STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155209	A. BUILDING 00 B. WING	04/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CLIFTY FALLS, THE	950 CROSS AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 29, 30, 31, and April 3, 4, 2023. Facility number: 000116 Provider number: 155209 AIM number: 100266330 Census Bed Type: SNF/NF: 90 Total: 90 Census Payor Type: Medicare: 10 Medicaid: 55 Other: 25 Total: 90 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 10, 2023.	F 0000		
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview, and record review, the facility failed to provide reasonable accommodations to meet the needs and	F 0558	**F-558** The right to reside and receive services in the facility with	04/22/2023

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

Ashley Bowling | Administrator | 04/22/2023

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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	preferences of a resident related to placement in the locked Dementia Unit for 1 of 24 residents reviewed for Residents' Rights. (Resident 50) Findings include: During an observation and interview on 03/29/23 at 2:14 P.M., Resident 50 was sitting in a wheelchair in her room on the locked Dementia Unit, Unit 3. She indicated she had talked to the nurse on the unit and told her that she did not like living on Unit 3. She liked it on Unit 2. She went over on Unit 2 the other day for therapy and residents were out by the nurse's station talking and they greeted her. She used to live over there. They didn't do many activities on the Dementia Unit. She used to participate in all kinds of activities on Unit 2. She felt sorry for the people on Unit 3 because most of them had mental problems. She told staff several weeks ago that she wanted to go back to Unit 2. If you go out in the hall here, on Unit 3, none of the residents can talk right. Residents gathered at the Nurses' Station on Unit 2 and just talked. During an observation on 03/31/23 at 11:31 A.M., the resident's room door was closed. Her niece was in the room with the resident and indicated the resident did not go to activities on the locked unit like she did on Unit 2 and the resident would like to move back to Unit 2. The resident was sitting in her wheelchair and verbalized agreement that she would like to move back to Unit 2. During an observation and interview on 04/03/23 at 9:58 A.M., the resident was alone in her room with the door closed lying in bed. She indicated the (name of baseball team) had won two out of three games this weekend. She would like to move back to Unit 2 where her friends were. She had		reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Including appropriate placement on secured dementia units. Resident #50 was moved off the secured dementia unit on 4/5/2023. Residents who reside in the facility have the potential to be affected by this finding. A 100% audit of diagnosis and condition was completed on 4/19/23 of all residents who reside on the dementia unit to ensure they were appropriately placed. Any issues found were addressed accordingly. Social Services/Designee will monitor new admissions, readmissions, or transfers to the dementia unit for appropriate placement. A dementia unit admissions audit tool will be used 5 days weekly for 4 weeks, then 3 days weekly for 4 weeks and then 1 day weekly for 4 months. The monitoring will take place for no less than 6 months. If the facility is within 100% compliance at the end of 6 months monitoring will be stopped. At an in-service held by the Administrator/Designee on_4/18/2023 for the IDT the following was reviewed: criteria to place residents on the dementia unit. resident's rights	

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	been over on Unit 2 today on her way to therapy and it had been so nice to see everyone for a minute. During an anonymous interview, Staff 50 indicated the resident used to live on Unit 2 and liked living on Unit 2. Upper management decided to move her to the Dementia Unit and the resident had not been happy since. She stayed in her room, she ate in her room, and seldom came out. When she lived on Unit 2, she was out in the hallway visiting with people and she enjoyed being on Unit 2. During an anonymous interview, Staff 51 indicated the resident did not like it on the Dementia Unit. The resident said the residents were mentally challenged and could not talk. She missed her friends on the other unit. The resident's clinical record was reviewed on 03/31/23 at 10:01 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 02/15/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, right shoulder fracture, dementia, lack of coordination, and difficulty walking. The complete Care Plan was provided by the DON (Director of Nursing) on 04/04/23 at 2:55 P.M. The record indicated the resident had a diagnosis of unspecified dementia without behavioral disturbance with short- and long-term memory problems. The date initiated was 02/08/22. The Care Plan had not been reviewed or updated since the initiation date. No intervention to move the resident to the locked Dementia Unit was documented. Wandering Risk assessments, dated 03/02/23 and			

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	04/01/23, were provided by the ADON (Assistant Director of Nursing) on 04/04/23 at 3:33 P.M. The assessments indicated the resident was able to follow instructions, move without assistance while in a wheelchair, communicate, had no history of wandering, and had a score indicating she was at a low risk for wandering. Social Service Evaluations, dated 11/28/22 and 03/22/23, were provided by the ADON on 04/04/23 at 3:33 P.M. The evaluations indicated the resident had moderate cognitive impairment, her mood was stable, and she had no noted behaviors. The Progress Notes were provided by the ADON on 04/04/23 at 3:33 P.M. A note, dated 03/08/23 at 12:00 P.M., indicated the resident was transferred to Room 308 (located on the locked Dementia Unit). The Progress Notes lacked documentation indicating the resident had any behaviors, cognitive decline, or was at risk for wandering prior to the room change from Unit 2 to the locked Dementia Unit (Unit 3). The record lacked documentation of monitoring for psychosocial adjustment following the room move. During an interview on 04/04/23 at 1:27 P.M., the SSD (Social Services Director) indicated the facility had 90 residents and only one SSD. The resident had been in the facility twice. Recently she had more of a decline. She wandered in her wheelchair, just kind of roamed, but was not exit seeking. They moved her to the Dementia Unit because she had a cognitive decline. In addition, it was a smaller unit of people. She had several falls in the last couple of months. The most recent fall was in her room prior to the move to the Dementia Unit. The move was discussed at length with the POA (Power of Attorney). The resident			

