STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155728	A. BUILDING 00 B. WING	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MANDERLEY HEALTH CARE CENTER	806 S BUCKEYE ST OSGOOD, IN 47037

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 4, 5, 6, 7, and 8, 2024 Facility number: 000493 Provider number: 155728 AIM number: 100291300 Census Bed Type: SNF/NF: 45 Census Payor Type: Medicare: 10 Medicaid: 32 Other: 3 Total: 45 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 13, 2024.	F 0000	The facility recognizes that it must persuade your office that appropriate systems are in place to assure ongoing compliance with the federal regulations for participation in the Medicare and Medicaid programs. Please accept the following as our process to ensure that the necessary steps will be taken to provide the best care possible to the residents at Manderley Healthcare. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. Manderley Healthcare respectfully requests consideration of a desk review for the alleged deficiencies within this plan of correction. Monica Ogden, LNHA Manderley Healthcare	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carla Poynter	Director of Nursing	03/25/2024

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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	§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation and interview, the facility failed to maintain resident records in a private manner related to records left unattended on the nurse's station counter and a computer screen left open with visible resident information for 3 of 45 residents who resided in the facility. (Residents 27, 14, and 20)	F 0583	**F583 Personal Privacy/Confidentiality of Records** 1 Resident #27 was alleged to have paperwork left on upper counter of nurse’s station with a visible doctor’s written order. Resident #27 paperwork was	04/01/2024

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	Findings include: 1a. During an observation 03/05/24 at 3:27 P.M., the paperwork for Resident 27 was left laying on the upper counter of the nurse's station with a visible doctor's written order. 1b. A report for Resident 14 was visible on top of a stack of several papers. These were the only two visible resident names. Independently mobile residents were walking by the nurse's station. No staff members were sitting at the nurses station near the papers. The current "Confidentiality of Information and Personal Privacy" policy with a revised date of October 2017, was provided by the DON on 03/08/24 at 3:23 P.M. The policy indicated, "...The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records...Access to resident personal and medical records will be limited to authorized staff and business associates..." 2. The computer screen on the med (medication) cart for the 200 hall was observed on 03/04/24 at 11:52 A.M. Resident 20's information was visible on the screen and the med cart was unattended. - On 03/04/24 at 11:53 A.M. a staff member walked by the med cart. - On 03/04/24 at 11:55 A.M., a resident walked by the med cart. - On 03/04/24 at 11:57 A.M., two CNAs (Certified Nurse Aides) and a housekeeping staff member walked by the med cart.		immediately removed from view and placed in file to be uploaded into PCC. Resident # 14 was alleged to have a report within visible view on top of a stack of several papers. Resident #14 report was uploaded into PCC and then placed in shred it box. Resident #20 information was allegedly left visible on the medication cart computer screen. Resident #20 information was closed from the computer screen. 2 All residents who reside in the facility have the potential to be affected by the alleged deficient practice. The Director of Nursing completed a 100% audit of the nursing station and facility computer screens to ensure resident information was protected and not left visible. Any identified concerns were immediately addressed. 3 The Administrator and Director of Nursing held an in-service with all staff regarding “Electronic Medical Records” and “Confidentiality of Information and Personal Privacy” policies as it relates to HIPPA and protecting resident health records/information. 4 The Director of Nursing/Designee will audit the Nursing Desk and facility computer screens to ensure	

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	- On 03/04/24 at 12:01 P.M., a CNA walked by the med cart. - On 03/04/24 at 12:02 P.M., a laboratory services technician walked by the med cart. - On 03/04/24 at 12:07 P.M., a visitor pushing a resident in a wheelchair walked by the med cart. - On 03/04/24 at 12:11 P.M., a visitor walked back by the med cart. - On 03/04/24 at 12:12 P.M., a message on the computer screen indicated it would log out of the system in one minute. - On 03/04/24 at 12:13 P.M., the computer logged out of the system due to inactivity. During an interview on 03/08/24 at 1:32 P.M., CNA 3 indicated computer screens should be locked and papers should be turned over to prevent resident's information being seen by others. The current facility policy, titled "Electronic Medical Records", with a revision date of March 2014, was provided by the Administrator on 03/08/24 at 1:19 P.M. The policy indicated, "...Only authorized persons...will be permitted access to the electronic medical records system...the facility will make reasonable efforts to limit the use or disclosure of protected health information..." 3.1-3(o)		resident information is not left unattended, left in view on the nursing desk, or with resident information on computer screens. The audit will be completed daily x 5 days a week on varying shifts x 4 weeks, then 3 days a week on varying shifts x 4 weeks, then 1 days a week on varying shifts x 4 weeks. Any identified concerns will be immediately addressed. This will continue for no less than 3 months and compliance is met. The Director of Nursing/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to			

