STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155699	A. BUILDING 00 B. WING	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF HARTFORD CITY	715 N MILL ST HARTFORD CITY, IN 47348

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: December 13, 14, 15, 18 and 19, 2023. Facility number: 000290 Provider number: 155699 AIM number: 100379970 Census Bed Type: SNF/NF: 30 Total: 30 Census Payor Type: Medicare: 3 Medicaid: 21 Other: 6 Total: 30 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed December 21, 2023.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted December 13-19, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of January 12, 2024. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0576 SS=D Bldg. 00	483.10(g)(6)-(9) Right to Forms of Communication w/ Privacy §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sarah Jackman	HFA	12/31/2023

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

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	with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law.			
	Based on record review and interview, the facility failed to ensure residents' right to receive mail on Saturdays was maintained for 9 of 9 residents interviewed during a resident council meeting. Findings include: During a resident council interview, on 12/15/23 at 2:00 p.m., the residents present indicated mail was	F 0576	**Tag 576 - Right to Forms of Communication with Privacy** *"Facility failed to ensure residents' right to receive mail on Saturdays was maintained for 9 of 9 residents interviewed during a resident council meeting."* **1: What corrective action(s) will**	01/12/2024

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	not delivered on Saturdays. During an interview, on 12/15/23 at 3:13 p.m., the Administrator indicated the mail was sorted and delivered to residents Monday through Friday, but they did not pass mail on Saturdays. Review of an undated, current facility policy, titled "INDIANA RESIDENT RIGHTS & FACILITY RESPONSIBILITIES," provided by the DON on 12/19/23 at 3:58 p.m., indicated it is the facility's policy to abide by all resident rights, and to communicate these rights to residents and their designated representatives in a language that they can understand...(s) The resident has the right to privacy in written communications, including the right to: (1) send and promptly receive mail that is unopened. 3.1-3(s)(1)		**be accomplished for those residents found to have been affected by the deficient practice?** 9 residents have been affected by the alleged deficient practice. Residents that stated deficient practice were given mail immediately. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents receiving mail have the potential to be affected by the alleged deficient practice. All mail was distributed to residents upon its mail delivery to the facility. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Activity Director/Designee will ensure mail is delivered to residents daily upon arrival to the facility. - Education and training were provided to BOM/Activities Director on 12/29/23 by the Executive Director. Education provided: Resident Rights and Facility Responsibilities.	

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			BOM/Activities Director/designee will complete monitoring through the clinical care meeting and the mail monitoring tool to ensure that any mail delivered to facility will be passed same day as it is received for proper monitoring procedure 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** BOM/designee will be responsible for the mail monitoring compliance of the delivery procedure for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 01/12/2024	
F 0699 SS=D	483.25(m) Trauma Informed Care			

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Bldg. 00	§483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on observation, interview, and record review, the facility failed to ensure a resident with PTSD (Post Traumatic Stress Disorder) received care to mitigate triggers that may cause re-traumatization for 1 of 1 residents reviewed for trauma informed care (Resident 26). Findings include: During an observation, on 12/15/23 at 10:34 a.m., Resident 26 was outside for a smoke break with a staff member and four other residents. Her clinical record was reviewed on 12/15/23 at 11:00 a.m. Diagnoses included PTSD. Current physician orders included Seroquel (anti-psychotic) 25 mg, give two tablets (50 mg) at bedtime for PTSD, ordered 10/6/23. A 10/17/23 admission MDS (Minimum Data Set) assessment indicated she was cognitively intact. She had no mood or behaviors. She received an anti-psychotic medication on a routine basis. A current care plan, dated 10/19/23, indicated she used anti-psychotic medications related to traumatic stress disorder. The goal, with a target date of 1/23/23, indicated she would remain free of psychotropic drug related complications, including movement disorder, discomfort,	F 0699	**Tag 699 – Trauma-informed care** *"Facility failed to ensure a resident with PTSD received care to mitigate triggers that may cause re-traumatization for 1 of 1 resident reviewed for trauma informed care."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 26 was affected by the alleged deficient practice. Resident 26 care plan and MDS assessments were immediately audited and corrected as appropriate. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents with potential trauma have the potential to be affected by the alleged deficient practice. All current in-house	01/12/2024

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	hypotension, gait disturbance, constipation/impaction, or cognitive/behavioral impairment through review date. The interventions, dated 10/19/23, indicated psychotropic medications would be administered as ordered and side effects and effectiveness would be monitored, ongoing need for medication discussed with physician and family, reviewed behaviors/interventions and alternate therapies attempted and their effectiveness, and monitor, document, and report as needed any adverse reactions of psychotropic medications. A current care plan, dated 12/7/23, indicated she had a behavior problem related to she got unnecessarily agitated/angry with staff. The goal, with a target date of 1/23/24, indicated she would have no evidence of behavior problems by review date. The interventions, dated 12/7/23, indicated medications would be administered as ordered and side effects and effectiveness would be monitored and documented, and if reasonable, resident's behavior would be discussed with her and an explanation for why behavior was inappropriate and/or unacceptable. The care plans lacked information of what triggered a re-traumatization for the resident and interventions/strategies to mitigate this risk. A Psychosocial Assessment, dated 10/30/23 at 9:45 a.m., indicated the resident had a verbal altercation with another resident. The diagnosis that may have contributed to the problem was PTSD. Triggers that may have caused behavioral outbursts included fighting or angry outbursts. She was re-directed to an area with less stimulation. A Psychosocial Note, dated 10/30/23 at 9:49 a.m.,		residents were immediately audited by the Social Service Director for Trauma Informed Care. No identified issues noted at this time. Residents with current identified trauma will have their care plan reviewed and updated immediately. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The ED and Social Services Director were educated on Trauma Informed Care and with concentration on, but not limited to, monitoring assessments and care plans as appropriate. - Education provided: Trauma Informed Care ED/SSD/designee will complete monitoring through the clinical care meeting and to ensure that all residents will have trauma informed care assessments completed as appropriate 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. **4: How the corrective action will be monitored to ensure the**	