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	was really excited about moving back to the Dementia Unit. When she initially moved back there she was in a room with a resident who was at a lower cognitive level. They moved the resident into a new room with a more cognitively intact roommate. The current undated "Resident Rights" policy was provided by the Regional Director of Operations on 04/04/23 at 2:55 P.M. The policy indicated, "...The preferences and goals of the resident should be honored as much as possible and the resident's comfort, safety and overall welfare must be promoted, protected and enhanced at all times..." 3.1-4(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 interview and record review, the facility failed to accurately complete MDS (Minimum Data Set) assessments related to anticoagulant medication and diagnoses for 2 of 18 residents reviewed for accuracy of assessments. (Residents 60 and 50) Findings include: 1. The clinical record for Resident 60 was reviewed on 03/31/23 at 11:20 A.M. A Significant Change MDS assessment, dated 02/27/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, stroke, Chronic Obstructive Pulmonary Disease, dementia, anxiety, and depression. The resident had received an anticoagulant for seven of seven	F 0641	**F-641** Accuracy of Assessments. The assessment must accurately reflect the resident's status Resident #50 &60 MDS were modified. All residents at the facility have the potential to be affected. The MDS will review all residents with anticoagulants, depression and or anxiety to ensure proper coding on the most recent MDS assessment. Any resident that has an improperly coded MDS will have a correction submitted by	04/22/2023

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	days during the review period. The physician's order for February 2023, indicated the resident was prescribed Clopidogrel (an antiplatelet) 75 mg (milligrams) once a day. The February 2023 EMAR (Electronic Medication Administration Record) lacked documentation that the resident had received an anticoagulant during the review period. During an interview on 04/04/23 at 11:04 A.M., the MDS Coordinator indicated Plavix (Clopidogrel) was coded in error and should have not been coded as an anticoagulant on the MDS assessments. 2. The clinical record for Resident 50 was reviewed on 03/31/23 at 10:01 A.M. A Quarterly MDS assessment, dated 02/15/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, right shoulder fracture, dementia, lack of coordination and difficulty walking. The resident had received an antianxiety and an antidepressant medication on 7 of the 7 days of the assessment review period. MDS assessment, dated 01/10/23, indicated the resident had received an antianxiety and an antidepressant medication on 7 of the 7 days of the assessment review period. Section "I", Active Diagnoses, for each of the above assessments was provided by the MDS Coordinator on 04/04/23 at 1:27 P.M. The record lacked documentation the resident had diagnoses of anxiety or depression. The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for January, February, and March 2023, were provided by the DON (Director		4/20/2023. Education was provided to the MDS Coordinators, and the IDT team by Regional MDS Consultant to cover section I & Section N of the RAI manual on 4/12/2023. MDS coordinator will review section I & N prior to signing the MDS. An audit was completed by MDS or designee for all residents receiving anticoagulant or anxiety medication was competed and MDS modified as needed by 4/20/23. 10 MDS's were audited a week for accuracy related to medications for 4 weeks, then 5 MDS's a week for 4 weeks, then 5 MDS's a month for 4 months. This monitoring will take place will no less than 6 months. If the facility is 100% complaint at the end of 6 months, the monitoring will be stopped. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be	

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	of Nursing) on 04/04/23 at 12:58 P.M. The records indicated the resident received the following medications: - Escitalopram 10 mg (milligrams) once a day for depression, with a start date of 11/15/22, and - Buspirone 5 mg three times a day for anxiety and skin picking, with a start date of 11/15/22. During an interview on 04/04/23 at 3:45 P.M., the Regional Director of Operations indicated they did not have a policy for completing the MDS assessments. They followed the RAI (Resident Assessment Instrument) manual. 3.1-31(c)(13)		written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution	
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. Based on observation, interview, and record review, the facility failed to administer physician ordered wound treatments and identify pressure ulcers in a timely manner for 2 of 5 residents	F 0686	**F-686** It is the policy of the facility to ensure the resident receives care, consistent with professional	04/22/2023