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	facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to follow physician's orders related to hold parameters for a blood pressure medication for 1 of 15 residents reviewed for quality of care. (Resident 27) Findings include: The clinical record for Resident 27 was reviewed on 03/07/24 at 2:02 P.M. A Quarterly (Minimum Data Set) assessment, dated 01/23/24, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, cirrhosis of the liver, hypertension, heart failure, anxiety, and depression. A current physician's order, with a start date of 01/03/24, indicated the resident was to get Midodrine 10 mg (milligrams), before meals, for hypertensive heart disease with heart failure. The staff were to hold the medication if the resident's systolic (top number) blood pressure was greater than 110. The January, February, and March 2024 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident had received the medication when the systolic blood pressure was greater than 110 or when the blood pressure was not obtained on the following dates and times:	F 0684	**F 684 Quality of Care** 1 Resident #27 was allegedly affected by the deficient practice. Resident #27 blood pressure parameters reviewed by facility Nurse Practitioner. New order received to d/c parameters. 2 Current residents receiving blood pressure medications and have parameters for administration have the potential to be affected by the alleged deficient practice. A 100% audit of current residents receiving blood pressure medications and having parameter for administration has been completed by the Director of Nursing and reviewed with the facility Nurse Practitioner. Any identified concerns were immediately addressed and new orders followed as provided by the facility Nurse Practitioner. 3 The Administrator and Director of Nursing held an in-service with licensed nurses regarding “Administering Medication” as it relates to following hold parameters for blood pressure medications. 4 The Director of	04/01/2024

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	- 01/05/24 at 7:00 A.M., the blood pressure was 124/68, - 01/08/24, at 4:00 P.M., the blood pressure was not documented, - 01/10/24 at 7:00 A.M., the blood pressure was 118/60, - 01/10/24 at 11:00 A.M., the blood pressure was not obtained, - 01/10/24 at 4:00 P.M., the blood pressure was not obtained, - 01/11/24 at 7:00 A.M., the blood pressure was 130/68, - 01/11/24 at 11:00 A.M., the blood pressure was not obtained, - 01/11/24 at 4:00 P.M., the blood pressure was not obtained, - 01/12/24 at 7:00 A.M., the blood pressure was 118/68, - 01/12/24 at 11:00 A.M., the blood pressure was not obtained, - 01/12/24 at 4:00 P.M., the blood pressure was not obtained, - 01/16/24 at 7:00 A.M., the blood pressure was 120/68, - 01/16/24 at 11:00 A.M., the blood pressure was not obtained, - 01/16/24 at 4:00 P.M., the blood pressure was not obtained, - 01/17/24 at 7:00 A.M., the blood pressure was 140/68, - 01/17/24 at 11:00 A.M., the blood pressure was not obtained, - 01/17/24 at 4:00 P.M., the blood pressure was not obtained, - 01/18/24 at 7:00 A.M., the blood pressure was 130/74, - 01/18/24 at 11:00 A.M., the blood pressure was not obtained, - 01/18/24 at 4:00 P.M., the blood pressure was not obtained,		Nursing/Designee will audit resident's receiving blood pressure medications with parameters to ensure parameters are being followed. The audit will be completed as follows: 5 residents with parameters x 4 weeks, then 3 residents with parameters x 4 weeks, then 1 resident with parameters x 4 weeks. Any identified concerns will be immediately addressed. This will continue for no less than 3 months and compliance is met. The Director of Nursing/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	- 01/19/24 at 11:00 A.M., the blood pressure was 120/64, - 01/19/24 at 4:00 P.M., the blood pressure was 118/64, - 01/20/24 at 7:00 A.M., the blood pressure was 146/80, - 01/22/24 at 7:00 A.M., the blood pressure was 120/66, - 01/22/24 at 4:00 P.M., the blood pressure was 116/68, - 01/26/24 at 11:00 A.M., the blood pressure was 112/70, - 01/26/24 at 4:00 P.M., the blood pressure was 112/74, - 01/30/24 at 4:00 P.M., the blood pressure was 112/62, - 02/01/24 at 4:00 P.M., the blood pressure was 114/62, - 02/02/24 at 4:00 P.M., the blood pressure was 116/60, - 02/08/24 at 7:00 A.M., the blood pressure was 112/68, - 02/09/24 at 11:00 A.M., the blood pressure was 118/68, - 02/15/24 at 4:00 P.M., the blood pressure was 114/68, - 02/20/24 at 7:00 A.M., the blood pressure was 126/68, - 02/20/24 at 11:00 A.M., the blood pressure was 126/68, - 02/22/24 at 7:00 A.M., the blood pressure was 112/66, - 02/28/24 at 4:00 P.M., the blood pressure was 112/70, and - 03/03/24 at 7:00 A.M., the blood pressure was 112/74. During an interview on 03/07/24 at 1:51 P.M., RN 5 indicated the blood pressure should be taken prior to the medication administration and if there were			