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	indicated no mood or behavior changes noted. A facility form, titled "Behavior Monthly Flow Sheet," indicated the following behaviors were monitored, agitated/angry and uncooperative/refusal of care. In October the following behaviors had been observed: agitated/angry on 10/7/23 and uncooperative/refused care on 10/26/23. In November the following behaviors had been observed: she had been uncooperative/refused care on 11/4/23. A Mood and Behavior Communication Memo, dated 12/17/23 at 10:00 p.m., indicated the resident and her roommate had argued about the television and lights. The interventions included, provided one on one and conversation of interest. The clinical record lacked information of what triggered a re-traumatization for the resident and interventions/strategies to mitigate this risk. During an interview, on 12/19/23 at 9:53 a.m., LPN 7 indicated not being able to take a smoke break triggered behaviors from the resident. The interventions used included activities were offered and she played games on her phone. During an interview, on 12/19/23 at 10:33 a.m., the Social Service Director indicated her triggers were being around abusive men. Her behaviors were not something that medication would improve. She gathered information from behavior memos and reviewed progress notes to log behaviors, what interventions had been attempted, and effectiveness of interventions. During an interview, on 12/19/23 at 11:06 a.m., the DON indicated the resident's triggers included not		**deficient practice will not recur i.e., what quality assurance program will be put into place?** ED/designee will be responsible for monitoring compliance of the trauma informed care procedure for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 01/12/2024	

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	being able to go out to smoke because of weather, when someone disagreed with her, and when she wasn't first at something. Review of a current facility policy, titled "Trauma Informed Care (TIC) Policy," dated 2019 and provided by the DON on 12/19/23 at 3:58 p.m., indicated "...The facility will ensure that residents who are survivors receive culturally competent, trauma informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident...Trauma informed activities of the facility include, but are not limited to:...Care planning person centered approaches and interventions in response to the universal screening and/or periodic assessment of resident survivor needs including but not limited to honoring individual preferences and routines and responding to the emotional and psychosocial needs of resident survivors...Implementation of monitoring the staff implementation of interventions and performing quality improvement measures in response to identified needs and/or as problems are identified...."			
F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.			

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	§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on record review and interview, the facility failed to ensure a Registered Nurse (RN) worked 8 consecutive hours in the facility on any given day. This had the potential to affect 30 of 30 residents who resided in the facility. Findings include: A Payroll Based Journal (PBJ) report, compiled on 12/7/23 for Fiscal Year 2023's 3rd quarter (April 1 - June 30), indicated four or more days within the quarter with no RN hours. The report indicated the dates without RN coverage included April 1, April 2, April 15, April 29, May 13, and May 14. A review of the facility's Daily Nursing Assignment Sheets indicated the following: On April 1, there had not been an RN for eight consecutive hours at the facility. On April 2, there had not been an RN for eight consecutive hours at the facility. On April 15, there had not been an RN for eight consecutive hours at the facility. On April 29, the DON was included as having been at the facility for eight consecutive hours for RN coverage. On May 13, there had not been an RN for eight consecutive hours at the facility. On May 14, there had not been an RN for eight	F 0727	**Tag 727- RN 8hrs/7days/Wk, Full Time DON** *"Facility failed to ensure a Registered Nurse (RN) worked 8 consecutive hours in the facility on any given day. This had the potential to affect 30 of 30 residents who resided in the facility."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents have the potential to be affected by the alleged deficient practice. Schedule reviewed and no new adjustments were needed at this time. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**	01/12/2024

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	consecutive hours at the facility. During an interview, on 12/19/23 at 11:02 a.m., the DON indicated there had been dates when an RN was not at the facility for eight consecutive hours. There had been times that she was in the facility as RN coverage, but did not work eight consecutive hours. During an interview, on 12/19/23 at 11:28 a.m., the Business Office Manager indicated when the DON or MDS (Minimum Data Set) Nurse were in the facility for RN coverage, she coded their hours to reflect the hours were counted as RN coverage. Review of a current facility policy, titled "RN Coverage," with a last revision date of 6/1/2023 and provided by the Regional Administrator on 12/19/23 at 4:33 p.m., indicated "...Registered Nurse (RN): Registered nurses (RNs) are responsible for the overall delivery of care to the residents...Nursing homes must have at least one RN for at least 8 straight hours a day, 7 days a week...." 3.1-17(b)(3)		The DNS and ADNS were educated on Payroll Based Journal (PBJ) and procedure with concentration on, but not limited to, monitoring 8 hours of RN coverage daily. - Education provided: Payroll Based Journal (PBJ) requirements and practices. ED/DNS/designee will complete monitoring through morning standup meeting to ensure staffing is appropriate with 8 hours of RN coverage in a 24-hour period within state regulations, monitoring 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place.** ED/DNS/designee will be responsible for staffing and PBJ monitoring for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less	

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			than 6 months. **5. Date of completion:** 01/12/2024	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to ensure a resident received individualized, non-pharmacological interventions for dementia-type behaviors before increasing psychoactive medications for 2 of 5 residents reviewed for dementia care (Resident 18 and 25). Finding includes: 1. During an observation, on 12/15/23 at 9:53 a.m., Resident 18 was conversing with her roommate in her room. During an observation, on 12/19/23 at 10:34 a.m., Resident 18 was sitting in her wheelchair in her room crocheting. Resident 18's clinical record was reviewed on 12/15/23 at 9:15 a.m. She was admitted on 12/5/22. Her diagnoses included anxiety disorder, unspecified, unspecified dementia, unspecified severity with anxiety, unspecified dementia, unspecified severity, with mood disturbance, major depressive disorder, single episode, moderate, and unspecified dementia, unspecified severity, with agitation.	F 0744	**Tag 744 – Treatment/Service for Dementia** *"Facility failed to ensure a resident received individualized, non-pharmacological interventions for dementia-type behaviors before increasing psychoactive medications for 2 of 5 residents reviewed for dementia care (Resident 18 and 25).* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents 18 and 25 were affected by the alleged deficient practice. Residents 18 and 25 had interventions related to dementia care immediately reviewed and adjusted as appropriate including non-pharmacological and pharmacological interventions. **2: How other residents having**	01/12/2024