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	reviewed for pressure ulcers. (Residents 57 and 36) Findings include: 1a. Resident 57 was observed in her room on 03/30/23 at 2:59 P.M. The resident was laying on her right side in bed. The resident indicated she was admitted to the facility last year with a pressure ulcer on her backside; and surgical wounds and pressure ulcers on her feet. The resident saw the Wound NP (Nurse Practitioner) in the facility and went to a local wound clinic. The resident's clinical record was reviewed on 03/31/23 at 11:25 A.M. An Admission MDS (Minimum Data Set) assessment, dated 09/07/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, sub-acute osteomyelitis of the left ankle and foot, anemia, cirrhosis with ascites, diabetes, and acquired absence of left toes. The resident required extensive assistance from two staff members for toileting, had an indwelling urinary catheter, and was occasionally incontinent of bowel. The resident was at risk for pressure ulcers and was admitted with an Unstageable (presents as an ulcer in which depth of tissue damage is not able to be determined due to the presence of nonviable tissue) pressure ulcer and a surgical wound. A Wound NP assessment, dated 09/08/22, indicated the resident was admitted with a Stage IV (Full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcer on her sacrum. The wound measured 8.9 cm (centimeters) x (by) 8.83 cm, with a depth of 6.50 cm. The wound was malodorous, with heavy serosanguinous (pale red to pink, thin and watery) drainage. The wound		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. Residents #57 & 36 wounds were assessed and no negative outcome for this deficient practice on 4/5/2023. Residents who reside in the facility have the potential to be affected by this finding. A facility wide skin sweep was completed on 4/10/2023. All pressure ulcers were reviewed with the wound NP to ensure all wounds were staged appropriately and had appropriate treatments and orders in place. Any changes or corrections were addressed and changed as indicated. DON/Designee will monitor skin assessments, weekly wound evaluations and following physicians orders for 10 residents weekly for a period of 4 weeks. The tool will then be used for 5 residents weekly for 4 weeks.	

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	tissue was 50% granulation (new connective tissue, usually red and moist), 40% slough (wet, dead tissue)/eschar (dried out dead tissue) and 10% epithelialization (pink tissue with a shiny, pearl appearance). A physician's order, with a start date of 09/01/22 and a discontinued date of 09/18/22, indicated the wound was to be cleansed with normal saline, apply a wet to dry dressing, apply an antimicrobial dressing to the excoriated area, and cover with a bordered gauze dressing daily and as needed. The September 2022 ETAR (Electronic Treatment Administration Record) lacked documentation the treatment was administered on the following days: - 09/01/22, - 09/02/22, - 09/05/22, - 09/09/22, - 09/10/22, - 09/12/22, - 09/14/22, and - 09/18/22. A physician's order, with a start date of 09/18/22 and a discontinued date of 09/29/22, indicated the wound was to be cleansed with a wound cleanser, packed with Dakin's (a hypochlorite solution that contained diluted bleach) moistened gauze, covered with an absorbent pad every 12 hours as needed. The ETAR lacked a routine, daily order for the dressing change. The ETAR lacked documentation the treatment was administered on the following days: - 09/19/22, - 09/22/22, - 09/23/22,		Then weekly for 1 resident ongoing for a period of no less than 6 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Administrator/Designee on_4/19/2023 for all nursing staff the following was reviewed: 1. Turning and repositioning, preventative skin care 2. Pressure ulcer injuries and staging 3. Dietary prevention for pressure ulcers 4. Following Physicians Orders 5. Wound Prevention Policy/SWAT policy Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	- 09/24/22, - 09/25/22, - 09/26/22, - 09/27/22, and - 09/28/22. A physician's order, with a start date of 09/29/22 and a discontinued date of 12/22/22, indicated the wound was to be cleansed with a wound cleanser, packed with Dakin's moistened gauze, apply an antimicrobial wound dressing to the right lateral tissue, and covered with an absorbent pad every day. The October 2022 lacked documentation the treatment was administered on the following days: - 10/07/22, - 10/08/22, - 10/15/22, - 10/19/22, - 10/21/22, - 10/22/22, - 10/24/22, and - 10/30/22. A Wound Clinic visit document, dated 10/26/22, indicated the resident's sacral wound measured 8 cm x 6 cm, with a depth of 5 cm. There was some slough and drainage. A culture of the wound bed was obtained, and the resident began an antibiotic for a wound infection. During an interview on 04/03/23 at 3:40 P.M., the FWN (Facility Wound Nurse) indicated wound treatments should be checked off on the ETAR. If a resident refused a treatment, there was a code to enter on the ETAR, and place to make a note to indicate why the treatment wasn't administered. There shouldn't be blank spaces on the ETAR. The treatment orders changed a lot in September, she was not sure why there wasn't a daily order			

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	for the treatment from 09/18/22 through 09/29/22 in addition to the "as needed" order, there should have been. The resident's sacral wound was observed with LPN (Licensed Practical Nurse) 6 on 04/04/23 at 2:11 P.M. The wound measured approximately 3 cm x 2 cm, with a depth of 1 cm. The wound bed was clean, with pink/red tissue. There was a moderate amount of serosanguinous drainage. There was no odor or signs of infection. The current, undated, facility policy titled, "Physician Order-(Following Physician Orders)" was provided by the Administrator on 04/04/23 at 9:45 A.M. The policy indicated, "...It is the policy of the facility to follow the orders of the physician..." 1b. A Wound NP assessment, dated 02/09/23, indicated the resident acquired an Unstageable pressure ulcer to her left hip on 02/09/23. The wound measured 1.51 cm x 1.44 cm, with a depth of 0.10 cm. The wound was without odor and had a moderate amount of serosanguinous drainage. The wound tissue was 10% granulation, 80% slough/eschar, and 10% epithelialization. During an interview on 04/03/23 at 3:40 P.M., the FWN indicated the wound on the resident's left hip was identified as an unstageable wound when it was first identified on 02/09/23. The resident's wound had worsened. The resident was extremely non-compliant with turning and repositioning, and at times would spend several hours sitting up in her wheelchair outside. The resident refused a low air loss mattress. The resident had been continually educated on interventions in place to prevent skin impairments and to prevent the worsening of skin impairments but remained			