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	hold parameters, they should be followed. The current facility policy titled, "Administering Medications", with a revised date of December 2012, was provided by the Director of Nursing on 03/08/24 at 8:53 A.M. The policy indicated, " ...2. Medications must be administered in accordance with the orders..." 3.1-37(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to address and monitor weight loss concerns in a timely manner (Residents 41 and 35) and monitor fluid intake (Resident 4) for 3 of 5 residents reviewed for	F 0692	**F692 Nutrition/Hydration Status Maintenance** 1 Resident #41 was allegedly affected by the deficient practice.	04/01/2024

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	nutrition and hydration. Findings include: 1. Resident 41's clinical record was reviewed on 03/07/24 at 11:15 A.M. An Admission MDS (Minimum Data Set) assessment, dated 10/30/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension and diabetes. The resident was 6' 3" and weighed 226 Lbs. (pounds). The resident had no swallowing issues and did not receive a therapeutic or mechanically altered diet. Weight loss or weight gain was unknown. The following weights were documented in the resident's EHR (Electronic Health Record): - On 10/23/23 the resident weighed 226.2 Lbs., - On 11/03/23 the resident weighed 227.6 Lbs., - On 11/13/23 the resident weighed 225.2 Lbs., - On 11/14/23 the resident weighed 202.6 Lbs., and - On 11/20/23 the resident weighed 202.6 Lbs. The EHR lacked any indication the resident's weight loss was acknowledged or addressed. A Dietary Note, dated 12/12/23 at 12:51 P.M., indicated the resident was recently in the hospital. There was a possible weight variance due to the resident's current weight being below his usual weight range. Recommendations included, but were not limited to, obtaining a current weight, and weighing the resident weekly for monitoring related to the weight variance. The RD (Registered Dietician) added a reduced concentrated sweets		Resident #41 has been reviewed by the RD (Registered Dietician) with review of current Remeron orders for effectiveness recommended. Weekly weights in place. Nutritional shakes increased to 3 times a day. Care plan was held with Resident #41 and his family with resident #41 requesting to be made DNR and he does not desire to have a feeding tube placed. Further discussion was held regarding hospice services which Resident #41 requested time to think about. Resident #35 was allegedly affected by the deficient practice. Resident #35 has been reviewed by the RD (Registered Dietician) with nutritional shakes increased to 4 times a day. Weekly weights in place. Resident moved to the assist table in the dining room for all meals for cueing and assistance as needed. Resident #4 was allegedly affected by the deficient practice. Resident #4 clinical information was reviewed by the Nurse Practitioner and order received to discontinue the fluid restriction for this resident. 2 Current residents having weight loss or fluid restrictions have the potential to be affected by the alleged deficient practice.	