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	Her physician's orders included donepezil (for Alzheimer's disease)10 mg at bedtime (12/5/22), quetiapine fumarate (antipsychotic) 50 mg daily (8/26/23), quetiapine fumarate 50 mg - 2 tablets at bedtime (8/26/23), sertraline (antidepressant) 100 mg daily - take with 1.5 tablets of 50 mg to equal 175 mg (12/21/22), and sertraline 50 mg 1.5 tablets daily - take with 100 mg tablet to equal 175 mg (12/21/22). An 11/15/23 quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately cognitively impaired. She had no mood indicators for depression. She had no behaviors. She took antidepressant and antipsychotic medications. A care plan, initiated on 12/5/22, indicated the resident was at risk for elopement related to cognitive impairment and/or impaired safety awareness. Interventions, initiated on 12/5/22, included offer distractions when resident is wandering such as activities of choice, pleasant diversion, food, conversation, television, music, etc., offer resident baby doll or stuffed animal to care for, offer resident the restroom, and redirect the resident to appropriate areas. A care plan, initiated on 12/8/22 and revised on 6/22/23, indicated the resident had impaired cognitive function related to dementia, long-term memory loss, and short-term memory loss. Interventions, initiated 12/8/22, included administer medications as ordered. Monitor/document for side effects and effectiveness. Communication: use the resident preferred name. Identify yourself at each interaction. Face the resident when speaking and make eye contact. Reduce any distractions - turn off television, radio, close door, etc. The resident		**the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - Residents with a diagnosis of dementia have the potential to be affected by the alleged deficient practice. All residents with a diagnosis of dementia had non-pharmacological and pharmacological interventions reviewed and implemented or adjusted as appropriate. No new adjustments were recommended at this time. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DNS and Social Service Director were educated on dementia specific care and appropriate dementia related care plans and interventions. - Education provided: Envive Healthcare Personalized Care Policy DNS/SSD/designee will complete monitoring through the clinical care meeting to ensure that any resident with a dementia diagnosis has proper interventions with proper monitoring procedure 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in	

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	understands consistent simple directive sentences. Provide the resident with necessary cues - stop and return if agitated. Keep the resident's routine consistent and try to provide consistent care givers as much as possible to decrease confusion. Monitor/document/report as needed any changes in cognitive function, specifically expressing self, difficulty understanding others, level of consciousness, mental status. Provide a program of activities that accommodates the resident's abilities. Provide the resident with a homelike environment. A care plan, initiated on 12/8/22 and revised on 8/18/23, indicated the resident may exhibit restlessness, nervousness, and/or other anxiety symptoms related to anxiety. Interventions, initiated on 12/8/22, included: The resident was on a behavior monitoring program. Give medications as ordered. Medication review as indicated. A care plan, initiated and revised on 12/8/23, indicated the resident was at risk for exhibiting crying, tearfulness and/or expressions of sadness related to depression. Interventions included: Behavior monitoring as indicated (12/8/22). Medication review as indicated (12/8/22). Provide comfort and one on one as needed (11/28/23). A care plan, initiated and revised on 9/10/23, indicated the resident has delusions related to the resident telling staff her son had been in and he would be back to take her home. Interventions, initiated on 9/10/23, included: Behavior Monitoring Program as indicated. Medication review as indicated. Delusions: Assist resident to an area with less stimulation; Assure resident that the delusion is not real and that she is safe; Explain task to the resident.		QAPI for 6 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** DNS/SSD/designee will be responsible for monitoring compliance for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 01/12/2024	

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	A Social Services note, on 8/17/23 at 2:15 p.m., indicated the resident had been seen by the psych NP. Her quetiapine had been reduced from 50 mg twice a day to 50 mg daily at bedtime. A Progress note, on 8/25/23 at 8:00 p.m., indicated the resident's representative voiced concerns that the resident was having increased confusion and agitation. The resident had insisted that her family was coming to take her home and refused to go to bed several evenings in a row. According to the resident's representative, when the resident lived with the resident's representative, the quetiapine dose had been reduced and she had worsening behaviors. The physician was notified. A Nurses note, on 8/26/23 at 6:01 p.m., indicated the resident was at the nurse's station stating her family was coming to pick her up like he picked up last evening. The nurse told the resident she had not left the previous evening. The resident's representative was called and indicated the family was not coming to get her that evening. A Nurses note, on 8/26/23 at 8:28 p.m., indicated the on-call physician was notified and gave the order to restart the resident at the original dose of quetiapine. The order for quetiapine was to take 50 mg every morning and 100 mg every bedtime. The recent gradual dose reduction had failed due to increased delusions. A Nurses note, on 8/27/23 at 6:10 p.m., indicated the resident was slightly agitated and anxious. She packed her belongings and indicated her son was coming to get her. The progress notes lacked additional documentation of behaviors or interventions provided from 8/27/23 through 12/13/23.			