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	non-compliant. The resident had recently been hospitalized for a urinary tract infection and the wound had gotten worse while she was out of the facility as well. The resident's left hip wound was observed with LPN 6 on 04/04/23 at 2:22 P.M. The wound was about the size of a half-dollar coin, with a depth of about 1.5 cm. LPN 6 indicated the wound had been debrided when the resident was in the hospital less than two weeks ago. The tissue in the wound bed was mostly pink/red. Approximately 20% of the wound was covered in yellow slough. There was no odor or signs of infection. During an interview on 04/04/23 at 3:01 P.M., LPN 6 indicated if she identified a skin impairment on a resident she would document the impairment in the computer, notify the MD of the finding, and request a treatment. She would tell the FWN. There was an opportunity to visualize the resident's skin by aides or nursing staff every day when they were providing peri-care or administering skin treatments. During an interview on 04/04/23 at 3:35 P.M., the FWN indicated the wound on the resident's hip should have been identified before it became unstageable. 2. Resident 36 was observed in his room on 03/30/23 at 10:33 A.M. He was sitting in his wheelchair listening to music. He indicated he had an opened area on his buttock. The clinical record for Resident 36 was reviewed on 04/04/23 at 9:52 A.M. An Annual MDS assessment, dated 01/20/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, Cerebral Palsy,			

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	hypertension, diabetes, a seizure disorder, and arthritis. The resident was at risk for pressure ulcers but, had no pressure ulcers during the assessment period. He required the extensive assistance of two staff members for ADLs (Activities of Daily Living) and was frequently incontinent of bowel and bladder. During an interview on 04/04/23 at 1:22 P.M., CNA (Certified Nurse Aide) 2 indicated when she provided personal care to a resident and discovered a skin issue, she would call the nurse to come observe the skin and document the skin concern on the shower sheet. The shower sheet was signed and would be given to the nurse who also signed it. The nurse would give the shower sheet to the ADON (Assistant Director of Nursing). The Shower sheet, dated 03/22/23, indicated the resident had no open areas on his skin. The shower sheet, dated 03/24/23, indicated the resident had an area on his coccyx labeled as old and still opened. The Weekly Skin Assessment completed on 03/22/23 indicated the resident had no skin integrity loss nor new skin integrity loss. The Wound NP assessment, dated 03/24/23, indicated the resident had an Unstageable pressure ulcer on his left buttock. The wound measured 2.83 cm x 1.83 cm x 0.2 cm and was covered with yellow slough. The Wound NP assessment, dated 03/27/23, indicated the resident had an Unstageable pressure ulcer on his left buttock. The wound measured 2.71 cm x 1.27 cm x 0.2 cm and was			

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	covered with yellow slough. A physician's order, with a start date of 03/27/23 and a discontinued date of 04/01/23, indicated the wound on the left buttock was to be cleansed with normal saline, pat dry, apply Medihoney to the wound bed, and cover with a border foam dressing daily and as needed. The Wound NP assessment, dated 03/27/23, indicated the resident had a Stage III (Full thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue was often present) pressure ulcer on the right upper buttock. The wound measured 0.7 cm x 0.7 cm with no measurable depth. A physician's order, with a start date of 03/27/23, indicated the wound on the right upper buttock was to be cleansed with normal saline, pat dry, apply Medihoney, and cover with a border foam dressing daily for Stage III wound care. The Wound NP assessment, dated 04/04/23, indicated the Stage III pressure ulcer on the resident's right buttock was healed. During an interview on 04/04/23 at 11:52 A.M., the FWN indicated the resident had a pressure relieving cushion in his wheelchair. The resident would spend as much as 12 hours per day in his wheelchair. The wounds on the resident's buttocks should have been identified before they became Stage III and Unstageable wounds. The current undated "Preventive Skin Care" policy was provided by the RDO (Regional Director of Operations) on 04/04/23 at 1:51 P.M. The policy indicated, "...It is the intent of the facility that the facility provide preventive skin			

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	care...to keep residents...free from pressure sores..." The current undated "SKIN OBSERVATION/ASSESSMENT" policy was provided by the RDO on 04/04/23 at 1:34 P.M. The policy indicated "...Only a licensed nurse can assess the skin...Nurses will do skin assessments at least weekly (or as indicated)..." 3.1-40(a)(1) 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to follow Fall Care Plan interventions related to identified falls for 1 of 5 residents reviewed for accidents. (Resident 43) Findings include: During an observation and interview on 03/30/23 at 10:09 A.M., Resident 43 was sitting in her room in a wheelchair. She indicated she had recently fallen a few times and was supposed to call for help to get up. She had felt faint and lightheaded at times. The clinical record was reviewed on 04/03/23 at	F 0689	**F-689** It is the policy of the facility to ensure the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The physician for resident #43 was notified that the facility did not obtain CBC CMP orthostatic blood pressure readings or pules in relation to the residents fall on	04/22/2023