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	diet, related to the resident's diagnosis of diabetes. - On 12/12/23 at 12:33 P.M., the resident weighed 196.6 Lbs. The resident's EHR lacked documentation the resident's weight was obtained again in the month of December 2023. The RD Recommendations Worksheet, dated 12/29/23, indicated several residents in the facility were reviewed. The worksheet lacked any indication the RD reviewed Resident 41. - On 01/02/24 the resident weighed 180.2 Lbs. - On 01/06/24 the resident weighed 181.4 Lbs. An NP (Nurse Practitioner) Progress Note, dated 01/10/24, indicated a new order for the resident to receive Remeron (as an appetite stimulant) 7.5 mg (milligrams) daily. During an interview on 03/08/24 at 9:52 A.M., the DON (Director of Nursing) indicated they recently hired a new RD. They started giving the resident health shakes last month in addition to the appetite stimulant prescribed in January. 2. On 03/05/24 at 12:14 P.M., Resident 35 was observed in the main dining room with her meal in front of her on a regular plate. The resident's eyes were closed, and her head was bowed. She had no staff members assisting her with her meal. The resident had a plate of smoked sausage, sauerkraut, and apple sauce, a full cup of ice water, and a full cup of chocolate milk. At 12:18 P.M., the resident was covering her mouth with her clothing protector in a huddled position.		The Director of Nursing/Designee has completed a 100% audit of current residents to identify residents with 5% weight loss over 30 days and 10% weight loss over 30 days. Residents identified have been reviewed to ensure weekly weights are obtained and interventions are in place. Any identified concerns were immediately addressed. The Director of Nursing/Designees has completed 100% audit of current residents with fluid restrictions in place to ensure orders are entered with ability to document fluid intake outside the allotted amount. Any identified concerns were immediately addressed. 3 The Administrator/Director of Nursing held an in-service with the Dietary Department and Nursing Department regarding "Encouraging and Restricting Fluids" as it relates to weight loss and fluid restrictions. 4 The Director of Nursing/Designee will audit current residents with weight loss of 5% over 30 days and 10% over 180 days to ensure they are on weekly weights, have nutritional interventions and reviewed in NAR meeting as follows: 5 residents per week x 4 weeks, then 3 residents per week x 4 weeks, then 1 resident per week x 4 weeks. Any identified concerns	

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	On 03/06/24 at 11:06 A.M., the resident was observed in her wheelchair in the main dining room covered with a blanket. Her eyes were closed and she sat in a huddled position. At 11:42 A.M., the resident was served three drinks. Two cups of chocolate milk with lids and straws, and one cup of ice water. The staff did not tell the resident she had drinks or where they were located, they just sat them down on the table and left. At 11:57 A.M., a staff member served the resident her meal and directed her hand to the spoon in her bowl of chili. The resident fed herself one bite then stopped, appearing to dose off. At 12:23 P.M., the resident took her hand off her spoon and covered her mouth with her hand and her clothing protector. No staff offered her assistance or cueing for her meal until 12:25 P.M., 28 minutes after her meal was served, when CNA 3 told her where her food was located based on a clock. The resident refused his help and gave herself one more bite of chili then went back to her huddled position. The clinical record was reviewed on 03/06/24 at 12:09 P.M. An Annual MDS/State Optional assessment, dated 03/01/24, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, legal blindness, arthritis, dementia, anxiety, depression, and psychotic disorder. The resident needed extensive assistance of one staff member for eating. A Quarterly/State Optional MDS assessment dated 11/30/23, indicated the resident needed supervision with one person's physical assistance for eating. On 08/01/2023, the resident weighed 142.8 lbs. On 02/01/2024, the resident weighed 122.6 pounds		will be immediately addressed. This will continue for no less than 3 months and compliance is met. The Director of Nursing/Designee will audit current residents with fluid restriction orders to ensure the order reflects intake amount for nursing and dietary, and prn order for additional fluid intake to be monitored. This will occur as follows: 3 residents per week x 4 weeks, then 2 residents per week x 4 weeks, then 1 resident per week s 4 weeks. Any identified concerns will be immediately addressed. This will continue for no less than 3 months and compliance is met. The Director of Nursing/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	155728	A. BUILDING 00 B. WING	03/08/2024