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	No behaviors or interventions were documented in the tasks list from 11/18/23 through 12/18/23. During an interview, on 12/19/23 at 2:16 p.m., LPN 52 indicated the resident did not have behaviors except when she had a bladder infection several months ago. During an interview, on 12/19/23 at 2:18 p.m., the Social Services Designee (SSD) indicated she had questioned the increase in the quetiapine when she reviewed the behaviors. There was one behavior documented on 8/25/23 on the behavior monthly flow sheet of delusions with the interventions being ineffective. The on-call physician had increased the resident's quetiapine dosage, not the psych NP. She was uncertain why the psych NP had not addressed the increase in the medication. 2. During an observation, on 12/14/23 at 3:28 p.m., Resident 25 was sitting in a wheel-chair in the doorway of her room. On 12/15/23 at 10:37 a.m., she was sitting in a wheel-chair in her room. On 12/15/23 at 1:45 p.m., she was sitting in a wheel-chair in her room with a blanket draped over her. On 12/18/23 at 9:33 a.m., she was in a wheel-chair propelling herself around the facility. On 12/18/23 at 9:38 a.m., she had propelled the wheel-chair in front of the nurses' station and asked if she could leave. A QMA dialed the phone for her and she spoke with her daughter. On 12/18/23 at 9:43 a.m., she was in wheel-chair near the nurses station writing checks with her purse on her lap.			

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	On 12/19/23 at 8:28 a.m., she was sitting in her room in a wheel-chair. On 12/19/23 at 8:45 a.m., she was sitting in her room in a wheel-chair. Resident 25's clinical record was reviewed on 12/15/23 at 9:36 a.m. Diagnoses included, anxiety disorder and dementia, unspecified severity, with anxiety that had been added to her list of diagnoses on 11/27/23. Current physician orders included Xanax (anti-anxiety) 0.25 mg, give two tablets (0.5 mg) every 24 hours PRN (as needed) for breakthrough anxiety (order date 12/16/23), Xanax 0.25 mg, one tablet three times a day for anxiety (order date 12/18/23), Xanax 0.25 mg, give two tablets (0.5 mg) in the afternoon for anxiety (order date 12/19/23), and target behaviors: anxiety: self-reported nervousness, restlessness, sleeplessness, at the end of each shift mark how often behavior occurred, intensity, and how she responded to redirection (order date 12/13/23). An 10/5/23 admission MDS assessment indicated she had severe cognitive impairment. Her preferences indicated it was somewhat important to her to have snacks between meals, to have books, newspaper, and magazines, to listen to music, to do things with groups of people, and to participate in religious activities. It was very important to her to keep up with the news, to do her favorite activities, and go outside when the weather permitted. A current care plan, dated 11/27/23, indicated she exhibited restlessness, nervousness and/or other anxiety/confusion symptoms related to she			

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	thought her daughter had left her here and was confused as to why she was at the facility and wanted to go home. The goal, initiated on 11/27/23 and with a target date of 1/11/24, indicated she would have decreased anxiety symptoms through next review. Interventions dated 11/27/23 included, behavior monitoring program as indicated, and give medications as ordered. Interventions dated 12/5/23 included, resident assured her family knew she was at facility and didn't forget her, redirected to her room to see that her personal items were there, offered food or drink of her choice, and provided comfort and emotional support. A Mood and Behavior Communication Memo, dated 11/15/23, indicated she had hollered out, got up, and walked in the hallway. Interventions that had been attempted without effectiveness included, toileting, change position, provided fluids, provided quiet environment, placed in chair and/or bed, provided one on one, allowed her to vent her feelings, provided reassurance and comfort, allowed time to calm/re-approach, and re-direction. A Mood and Behavior Communication Memo, dated 11/23/23 at 6:00 p.m., indicated she had been restless and rejected care. Interventions that had been attempted without effectiveness included toileting, provided fluids, provided quiet environment, provided one on one, allowed her to vent her feelings, provided reassurance and comfort, allowed time to calm/re-approach, and re-direction. A progress note, dated 11/27/23 at 4:04 a.m., indicated she had been anxious, restless, and confused all evening. She was assisted to bed and had rested well.			

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	A progress note, dated 11/27/23 at 11:56 a.m., indicated she continued to be anxious while self propelling in hallway. A progress note, dated 11/27/23 at 1:39 p.m., indicated a new order to add a diagnosis of dementia. A progress note, dated 11/29/23 at 5:30 p.m., indicated she had increased anxiety, PRN medication for anxiety had been given with little effectiveness. She had been tearful, shaky, and stated she was scared. Staff had provided one on one time with re-direction that had been somewhat effective, wanted to be with someone at all times, and physician was notified. A Mood and Behavior Communication Memo, dated 11/29/23, indicated she had been restless through the night. Interventions that had been attempted without effectiveness included toileting, changed position, provided fluids, provided quiet environment, mental health services, and validation of feelings and words. A progress note, dated 11/30/23 at 1:13 p.m., indicated the physician had ordered an increase in her anti-anxiety medication. A facility form, titled "Behavior Monthly Flow Sheet," indicated the following behaviors were monitored, restlessness/nervous, hallucinations/paranoia/delusion, refusal of care, and wandering. In November the following behaviors had been observed, she had been restless/nervous on 11/15, 11/23, 11/29, and 11/30/23, and she had a refusal of care on 11/23/23.			