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	1:12 P.M. A Significant Change MDS (Minimum Data Set) assessment, dated 03/06/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, diabetes, hypertension, dementia, anxiety, depression, and muscle weakness. The resident required supervision and one staff member's physical assistance with transfers, toilet use, and personal hygiene. The resident had two or more falls since the last assessment. The Progress Notes for February 2023, were provided by the Administrator on 04/04/23 at 9:45 A.M. An IDT (Interdisciplinary Team) Note, dated 02/13/23 at 9:34 A.M., related to the resident's fall on 02/13/23, indicated the resident was found in a sitting position between the toilet and sink. The resident stated that she became dizzy upon standing up from the toilet. The interventions were to obtain labs, a CBC (Complete Blood Count) and a CMP (Comprehensive Metabolic Panel); and obtain orthostatic blood pressures and pulse rates. During an interview on 04/03/23 at 11:18 A.M., the ADON (Assistant Director of Nursing) indicated lab orders would go into the EMAR/ETAR (Electronic Medication Administration Record/Treatment Administration Record). Orders for Orthostatic blood pressures would be documented on the EMAR/ETAR as well. During an interview on 04/03/23 a 11:51 A.M., the ADON indicated he could not find the labs, the orthostatic blood pressures, or pulse records and they should have been completed. The clinical record was reviewed and the February EMAR/ETAR lacked orders for the labs or the orthostatic blood pressures and pulse values.		2/13/2023. The physician did not request those values to be collected at this time 4/21/23 All Residents who reside in the facility have the potential to be affected by Physician order not being entered into electronic health record in a timely manner. A facility wide audit was completed on 4/19/2023 to ensure fall care plan interventions were in place and being followed for all residents. Any changes or corrections were addressed and changed as indicated. DON/Designee will monitor residents that have had a new accidents/incident at least 5 times weekly to ensure that fall care plan interventions and physician orders were in place and being followed x 4 weeks. The tool will then be used for 5 residents weekly for 4 weeks. Then weekly for 1 resident ongoing for a period of no less than 6 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Administrator/Designee on 4/19/2023 for all nursing staff the following was reviewed: 1. Accident/ Incident policy and procedure	

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	The Progress Notes and Vitals Records for February 2023, were provided by the Administrator on 04/04/23 at 9:45 A.M. The records lacked documentation the orthostatic blood pressures and pulse values had been obtained. The Care Plans related to falls were provided by the Administrator on 04/04/23 at 9:45 A.M. An intervention indicated staff were to perform orthostatic blood pressures lying, sitting, and standing for 72 hours related to dizziness. The current undated "INCIDENTS/ACCIDENTS/FALLS" policy was provided by the Administrator on 04/04/23 at 9:45 A.M. The policy indicated, "...Orders for treatment and any interventions will be obtained...Any actions/communications will be documented in the medical record..." 3.1-35(a) 3.1-49(a)		2. Staff education on fall care plan interventions 3. Staff education on entering physician orders timely Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	
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			

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	resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be 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, the facility failed to monitor residents while taking psychotropic medications for adverse side effects for 2 of 5 residents reviewed for unnecessary medications. (Residents 44 and 50)	F 0758	**F-758** Free from Unnecessary Psychotropic Meds/PRN Use	04/22/2023

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	Findings include: 1. The clinical record for Resident 44 was reviewed on 04/03/23 at 10:00 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 12/01/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, anemia, hypertension, diabetes, anxiety, depression, and schizophrenia. The August, September, and October 2022 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident was administered the following medications: - Aripiprazole (an antipsychotic medication) 15 mg (milligrams) once a day for paranoid schizophrenia, with a start date of 08/29/22, - Trazodone (an antidepressant medication) 50 mg, at bedtime for insomnia, from 08/26/22 through 09/23/22, - Trazodone 100 mg, at bedtime for insomnia, from 09/23/22 through 10/21/22, and - Eszopiclone (a sedative medication) 2 mg, at bedtime for insomnia, from 10/21/22 through 11/18/22. The records lacked documentation the resident was being monitored for possible ASE (Adverse Side Effects). 2. The clinical record for Resident 50 was reviewed on 03/31/23 at 10:01 A.M. A Quarterly MDS assessment, dated 02/15/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, right shoulder fracture, dementia, lack of coordination, and difficulty walking. The resident had received an antianxiety and an antidepressant medication		It is the policy of the facility to ensure Residents are free from unnecessary psychotropic medications. Including, monitoring residents who are taking psychotropic medications for adverse side effects. Resident 44 & 50's orders were updated for psychotropic medication side effect monitoring. Residents who reside in the facility have the potential to be affected by this finding. A facility wide audit was completed for all residents to ensure appropriate psychotropic medication side effect monitoring is in place on 4/20/2022 Social Services/Designee will monitor 10 residents on psychotropic medications to ensure side effects monitoring is in place 5 days weekly for a period of 4 weeks. The tool will then be used for 4 residents 3 days weekly for 4 weeks then 1 resident 1 day weekly ongoing for a period	