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	which was a - (negative) 14.15 % Loss in 180 days. On 12/07/2023, the resident weighed 134.2 lbs. On 01/01/2024, the resident weighed 124.4 pounds which was a -7.30 % Loss in 30 days. The resident's weight loss was not mentioned or addressed in the "RECOMMENDATIONS WORKSHEET - REGISTERED DIETICIAN" records for January 23, 2024, or February 6, or 20, 2024. The February 2024 records indicated the RD was in the building on 02/06/24 and 02/20/24. The resident's weight loss was not addressed until 03/06/24, when Mirtazapine 7.5 mg (milligrams) was ordered for an appetite stimulant. The current "West CNA Report Sheet" was provided by CNA 3 on 03/06/24 at 9:40 A.M. The record indicated Resident 35 needed extensive assistance of one to two staff members, was blind, incontinent, on a regular diet with thin liquids, had their own teeth, and was to have finger foods. During an interview on 03/07/24 at 10:36 A.M., the DON indicated the RD was in every two weeks and usually had recommendations each time she was in the building. All residents were weighed monthly. She reviewed the weights, and the RD did as well. If a resident's weight changed by three to five pounds or more in a month, she would obtain a reweigh. Then, once she had the weights in, she would look at them to see who was triggering for a 5% or 10% weight loss or gain over the last 30 or 180 days. When she identified those individuals, she looked to see if it was a desired weight loss, if it was edema (swelling), or if a resident was trying to lose weight. She also communicated that to the NP (Nurse Practitioner) and the RD. The RD reviewed the residents' weights when she was in the building and the			

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	DON would alert her to any significant weight changes for the residents. If it was not a desired weight loss and the DON felt a resident needed a supplement, she would talk to the NP to ensure the residents got an order for what they needed. When a resident had significant weight loss, the staff should address the concerns right away. The NP was in every week and the staff communicated significant weight changes to her. The staff could get an order though Telehealth 24 hours a day, seven days a week. The DON had the NP's phone number and could contact her directly. The "Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol" policy, was provided by the DON on 03/06/24 at 11:11 A.M. The policy indicated, "...The staff...will...identify individuals with...weight loss or gain, and significant risk for impaired nutrition...The staff will report to the physician significant weight gains or losses...The physician will limit prescribing of "appetite stimulants" to situations in which underlying causes cannot be identified or treated, other pertinent interventions have not worked or are not feasible, these medications have a valid indication, and improving appetite and weight is consistent with the individual's condition, prognosis, and wishes...A pertinent assessment and meaningful review of possible medical and non-medical causes of altered nutritional status should precede the use of such medications..." The current "Serving of Food" policy, with a revised date of 07/2023, was provided by the DM on 03/08/24 at 1:51 P.M. The policy indicated, "...Food shall be prepared and served in a manner that meets the individual needs of each resident...The Culinary and Nutritional Services team member will work in conjunction with the Nursing team member to ensure the correct food			

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	items are provided to the resident to meet meal preferences and diet restrictions... Residents who require assistance with eating will be provided with self-help devices or provided staff assistance as needed..." 3. The clinical record for Resident 4 was reviewed on 03/05/24 at 2:17 P.M. A Quarterly MDS assessment, dated 02/28/24, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, anemia, hypertension, diabetes, and depression. A Medical Diagnosis list included, but was not limited to, hypertensive heart and chronic kidney disease without heart failure, with Stage 1 through Stage 4 chronic kidney disease, or unspecified chronic kidney disease. An open-ended physician's order, with a start date of 01/18/24, indicated the resident was on a fluid restriction: 1500 ml (milliliters) total per 24 hours. The Dietary department total was 1080 ml to be served with meals: (breakfast 360 ml, lunch 360 ml, and dinner 360 ml). The Nursing department total was 420 ml: (days 180 ml, afternoons 150 ml, and evenings 90 ml). The clinical record lacked any documented fluid intake amounts. During an interview on 03/05/24 at 2:39 P.M., RN 4 indicated the resident was on a fluid restriction. They would keep track of the resident's fluid intakes. His mother brought in sodas for him. The facility would educate the resident on the importance of the fluid restriction. The resident's order for a fluid restriction was written as an FYI (For your Information) with nowhere to document how much the resident had consumed.			