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	A progress note, dated 12/2/23 at 7:52 a.m., indicated she had increased anxiety, the PRN anti-anxiety medication had been given. She had been shaky and stated she was scared. Staff had provided one on one with re-direction that had been somewhat effective. She had a hallucination of a little boy and girl in her room that had told her she had to leave. Staff continued to assure her she was safe. A progress note, dated 12/4/23 at 12:20 p.m., indicated a new order had been received to discontinue the PRN anti-anxiety medication and start Xanax 0.5 mg tablet four times a day. A progress note, dated 12/8/23 at 8:16 a.m., indicated the Xanax was decreased to 0.25 mg three times a day. A progress note, dated 12/9/23 at 8:16 a.m., indicated Resident 25 had been anxious, followed the nurse around the facility, and was not easily re-directed. Scheduled medication had been given but had not been effective. Call placed to physician for an order for a PRN dose of Xanax for breakthrough anxiety. A progress note, dated 12/12/23 at 12:08 p.m., indicated an order for Xanax 0.25 mg one tablet every 24 hours PRN had been received. A progress note, dated 12/16/23 at 9:57 a.m., indicated she had been anxious, followed nurse around the facility, and was not easily re-directed. Scheduled medication given as ordered but was not effective. She had called her son three times and her daughter twice that morning. A progress note, dated 12/16/23 at 12:06 p.m., indicated the physician was notified of her			

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	behavior, and an order to had been received to increase the PRN Xanax to 0.5 mg for breakthrough anxiety. A progress note, dated 12/17/23 at 2:51 a.m., indicated she was awake and sitting on the side of her bed yelling and trying to get up. Staff explained it was too early to get up and assisted her back into the bed. A progress note, dated 12/18/23 at 1:50 p.m., indicated order had been received to adjust the routine Xanax order to 0.25 mg three times a day and 0.5 mg in the afternoon. A Mood and Behavior Communication Memo, dated 12/12/23 at 2:45 a.m., indicated restlessness, she had gotten herself up in the wheelchair and was going down the hallway. She indicated she didn't want to go to bed. Interventions: provided snack, provided one on one, allowed her to vent her feelings. The outcome, she her eventually allowed staff to put back to bed. A Mood and Behavior Communication Memo, dated 12/16/23 at 11:58 a.m., indicated she had been verbally aggressive and exit seeking, and tried to open front door to leave. She had been told she could not leave because she lived here, and she turned around and screamed that she did not live there. Interventions: allowed time to calm/re-approach, re-direction, PRN medication administered. The outcome, she continued to exit seek. A Mood and Behavior Communication Memo, dated 12/17/23 at 1:30 a.m. and 3:00 a.m., indicated she had walked around her room without staff assistance, she was assisted back into bed but she continued to get up. Interventions: provided			

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	snack, provided one on one, allowed her to vent her feelings, and re-direction. The outcome, she continued to try to get up. During an interview, on 12/19/23 at 9:53 a.m., LPN 7 indicated Resident 25 had a short attention span, liked interactions with others, and felt most comfortable when her daughter was there. The interventions she used included, encouraged her to attend activities, assisted her with calling her son or daughter, and the PRN Xanax. Her dementia was the cause of her behaviors. If a behavior was noted, it got documented in Risk Management section of the electronic clinical record and the SSD (Social Service Director) reviewed those notes. During an interview, on 12/19/23 at 10:45 a.m., the SSD indicated the resident had a short attention span and her behaviors were related to dementia. Staff had attempted to re-direct her, offer her snacks, and assist her to call her family. It was sometimes hard to distract her and better to give her the anti-anxiety medication instead. She reviewed the Mood and Behavior Communication Memos and checked progress notes daily for the behavior monitoring and tracking. During an interview, on 12/19/23 at 11:15 a.m., the DON indicated staff were expected to fill out the behavior communication paper and give to the SSD when a resident had a behavior. It would include interventions that would have been tried and if they had been effective. Her behaviors were related to dementia. Non-pharmacological interventions were expected to be attempted before administering the PRN Xanax. Review of a current facility policy, titled "Personalized Care," dated 6/1/2023 and provided			

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	by the DON on 12/19/23 at 3:58 p.m., indicated "...1. All staff will be involved in life enrichment programming during the residents' waking hours. The life enrichment programming in the facilities is designed to engage the residents and facilitate the highest level of function...2. Although residents with memory impairment do better when a basic routine is followed, individualized, center focused care provides flexibility and facilitates honoring personal interests and preferences...." 3.1-37(a)			
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--- §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			

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	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 observation, interview, and record review, the facility failed to ensure non-pharmacological interventions were employed prior to increasing an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications (Resident 18). Finding includes: During an observation, on 12/15/23 at 9:53 a.m., Resident 18 was conversing with her roommate in her room. During an observation, on 12/19/23 at 10:34 a.m., Resident 18 was sitting in her wheelchair in her room crocheting.	F 0758	**Tag F758 – Free from Unnecessary Psychotropic Meds/PRN Use** *"Facility failed to ensure non-pharmacological interventions were employed prior to increasing an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications (Resident 18)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Residents 18 was affected	01/12/2024

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	Resident 18's clinical record was reviewed on 12/15/23 at 9:15 a.m. She was admitted on 12/5/22. Her diagnoses included anxiety disorder, unspecified, unspecified dementia, unspecified severity with anxiety, unspecified dementia, unspecified severity, with mood disturbance, major depressive disorder, single episode, moderate, and unspecified dementia, unspecified severity, with agitation. Her physician's orders included donepezil (for Alzheimer's disease)10 mg at bedtime (12/5/22), quetiapine fumarate (antipsychotic) 50 mg daily (8/26/23), quetiapine fumarate 50 mg - 2 tablets at bedtime (8/26/23), sertraline (antidepressant) 100 mg daily - take with 1.5 tablets of 50 mg to equal 175 mg (12/21/22), and sertraline 50 mg 1.5 tablets daily - take with 100 mg tablet to equal 175 mg (12/21/22). An 11/15/23 quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately cognitively impaired. She had no mood indicators for depression. She had no behaviors. A care plan, initiated and revised on 12/8/22, indicated the resident used antipsychotic medications and was at risk for complications. Interventions included administer psychotropic medications as ordered by physician and monitor for side effects and effectiveness every shift, discus with physician, family about ongoing need for use of medication, review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. A medication regimen review by the pharmacist was completed on 6/26/23. A reduction in the dose of quetiapine from 100 mg at bedtime and 50		by the alleged deficient practice. Resident 18 immediately had non-pharmacological interventions reviewed and adjusted as appropriate. Medications were also immediately reviewed with MD for appropriateness. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents receiving psychotropic medications have the potential to be affected by the alleged deficient practice. All residents receiving psychotropic medications immediately had interventions and medications reviewed for appropriateness. No new adjustments were recommended at this time. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DNS and Social Service Director were educated on psychotropic medications, appropriate non-pharmacological and pharmacological interventions, with concentration on, but not limited to, monitoring behaviors for appropriate intervention. - Education provided: Pharmacy Manual and Policy	

