's room. PPE worn was only gloves. CNA 25 indicated she had provided care for the resident and drained the Nephrostomy tube, and staff did not have to wear a gown in the room. A record review was completed on 2/27/2024 at 1:10 P.M. Resident 11's diagnoses included, but were not limited to: MRSA, Bacteremia, Type 2		Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for completing the QAPI Audit tools labeled “Infection Control QAPI” and “Perineal Care Observation” weekly for 4 weeks and monthly for at least 6 months. The Director of Nursing/Designee will audit all residents to ensure appropriate transmission-based precautions are in place. The Director of Nursing/Designee will complete staff observations related to peri care to ensure proper handwashing, glove use, and cleaning are being met. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	

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	diabetes, Nephrostomy catheter, paraplegia, hypertensive heart disease, morbid obesity, major depressive disorder, hyperlipidemia and obstructive sleep apnea. A Quarterly MDS (Minimum Data Set) assessment, dated 2/1/2024, indicated Resident 11 had intact cognition. She was totally dependent on staff for bed mobility, transfers, toileting, personal hygiene and bathing. Resident has impairment to bilateral lower extremities. Current Physician Orders indicated: Change Nephrostomy bag/tubing every month on the 14th of the month. Change Nephrostomy bag/tubing PRN occlusion as needed. Drain her Nephrostomy tube on her left, flush with sterile saline 10 cc as needed for occlusion. A current Care Plan, dated 8/24/2023 with a goal target date of 4/5/2024, indicated the resident had a history of e.coli in the urine and required Enhanced Barrier Precautions. A current Care Plan, dated 5/3/2023 with a revision date of 8/3/2023, indicated the Resident needed assistance with activities of daily living related to MRSA Bacteremia, right foot osteomyelitis, diabetes, neuropathy, bilateral Nephrostomy catheters and paraplegia bilateral lower extremities. A policy titled, "Infection Prevention and Control Program" was provided by the Administrator on 2/29/2024 at 8:39 A.M., and indicated this is the current policy being used by the facility. The policy indicated, "...a. A system of surveillance is utilized for prevention, identifying, reporting, investigating, and controlling infections and			

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	communicable diseases for all residents, staff, volunteers, visitors and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards...." 3.1-18(a)(2)			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.			

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	§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on interview and record review, the facility failed to ensure 3 of 5 residents reviewed for immunizations/vaccine administration, had received them. (Residents 4, 95 and 51) Findings include: 1. On 3/2/24 at 9:13 A.M., the clinical record for Resident 4 was reviewed. The record indicated the resident had signed a consent form titled, "2023-2024 Covid-19 Vaccine Consent Form, on 10/25/23. The Medication Administration Record (MAR)	F 0883	**F883 – Influenza and Pneumococcal Immunizations** It is the practice of this facility to ensure residents immunizations/vaccinations are provided. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 4 – resident not on identifier list provided by ISDH	03/22/2024

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	indicated the resident was to have the vaccine, on 12/27/23. The MAR had no initials (blank) which indicated the vaccine had not been administered, as ordered. 2. On 3/2/24 at 9:16 A.M., the clinical record for Resident 95 was reviewed. The record indicated the resident had signed a consent form titled, "Informed Consent for Influenza Vaccine", on 1/3/24. The Active Orders indicated the resident "may have annual Flu vaccine and annual Pneumonia Vaccine". There was no documentation which indicated the resident had received those vaccines, at the facility. 3. On 3/2/24 at 9:22 A.M., the clinical record for Resident 51 was reviewed. The record indicated the resident had signed a consent form titled, "Informed Consent for Pneumococcal Vaccine, dated 1/29/24. The Active Orders, indicated the resident "may have annual Flu vaccine and annual Pneumonia Vaccine". There was no documentation which indicated the resident had received any vaccines at the facility During an interview, on 3/2/24 at 9:52 A.M. the Assistant Director of Nursing (ADON) indicated there was no no CHIRP (Children and Hoosier Registry Program) report for Resident 95 or Resident 51 to determine what vaccines the resident had received prior to entering the facility. On 2/29/24 at 8:41 A.M. the Executive Director provided a policy titled, "Covid-10 Vaccination", dated 1/15/24, and indicated the policy was the one currently used by the facility. The policy		Resident 95 – vaccinations offered and scheduled to be administered. Resident 51 – resident not on identifier list provided by ISDH. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the deficient practice. All resident who requested or consented to vaccination have been reviewed and offered vaccination as appropriate. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 3/22/2024. This in-service will be conducted by the Director of Nursing or Designee and will include a review of resident vaccinations; Covid, Influenza, and Pneumococcal. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality	