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	on 7 of the 7 days of the assessment review period. The EMAR/ETAR for January, February, and March 2023 were provided by the DON (Director of Nursing) on 04/04/23 at 12:58 P.M. The records indicated the resident received the following medications: - Escitalopram 10 mg once a day for depression, with a start date of 11/15/22, and - Buspirone 5 mg three times a day for anxiety and skin picking, with a start date of 11/15/22. The records lacked documentation the resident was being monitored for possible ASE. During an interview on 04/04/23 at 11:40 A.M., LPN 5 indicated for residents on psychotropic medications staff monitored for Adverse Side Effects on the EMAR/ETAR, and the possible side effects to watch for would be listed on the order. It was documented every shift. All residents on antidepressants, antianxiety, and antipsychotic medications should have an order for monitoring for ASE. The current undated Psychotropic Drugs Usage policy was provided by the DON on 04/04/23 at 2:30 P.M. The policy indicated, "...The assessment of side effects for resident receiving antipsychotic therapy includes the following adverse effects: tardive dyskinesia, postural or orthostatic hypotension, cognitive and/or behavior impairment, akathisia, and Parkinsonism..." 3.1-48(a)(3)		of no less than 6 months. If the facility is in 100% compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Administrator/Designee on 4/18/2023 for all nurses and the IDT the following was reviewed: 1.psychotropic medication monitoring 2.order entry related to psychotropic medication monitoring. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the Social Services/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action	

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			Plan will be monitored by the Administrator weekly until resolution.	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on record review and interview, the facility failed to prevent significant medication errors and monitor side effects related to Coumadin (a blood thinner medication) for 1 of 5 residents reviewed for unnecessary medications. (Resident 44) Findings include: 1a. During an observation on 04/03/23 at 4:08 P.M., Resident 44 was outside with staff and other residents. The clinical record for Resident 44 was reviewed on 04/03/23 at 10:00 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 12/01/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, anemia, hypertension, diabetes, anxiety, depression, and schizophrenia. A Physician's Note, dated 09/02/22, indicated the facility was to discontinue the residents Aspirin and Clopidogrel (an aniplatelet), and start Warfarin 5 mg once a day for prosthetic heart valve. A physician's order, dated 09/03/22 through 09/11/22, indicated the staff were to administer Warfarin (Coumadin), 5 mg (milligrams), once a	F 0760	**F-760** It is the policy of the facility to ensure Residents are free from significant medication errors. Including failing to prevent significant medication errors and monitor side effects related to Coumadin (a blood thinner medication). Resident 44's labs that were drawn after the medication error indicated he was still within therapeutic range. Labs were completed on 10/7/2022. Residents who reside in the facility have the potential to be affected by this finding. A facility wide audit was completed to ensure all residents on coumadin had correct orders and monitoring in place. Any issues found were addressed accordingly. DON/Designee will monitor all residents on coumadin for holes in	04/22/2023

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	day. A physician's order, dated 09/09/22 through 09/11/22, indicated the staff were to administer Warfarin, 6 mg, once a day. A physician's order, dated 09/12/22 through 09/22/22, indicated the staff were to administer Coumadin, 7.5 mg, once a day. A physician's order, dated 09/23/22 through 10/17/22, indicated the staff were to administer Warfarin, 6 mg, once a day; and hold the medication on 09/30/22. An open-ended physician's order, with a start date of 10/13/22 indicated the staff were to administer Coumadin, 7 mg, once a day. The September and October 2022 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) lacked documentation the resident had received the medication on the following dates: - 09/05/22, - 09/07/22, - 09/09/22, - 09/10/22, - 09/13/22, - 09/14/22, - 09/16/22, - 09/17/22, - 09/21/22, - 09/26/22, - 09/27/22, - 09/28/22, - 10/01/22, and - 10/02/22.		the MAR 5 days weekly for a period of 4 weeks. The tool will then be used 3 days weekly for 4 weeks, then 1 day weekly ongoing for a period of no less than 6 months. If the facility is in 100% compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the DON/Designee on 4/19/2023 for all nurses the following was reviewed: 3. following physician orders 4. med administration documentation on the MAR 5. Medication instructions change policy & procedure 6. Medication disposal/discontinuing medications. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	The medication was marked as administered on 09/30/22 (when it should have been held). The October 2022 EMAR indicated the following doses were administered: - On 10/13/22 the resident received 4 mg (the physician's order was for 7 mg), - On 10/14/22 the resident received 4 mg (the physician's order was for 7 mg), - On 10/15/22 the resident received 13 mg (the physician's order was for 7 mg), and - On 10/16/22 the resident received 13 mg (the physician's order was for 7 mg.) During an interview on 04/04/23 at 9:39 A.M., RN 3 indicated when she administered a resident's medication, she signed them off on the electronic EMAR. If there was a blank in the EMAR, it could mean that the medication was discontinued. The resident's medications should have been administered per the physician's order. If the physician or Nurse Practitioner changed an order the nurse was alerted of the new order, and they would transcribe it into the record. If a resident had received Coumadin a laboratory (lab) would need to be obtained. Once the lab was obtained per the order it would be faxed to the physician and they would reply with any changes. The medication shouldn't be administered until the lab was reviewed by the physician. During an interview on 04/04/23 at 1:03 P.M., LPN (Licensed Practical Nurse) 5 indicated the lab would come in and obtain routine lab blood draws on Mondays, Wednesdays, and Fridays. If a resident had a lab to be drawn for Coumadin, the lab service would come and draw the lab and the facility would get the results the same day. They would be faxed to the physician and a response			