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	mg daily to quetiapine 75 mg at bedtime and 50 mg daily (a reduction of 175 mg to 125 mg total daily) was recommended. The physician agreed on 6/27/23 and the order was changed on 6/30/23. A NP progress note, on 7/20/23 at 9:39 a.m., indicated the resident had a gradual dose reduction of quetiapine on 6/30/23. Psychotropic medications and behaviors were reviewed. No behaviors had been reported over the review period. The plan for the resident was to decrease the quetiapine to 50 mg twice a day as a gradual dose reduction attempt. A NP progress note, on 8/17/23 at 4:14 p.m., indicated the NP attended a behavior management meeting and reviewed the psychotropic medications and behaviors. No behaviors had been reported over the review period. The plan for the resident was to decrease the quetiapine to 50 mg at bedtime as a gradual dose reduction attempt. A Progress note, on 8/25/23 at 8:00 p.m., indicated the resident's representative voiced concerns that the resident was having increased confusion and agitation. The resident had insisted that her family was coming to take her home and refused to go to bed several evenings in a row. According to the resident's representative, when the resident lived with the resident's representative, the quetiapine dose had been reduced and she had worsening behaviors. The physician was notified. A Nurses note, on 8/26/23 at 6:01 p.m., indicated the resident was at the nurse's station stating her family was coming to pick her up like he picked up last evening. The resident had not left the previous evening. The resident's representative was called and indicated the family was not		regarding Psychotropic Medications DNS/SSD/designee will complete monitoring through the clinical care meeting to ensure that any resident with psychotropic diagnosis and/or medications will have proper monitoring for 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ED will be responsible for monitoring compliance for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 01/12/2024	

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	coming to get her that evening. A Nurses note, on 8/26/23 at 8:28 p.m., indicated the on-call physician was notified and gave the order to restart the resident at the original dose of quetiapine. The order for quetiapine was to take 50 mg every morning and 100 mg every bedtime. The recent gradual dose reduction had failed due to increased delusions. A Nurses note, on 8/27/23 at 6:10 p.m., indicated the resident was slightly agitated and anxious. She packed her belongings and indicated her son was coming to get her. Behavior Monthly Flow Sheets for June, July, and August 2023, provided by the Social Service Director on 12/19/23 at 2:15 p.m., indicated the resident had one behavior of delusions on 8/26/23 with no additional behaviors documented for other months or days. During an interview, on 12/19/23 at 2:16 p.m., LPN 52 indicated the resident did not have behaviors except when she had a bladder infection several months ago. During an interview, on 12/19/23 at 2:18 18 p.m., the Social Services Designee indicated the resident had been admitted with the quetiapine order and other psychotropic medications. The psych NP had been working on reducing the quetiapine and did not order the increases. The son did not think the reduction in the quetiapine would be successful, but it was. The increase in the dose was ordered by the on-call doctor over a weekend. Generally, if a dose reduction had failed, the medication would not immediately be increased to the original dose before the two previous reductions. The resident had not had			

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	behaviors until the last gradual dose reduction. A current facility policy, dated 2020, provided by the DON on 12/19/23 at 3:58 p.m., titled "Monitoring of Anti-Psychotics," indicated " ...Gradual dose reduction is attempted with all residents who receive antipsychotic medications, unless clinically contraindicated. Contraindication to dose reduction must be documented in the resident's medical record by the responsible physician ...During the last seven days of each month in which the dose is reduce an assessment of the behavior is completed by the nursing staff, to guide the physician in making dose reductions ...." 3.1-48(b)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs			

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	listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. A. Based on observation, interview, and record review, the facility failed to ensure biologicals requiring refrigeration were monitored per CDC guidelines for 1 of 1 refrigerators reviewed for medication/biological storage. B. Based on observation, interview, and record review, the facility failed to ensure residents' medications were properly disposed of or sent back to the pharmacy for credit for 1 of 1 medication storage rooms observed. Findings include: A. During an observation of the medication storage room beginning on 12/18/23 at 8:49 a.m., with RN 51, the medication refrigerator contained 10 vials/doses of influenza vaccines and had a standard thermometer. The refrigerator log indicated the refrigerator temperature was monitored daily. A facility document, provided by the DON on 12/18/23 at 10:08 a.m., titled "Daily Freezer/Refrigerator Temperature Log," indicated the location was the medication room for December 2023. Temperatures for the refrigerator were taken daily. During an interview, on 12/18/23 at 10:08 a.m., the DON indicated the refrigerator containing the vaccines had always been monitored daily not twice a day.	F 0761	**Tag F761 – Label/Store Drugs and Biologicals** *"Facility failed to ensure residents' medications were properly disposed of or sent back to pharmacy for credit for 1 of 1 medication storage rooms observed."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. All medications were immediately audited and adjusted as appropriate. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents receiving medications have the potential to be affected by the alleged deficient practice. All medications were audited for appropriateness. No medications adjustments were necessary at this time.	01/12/2024