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	During an interview on 03/05/24 at 2:48 P.M., the DON (Director of Nursing) indicated if a resident was on a fluid restriction and had and order for it then the resident's fluids would be monitored. The staff would monitor how much the resident was given throughout the day. The order indicated how much the resident was allotted from dietary and nursing. Outside of the amount the resident could drink, there was no documentation of how much they consumed. There was no place to document if the resident had more than the recommended amount. The current facility policy titled, "Encouraging and Restricting Fluids" with a revision date of 1/2019 and provided by the DON on 03/06/24 at 8:45 A.M. The policy indicated, "...The purpose of this procedure is to provide the resident with the amount of fluids necessary to maintain optimum health. This may include encouraging or restricting fluids...Record fluid intake on the intake side of the intake and output record as per md [MD] order..." 3.1-46(a)(1)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must			

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	provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to follow a physician's order related to medication reduction for 1 of 5 residents reviewed for pharmacy services. (Resident 25) Findings include: During an observation on 03/07/24 at 9:00 A.M., Resident 25 was lying in bed, awake and eating breakfast. His call light was in reach, and he had no concerns. The clinical record was reviewed on 03/06/24 at 9:43 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 01/06/24, indicated the resident was cognitively intact. The diagnoses included,	F 0755	**F755 Pharmacy services/Procedures/Pharmacist/Records** 1 Resident #25 was allegedly affected by the deficient practice Resident #25 medication order was entered as per physician's order for medication reduction. 2 Current residents with orders for medication reduction have the potential to be affected by the alleged deficient practice. The Director of Nursing/Designee completed a 30 day look back of current residents with medication reduction orders to ensure completion as ordered. Any	04/01/2024

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	but were not limited to, respiratory failure, anemia, hypertension, renal insufficiency, diabetes, anxiety, and depression. The resident had received an antidepressant during the review period. A Care Plan for taking an antidepressant, with a start date of 11/24/23, included an intervention, but was not limited to, "...Give antidepressant medications ordered by the physician...", with a start date of 11/24/23. A Psychiatry Progress Note, dated 02/26/24, indicated the resident was to continue Zoloft (sertraline), 50 mg (milligrams), daily and will decrease next visit. A Physician's Order, dated 02/26/24, indicated to discontinue sertraline 100 mg every day and start sertraline 50 mg every day. A Progress Note, dated 02/26/24 at 1:57 P.M., indicated there was a new order to lower the resident's Zoloft from 100 mg daily to 50 mg daily per the Psychiatry Nurse Practitioner (NP). The family was made aware. The February and March 2024 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) lacked documentation that the resident started sertraline 50 mg after the sertraline 100 mg was discontinued on 02/26/24. During an interview on 03/07/24 at 1:13 P.M., the DON (Director of Nursing) indicated the resident was seen by psychiatry services. When the Psychiatry NP came to the facility she would visit with the residents and would write her orders on paper and give them to the nurse. The nurse		identified concerns were immediately addressed. 3 The Administrator/Director of Nursing held an in-service with the licensed nurses regarding “Physician Services” related to medication reductions and entering the physician order as written. 4 The Director of Nursing/Designee will review medication reduction orders received for current residents, the physician/NP note, and order entered for accuracy as follows: 5 residents per week x 4 weeks, then 3 residents per week x 4 weeks, then 1 resident per week x 4 weeks. Any identified concerns will be immediately addressed. This will continue for no less than 3 months and compliance is met. The Director of Nursing/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	would then transcribe the orders into the resident record. The NP would then send her notes from the visit, and they would be uploaded into the clinical record. No one reviewed the notes once they were faxed to the facility. The resident's order should have been started for 50 mg and was missed. The current facility policy titled, "Physician Orders", with a revision date of 1/2018, was provided by the DON on 03/07/24 at 3:03 P.M. The policy indicated, "...All physician/practitioner orders, including verbal/telephone orders, are recorded on the Physician's Order form for each resident and must be signed and dated within 14 days by the ordering physician, physician assistant or nurse practitioner unless state regulations mandate sooner...The receiving nurse or therapist immediately records telephone or verbal orders and documents their name, title, and the date..." 3.1-37(a)			
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. Based on interview and record review, the facility failed to follow the physician's orders to obtain blood tests for 1 of 5 residents reviewed for laboratory services. (Resident 12)	F 0770	**F770 Laboratory Services** 1 Resident #12 was allegedly affected by the deficient practice. Resident #12 validated to have a lab requisition in place per MD	04/01/2024