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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
	back would happen the next day. During an interview on 04/04/23 at 2:44 P.M., the ADON (Assistant Director of Nursing) indicated back in October one of their physicians had quit. The resident had a lab drawn on 10/07/22 that was not addressed until 10/13/22. When the physician addressed the lab on 10/13/22 the order was changed from 6 mg daily to 7 mg daily. The resident should have have received both doses, 6 mg and 7 mg on 10/14/22 and 10/15/22. If there was a blank in the EMAR it probably meant the medication wasn't signed out. There shouldn't have been blanks in the EMAR. The resident's lab from 10/07/22 should have been addressed sooner than 10/13/22. The current, undated, facility policy titled, "Medication Administration Errors", was provided by the ADON on 04/04/23 at 3:00 P.M. The policy indicated, "...A medication error is any preventable event that may cause or lead to inappropriate medication use. Such events may be related to professional practice, healthcare products, or procedures and systems, including prescribing, order communication, product labeling, packaging, compound dispensing, delivery, administration, monitoring, and use...3. Administration-based medication errors...Missed medication...Administration of medication which is greater/lesser than what is ordered..." The current, undated, facility policy titled, "Physician Order-(Following Physician Orders)" was provided by the Administrator on 04/04/23 at 9:45 A.M. The policy indicated, "...It is the policy of the facility to follow the orders of the physician..." The current, undated, facility policy titled,			

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	"Medication Administration" was provided by the ADON on 04/04/23 at 3:00 P.M. The policy indicated, "...To ensure that resident medications are administered in a timely manner and documentation is completed to substantiate administration...Medication Administration Record will be signed out after each medication administered to the resident..." 1b. The clinical record including the September and October 2022 EMAR/ETAR lacked indication Resident 44 was monitored with any frequency for the use of the anticoagulant usage. During an interview on 04/04/23 at 1:02 P.M., LPN 5 indicated a resident was to be monitored every shift for signs and symptoms of bleeding and bruising while taking Coumadin. The current, undated, facility policy titled, "Coumadin Guidelines" was provided by the ADON on 04/04/23 at 3:00 P.M. The policy indicated, "It is the intent of the facility to monitor the effects of the use of Warfarin or Coumadin, and anticoagulant medication that is used to prevent blood clotting... 3.1-48(c)(2) 3.1-48(a)(3)			
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.			

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	§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 listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to store medications appropriately for 2 of 3 medication carts reviewed. (100 Hall and 200 Hall medication carts) Findings include: 1. During a random observation on 03/29/23 at 9:56 A.M., the 100 Hall medication cart was left unattended. On top of the medication cart were approximately eight medication cards filled with medications. The medication cards were labeled with the resident's name, the name of the medication, the dosage, and how often the resident was to take the medication. The nurse was standing approximately 12 feet away from the medication cart. She was talking with a visitor. The nurse left the area, walked down the hall away from the medication cart. A few minutes later the Administrator walked to the medication cart, gathered the medication cards, placed them in a	F 0761	**F-761** It is the policy of the facility to ensure Medications and biological are stored safely, securely, and properly following the manufacturer or supplier recommendations. The Medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. No residents were identified as being affected by this practice. Residents who reside in the facility have the potential to be affected by this finding. A facility wide audit was	04/22/2023

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	secure office. During an interview on 03/29/23 at 10:00 A.M., the Administrator indicated the medications should not have been left unattended on top of the medication cart. 2. During a medication administration observation on 04/03/23 at 11:00 A.M., RN 3 prepared the medications for Resident 80. RN 3 turned away from the 200 Hall medication cart and entered Resident 80's room. The medication cart was left unlocked. When RN 3 returned to the medication cart the ADON (Assistant Director of Nursing) was standing beside the medication cart and locked the cart. During an interview on 04/03/23 at 11:03 A.M., the ADON indicated the medication cart should have been locked when unattended. The current undated "MEDICATION STORAGE IN THE FACILITY" policy was provided by the ADON on 04/03/23 at 11:18 A.M. The policy indicated, "...Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access..." 3.1-25(m)		completed to ensure all medications were stored appropriately. Any changes or corrections were addressed and changed as indicated. DON/Designee will monitor medication storage5 days weekly for a period of 4 weeks. The tool will then be used 3 days weekly, then weekly ongoing for a period of no less than 6 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Administrator/Designee on 4/19/2023 for all nursing staff, including RN 3, the following was reviewed: 1. Medication storage policy and procedure Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any	

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			written Action Plan will be monitored by the Administrator weekly until resolution.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to store and prepare foods in a safe and sanitary manner related to open trash containers, hair net usage, and labeling foods for 4 of 5 kitchen and snack refrigerators observations. Findings include: 1. The initial kitchen tour was conducted on 03/29/23 at 10:10 A.M., and the following was observed:	F 0812	**F-812** Food Procurement, Store/Prepare/Serve-Sanitary Food safety requirements. The facility must 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,	04/22/2023