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	During an interview, on 12/18/23 at 11:12 a.m., the DON indicated the facility did not have a policy on the storage of vaccines. The article "Vaccine Storage and Handling Toolkit - January 2023," was retrieved on 12/19/23 from the Centers of Disease Control and Prevention website at https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdfhttps://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf. The guidance indicated if the temperature monitoring device did not read maximum/minimum temperatures then the temperature must be checked and recorded a minimum of two times a day as a minimal action to protect the vaccine supply. B. During an observation of the medication storage room beginning on 12/18/23 at 8:49 a.m. with RN 51, a tub filled with multiple medications for multiple residents was on a bottom shelf. During an interview, at the same time, RN 51 indicated the medications were to be returned to the pharmacy. She was uncertain of the paperwork to be filled out or the process as she had not sent back medications herself. During an observation beginning on 12/18/23 at 10:08 a.m., the tub filled with medications was reviewed with the DON. The medications included Entresto (for heart failure), Xarelto (blood thinner), doxycycline (antibiotic), amoxicillin and clavulanic acid (antibiotic), cefuroxime (antibiotic), glucagon injection (for very low blood sugars), a discharged resident's insulin injectable pens (for diabetes), a deceased resident's Tresiba Flex touch injectable pens (for diabetes), a discharged resident's Prevnar 20 vaccine (vaccine), an unmarked used		**3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DNS and ADNS were educated on appropriate medication storage. - Education provided: Pharmacy Manual and Policy with focus on Medication storage and labeling. DNS/designee will complete monitoring to ensure that medications are labelled and stored appropriately and monitored 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** DNS/designee will be responsible for monitoring compliance for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less	

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	fluticasone propionate salmeterol inhaler (for difficulty breathing), and loose, unmarked albuterol/ipratropium vials for nebulizer (for difficulty breathing). A stack of six medication cards was near the bottom of the tub with return paperwork dated 12/10/23. During an interview, at the same time, the DON indicated one of the nurses periodically went through the medication carts and refrigerator to check for and remove expired/discharged residents' medications and discontinued medications. The medications had not been sorted yet, so no paperwork had been filled out. A current policy, dated 2020, titled "Medication Storage in the Facility," provided by the DON on 12/18/23 at 11:12 a.m., indicated " ...Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if a current order exists ...." A current policy, dated 2020, titled "Returning of Prescription Medications to the Pharmacy," provided by the DON on 12/18/23 at 11:12 a.m., indicated "POLICY: Each state has specific rules and regulations as it relates to returning medications- Each facility and pharmacy will adhere to their individual State's Rules and Regulations as it pertains to returns ...." 3.1-25(o) 3.1-25(q) 3.1-25(r)		than 6 months. **5. Date of completion:** 01/12/2024	
F 0812 SS=F	483.60(i)(1)(2) Food			

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Bldg. 00	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, interview, and record review, the facility failed to ensure the appropriate storage of refrigerated foods by the use of a refrigerator unable to maintain refrigeration at safe levels. This deficiency had the potential to affect 30 of 30 residents residing in the facility who received meals from the kitchen. Finding includes: During an observation, on 12/13/23 at 10:07 a.m., the kitchen refrigerator temperature was 46 degrees Fahrenheit (F). The refrigerator contained various items including cheese and other dairy products. The Dietary Manager, at the same time, indicated the staff had been in and out of the refrigerator recently. She thought this was why	F 0812	**Tag F812 – Food Procurement, Store/Prepare/ Serve-Sanitary** *"Facility failed to ensure the appropriate storage of refrigerated foods using a refrigerator unable to maintain refrigeration at safe levels. The deficiency had the potential to affect 30 of 30 residents residing in the facility who received meals from the kitchen."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	01/12/2024

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	the refrigerator temperature was reading 46 degrees F. Review of a facility "Resource: Refrigerator/Freezer Temperature Log," document, provided by the Administrator on 12/13/23 at 11:02 a.m., indicated the refrigerator temperatures for December 2023 were as follows: 12/1/23 morning 41 degrees, evening 46 degrees 12/2/23 morning 44 degrees, evening 45 degrees 12/3/23 morning 42 degrees, evening 43 degrees 12/4/23 morning 46 degrees, evening 49 degrees 12/5/23 morning 48 degrees, evening 49 degrees 12/6/23 morning 48 degrees, evening 49 degrees 12/7/23 morning 46 degrees, evening 47 degrees 12/8/23 morning 47 degrees, evening 46 degrees 12/9/23 morning 46 degrees, evening 46 degrees 12/10/23 morning 46 degrees, evening 47 degrees 12/11/23 morning 45 degrees, evening 47 degrees 12/12/23 morning 45 degrees, evening 46 degrees 12/13/23 morning 47 degrees. During an interview, on 12/14/23 at 3:20 p.m., the Dietary Manager indicated the facility had received and installed a new refrigerator that afternoon. All of the food stored in the previous refrigerator had been thrown away. She had no where else to store the refrigerated foods while waiting for the new refrigerator, as there were no other refrigerators in the kitchen. She had let maintenance know about the increased refrigerator temperatures on 12/1/23. During an interview, on 12/15/23 at 1:44 p.m., the Administrator indicated during morning meeting on 12/8/23, she learned about the refrigerator not staying cold. She reported the refrigerator's malfunctioning to her corporate managers. No other refrigerators were used in the kitchen. On 12/13/23, about midday, all the food in the		No residents were affected by the alleged deficient practice. All refrigerator temperatures were immediately inspected. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents receiving food from the kitchen have the potential to be affected by the alleged deficient practice. All refrigerators were audited and adjusted as appropriate. No adjustments needed at this time. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The ED and Dietary Manager were educated in food preparation and temperature regulation. - Education provided: Food Preparing and temperature regulation. ED/DM/designee will complete monitoring for storage of refrigerated foods 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months for appropriate food temperatures and storage. **4: How the corrective action**	