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	indicated "...It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications fro COVID-19 (SARS-CoV-2) by educating and offering our residents and staff the COVID-19 vaccine...." On 2/29/24 at 8:41 A.M. the Executive Director provided a policy titled, "Influenza Vaccination", dated 1/15/24, and indicated the policy was the one currently used by the facility. The policy indicated "...It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents, staff members and volunteer workers annual immunization against influenza...." On 2/29/24 at 8:41 A.M. the Executive Director provided a policy titled, "Pneumococcal Vaccine", dated 2001 and indicated the policy was the one currently used by the facility. The policy indicated "...All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections...." 3.1-13(a)		Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for completing the QAPI Audit tools labeled "Resident Vaccinations" weekly for 4 weeks and monthly for at least 6 months. The Director of Nursing/Designee will audit all residents to ensure that appropriate vaccinations are offered and administered as requested and available. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 03/22/2024** Compliance Date = 03/22/2024	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, record review, and interview, the facility failed to ensure walls and floors were maintained in a sanitary and comfortable condition for 2 of 3 nursing units observed. (Cedar and Birch units) Finding includes:	F 0921	**F921 – Safe/Functional/Sanitary/Comfortable Environment** It is the practice of this facility to ensure walls and floors are maintained in a sanitary and comfortable condition.	03/22/2024

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	During an environmental tour of the facility, on 2/29/2024 at 1:30 P.M., accompanied by the Administrator, the following was noted: 1. Birch unit a. Room 113-2: the bed linens in bed 1 had some light brown spots. The bed linens for Bed 2 had yellow staining in the middle of the bed sheets. b. Room 130 -1: the wallpaper around and above the television was loose and falling down. There was also dark brown paint around the room door handle. The Administrator indicated she was unaware if they fixed the door knob and used a different colored paint or why there was such a difference in color. - c. Room 131-2: there were two quarter sized areas above bed 2 with missing paint. There were also two nail holes on the wall across from bed one and a quarter sized area of missing paint on the wall. d. Room 136: there were 3 golf ball sized holes in the closet door and missing pain and trim by Bed 2. Cedar unit a. Room 224- the bathroom linoleum flooring was cracked b. Room 228- there was a large patched area on the bathroom wall c. Room 230- the bathroom linoleum floor was cracked. There were holes in the wall and patched areas on the bathroom wall. During the environmental tour, the Administrator indicated the facility was starting the process of		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Room 113- bed linens were immediately changed. Room 130 – wallpaper has been fixed and paint around the door handle has been color matched. Room 131 – room has been scheduled to be patched/painted Room 136 – room has been scheduled to be patched/painted Room 224 – bathroom flooring has been scheduled to be fixed Room 228 – bathroom wall has been patched and painted Room 230 – bathroom flooring has been scheduled to be fixed, wall has been scheduled to be patched and painted. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by the deficient practice. All resident rooms have been audited for any needed preventative maintenance and all needed preventative maintenance has been logged and to be scheduled. **What measures will be put into place or what systemic**	

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	pricing various floor options to replace the flooring in multiple areas of the facility. A facility policy, titled, "Preventative Maintenance Program" provided as current by the Administrator on 3/2/2024 at 8:45 A.M. indicated the Maintenance Director was responsible for ensure all aspects of the physical plant was maintained in a "...safe, functional, sanitary, and comfortable environment of residents, staff and the public." The policy referred to maintaining a preventative maintenance calendar and documenting all tasks. There was no plan presented regarding the issues noted during the environmental tour. 3.1-19(c)		**changes will be made to ensure that the deficient practice does not recur:** All staff will be in-serviced on or before 3/22/2024. This in-service will be conducted by the Executive Director or Designee and will include a review of preventative Maintenace and the use of TELS for communicating work orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for completing the QAPI Audit tools labeled “First Impressions” weekly for 4 weeks and monthly for at least 6 months. The Environmental Supervisor/Designee will audit all resident rooms and common areas for any needed preventative maintenance and all needs will be logged and scheduled. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic**	

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			changes will be completed: 03/22/2024 Compliance Date = 03/22/2024	