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	- A large silver stock pot, approximately two gallon size, was inverted on a low shelf of a silver food prep table next to the hand washing sink. The half of the pot nearest the sink was splatter with white dry drops and had a layer of dust on the bottom. - A medium size open box that sat on the floor next to the trash can by the hand washing sink was full of trash and contained wadded up gloves and paper products. - The DM (Dietary Manager) had a one inch by three inch shock of hair next to her right ear protruding from her hair net as she walked around the kitchen in the food prep areas. The walk-in refrigerator contained the following: - A clear plastic gallon bag of diced chicken, as identified by the DM, that was not labeled. The bag was tied shut in a knot. - Two trays of cups of fruit cocktail stacked on top of each other. The bottom tray had 16 cups. The top tray had 14 cups. The cups on the top tray were open to air and not covered. The bottom tray was covered with the bottom of the top tray. The trays were not labeled or dated. The DM indicated the facility had a "Marketing Day" the other day, and the fruit cocktail cups may have been for that occasion. They had lids that fit the cups and she had just recently ordered some. They could wrap the cups with plastic wrap. The cups should have been covered and dated. 2. The steam table temperatures were checked on		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. No residents were identified during survey as being affected by deficient practice. All residents have the potential to be affected by staff not wearing hairnets in a food preparation area, not properly dating and labeling food, open trash containers and sanitation. The administrator conducted an Inservice on 4/18/2023 on proper use of hair nets, closing trash containers, labeling, and dating of food and sanitation. The Administrator/Dietitian or Designee will complete random observations, using the Food Storage/Sanitation/Hairnet audit tool, to validate that hair nets,	

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	03/29/23 at 11:22 A.M. A medium size open box that sat on the floor next to the trash can by the hand washing sink was full of trash and contained wadded up gloves and paper products. The DM was working in the food preparation area with her hair net setting back on her head exposing approximately a two inch band of hair around her face and a shock of hair hanging out from under her hair net down to her shoulder. During an interview on 04/04/23 at 3:20 P.M., the Night Cook indicated hair nets were used to keep hair and dander out of food and they should cover all of your hair. The current "FOOD SAFETY & SANITATION" policy related to "Employee Health and Personal Hygiene, with a developed date of 04/2017, was provided by the RDO (Regional Director of Operations) on 04/04/23 at 3:26 P.M. The policy indicated, "...Food service employees shall maintain good personal hygiene...Hair restraints will be worn at all times..." 3. During an observation and interview on 04/04/23 at 3:10 P.M., the Living Well Unit's resident snack refrigerator contained the following: - four hard sandwiches that were undated, - a Styrofoam to-go container with a salad inside with no name or date, - a fast food bag and box with a piece of chicken inside with no name or date, - a Styrofoam to-go container with rice and a burrito with no name or date, - a Styrofoam to-go container with partially eaten rice and burrito with no name or date, - two yogurt cups with a use by date of 03/13/23, and - two yogurt cups with a use by date of 03/21/23.		labeling & dating, food sanitations are being used appropriately in accordance with professional standards for food service safety in both the kitchen and snack refrigerators. Any concerns identified during the dietary audits will be addressed at the time of the observation and additional education will be completed at that time. The Dietary Hair Net/Sanitation Quality Review Audit will be completed 5 times weekly for 4 weeks. Following the initial 4 weeks, 3 days weekly for 4 weeks, then 1 day weekly for 4 months. Monitoring will occur for no less than 6 months if the facility is within 100% compliance in 6 months monitoring will be stopped. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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LPN (Licensed Practical Nurse) 5 indicated she believed housekeeping or dietary were supposed to clean out the resident snack refrigerators.

4. During an observation and interview on 04/04/23 at 3:17 P.M., the Moving Forward Unit's resident snack refrigerator contained the following:

- an uncovered, Styrofoam plate with a piece of lasagna and garlic bread, the ADON (Assistant Director of Nursing) was unable to stick his finger in the lasagna because it was hard,
- an ¾ full unnamed, illegible date, container of chicken salad,
- a bowl of liquid substance with no name or date, the ADON indicated he thought it was oatmeal,
- a 1/2 full container of chicken chowder with a use by date of 03/13/23, with no name,
- a 1/2 full container of chicken salad with no name or date,
- a 1/2 full container of cottage cheese with a use by date of 02/24/23, with no name,
- a fast food to-go bag with a container inside with no name or date?, and
- two fast food drink cups with no names or dates?

The ADON indicated he was unsure if the drinks belonged to staff or residents. All items in the refrigerator should be labeled with a name and date. Only items for residents were allowed in the refrigerator. The refrigerator should be cleaned out by the dietary department.

The current, undated, facility policy titled, "Food Brought into the Facility by Friends/Family/Others (Outside Sources) for Residents" was provided by the DON (Director of

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	Nursing) on 04/04/23 at 4:05 P.M. The policy indicated, "...2. Foods or beverages brought in from the outside will be labeled and dated with the resident's name, room number and the date the item was brought into the facility for consumption/storage...Foods/beverages that are in the original manufacturer's container when brought in will be labeled appropriately but will be discarded after the expiration date. Cooked or prepared foods brought in for a resident will be stored in the resident's personal refrigerator or in the facility's appropriate pantry or refrigerator. They will be appropriately labeled and dated when accepted for storage and discarded after 48 hours...Nursing staff will monitor resident rooms, resident personal refrigerators, unit pantries as well as facility refrigerators and freezers for food and beverage disposal needs for safety..." 3.1-21(i)(3)			