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	refrigerator had been thrown away. The food thrown away included cottage cheese, cream cheese, other cheeses, and milk. During an interview, on 12/15/23 at 1:52 p.m., the Dietary Manager indicated she had placed frozen eggs in the old refrigerator to thaw and used them. The refrigerator had contained butter and tomatoes. She had purchased small amounts of milk at a time, so it was not in the refrigerator too long. She thought maintenance thawed the refrigerator on 12/13/23. An invoice for the new refrigerator, provided by the Administrator on 12/15/23 at 2:01 p.m., was dated 12/13/23. During an interview, on 12/15/23 at 2:22 p.m., the Maintenance Director indicated he learned about the malfunctioning refrigerator on 12/8/23. He unthawed the refrigerator on 12/8/23\, as it had a brick of ice on the coils. The refrigerator was working when he left the facility on 12/8/23. He told the administrator about the malfunctioning refrigerator. He unthawed the refrigerator again on 12/14/23, but it began accumulating ice on the coils within a very short time. The facility only had the one refrigerator. A current facility policy for "Kitchen Operations: Food Storage", dated 1/2023, provided by the Dietary Manager on 12/18/23 at 10:50 a.m., indicated " ...Food is stored at an appropriate temperature ...Temperatures for refrigerators should be <41 [degrees] Fahrenheit ...If temperature of refrigerator is above 40 [degrees] F, take food temperatures of item(s) stored within. If items remain at 41 [degrees] F or less, move items to working refrigeration unit. If items are above 41 [degrees] F, discard and log items discarded ...."		**will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ED/DM/designee will be responsible for compliance for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 01/12/2024	

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	3.1-21(i)(3)			
F 0887 SS=D Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following:			

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	(A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). Based on record review and interview, the facility failed to ensure residents were offered the latest and recommended COVID-19 vaccine for 4 of 5 residents reviewed for COVID-19 vaccinations (Residents 12, 25, 23, and 18). Findings include: 1. Resident 12's clinical record was reviewed on 2/18/23 at 9:42 a.m. . Diagnoses included, type 2 diabetes mellitus and malignant neoplasm of unspecified site of left female breast. A COVID-19 Resident Vaccine Education form, signed by the resident and dated 8/8/22, indicated she requested the facility ensured she was vaccinated as soon as available.	F 0887	**Tag F887 – COVID-19 Immunizations** *"Facility failed to ensure residents were offered the latest and recommended COVID-19 vaccine for 4 of 5 residents reviewed for COVID-19 vaccinations. (Residents 12,25,23, and 18)."* **1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficient practice. Residents 12, 25, 23, and 18	01/12/2024

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	155699	A. BUILDING 00 B. WING	12/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	A review of her immunization status indicated her last COVID-19 vaccine had been administered on 12/6/22. Her clinical record lacked information that she had been offered the latest and recommended vaccine for COVID-19. 2. Resident 25's clinical record was reviewed on 12/15/23 at 9:36 a.m. Diagnoses included, type 2 diabetes mellitus and atherosclerotic heart disease. An informed consent of COVID-19 vaccine was signed by the resident and dated 9/14/23. A review of her immunization history status indicated her last COVID-19 vaccine had been administered on 3/3/21. Her clinical record lacked information that she had been offered the latest and recommended vaccine for COVID-19.3. Resident 23's clinical record was reviewed on 12/15/23 at 9:17 a.m. Her diagnoses included pneumonia, atherosclerotic heart disease of native coronary artery without angina pectoris, acute, atrial fibrillation, and acute on chronic diastolic (congestive) heart failure. She had received COVID-19 vaccinations on the following dates 7/6/21, 8/9/21, 11/19/21, 2/11/22, and 8/9/22. She was offered and declined the COVID-19 vaccine on 7/3/23. Her clinical record lacked information that she had been offered the latest and recommended vaccine for COVID-19.		were immediately offered the latest and recommended COVID-19 vaccine. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents have the potential to be affected by the alleged deficient practice. All residents were offered the latest and recommended COVID-19 vaccine when it comes available. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DNS was educated on the antibiotic stewardship policy and procedure with concentration on, but not limited to, monitoring infection prevention and vaccine administration. - Education provided: Infection Prevention and Control General Guidelines Instructions for the Long-Term Care (LTC) vaccine administration. DNS/designee will complete monitoring through the clinical care meeting to ensure that all residents have been offered COVID-19 vaccine and continue proper monitoring procedures for 5	

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	4. Resident 18's clinical record was reviewed on 12/15/23 at 9:18 a.m. Her diagnoses included presence of cardiac pacemaker and atrial fibrillation. She lacked a COVID-19 immunization. Her resident representative was offered and declined the COVID-19 vaccine on 12/5/22. Her clinical record lacked information that she had been offered the latest and recommended vaccine for COVID-19. During an interview on 12/19/23 at 2:49 p.m., the DON indicated the facility offered the COVID-19 vaccine upon admission. If residents had received both boosters for COVID-19, then they were good. She was uncertain if the newest COVID-19 booster had been offered to the residents. During an interview on 12/19/23 at 3:50 p.m., the DON indicated she had called the pharmacy. The pharmacy had the new vaccine. The facility had not offered the latest COVID-19 vaccine to the residents. The article "Use of Updated COVID-19 Vaccines 2023-2024 formula for Persons Aged > 6 Months: Recommendations of the Advisory Committee on Immunization Practices [ACIP] - United States, September 2023" was retrieved on 12/19/23 from the Centers of Disease Control (CDC) website at https://www.cdc.gov/mmwr/volumes/72/wr/mm7242e1.htm#:~:text=On%20September%2012%2C%202023%2C%20ACIP,persons%20aged%20%E2%89%A56%20months. The guidance included: " ...On September 12, 2023, ACIP recommended vaccination with the updated 2023-2024 COVID-19 vaccine for all persons aged > 6 months ..."		days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 6 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** DNS/designee will be responsible for the procedure for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 01/12/2024	

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	A current facility policy, dated 8/2022, provided by the administrator with the entrance conference paperwork on 12/13/23, indicated " ...COVID-19 Boosters will be offered and given based on current CDC recommendations ...." 3.1-18(b)(5)			