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	Findings include: Resident 12's clinical record was reviewed on 03/07/24 at 1:41 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 02/22/24, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Alzheimer's dementia, coronary artery disease, hypertension, and COPD (Chronic Obstructive Pulmonary Disease). A current physician's order, dated 06/01/23, indicated the resident was to have a CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel), TSH (Thyroid Stimulating Hormone), Free T4 (Thyroxine), and a Depakote level obtained every six months, in March and September. The resident's record lacked documentation that the blood tests were obtained in September 2023. During an interview on 03/08/24 at 9:45 A.M., the DON (Director of Nursing) indicated the resident's blood tests were not obtained in September 2023 as ordered by the physician. The current facility policy, titled "Lab and Diagnostic Test Results - Clinical Protocol", with a revision date of September 2012, was provided by the Administrator on 03/08/24 at 1:19 P.M. The policy indicated, "...The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs...The staff will process test requisitions and arrange for tests..." 3.1-49(a)		order for March lab draw. 2 Current residents with lab orders have the potential to be affected by the alleged deficient practice. The Director of Nursing /Designee completed 100% audit of the last 60 days to ensure ordered labs were completed for current residents. Any identified concerns were immediately addressed. 3 The Administrator/Director of Nursing held an in-service with all licensed nursing staff related to “Lab and Diagnostic Test Results-Clinical Protocol” related to obtaining ordered labs. 4 The Director of Nursing/Designee will audit current residents with lab orders for completion as ordered as follows: 5 residents per week x 4 weeks, 3 residents per week x 4 weeks, 1 resident per week x 4 weeks. Any identified concerns will be immediately addressed. This will continue for no less than 3 months and compliance is met. The Director of Nursing/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance	

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			is achieved or if ongoing monitoring is required.	
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 prepare and serve food in a safe and sanitary manner for 2 of 3 dining observations. (Main Dining Room and 300 Hall Room Trays) Findings include: 1.a. During and observation and interview in the Main Dining Room on 03/04/24 at 12:13 P.M., Resident 4 indicated his meatloaf was not done and was pink in the middle. His meatloaf had a quarter size pink spot in the middle. He had asked	F 0812	**F812 Food Procurement, Store/Prepare/Serve-Sanitary** 1 Resident #4 was allegedly affected by the deficient practice. Resident #4 was immediately provided an alternative meal. Meal Service for dining room and 300 hall room trays was allegedly observed with hand sanitation not completed per policy. Administrator/Director of Nursing/Designee immediately	04/01/2024

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	for a grilled cheese sandwich, which he was eating at that time. Resident 19 was sitting at a different table with her head slumped down, asleep. Her meal tray was sitting in front of her, and her meatloaf was cut into pieces. There was a quarter size spot in the meatloaf that was pink. The Dietary Manager indicated the meat had been frozen and appear raw, but it was not. She would get any resident something else to eat if they wanted it. During an interview on 03/04/24 at 12:22 P.M., RN 8 indicated she had served resident's their meals and assisted with cutting up the meatloaf. She didn't see any concerns with the meat. If she had, she would have alerted the kitchen staff. During an interview on 03/04/24 at 12:23 P.M., CNA (Certified Nurse Aide) 9 indicated she had not seen any resident's meat that was not cooked. If she had seen undercooked meat, she would have taken the food, thrown it away, let the kitchen staff know, and gotten the resident new food. During an interview on 03/04/24 at 12:25 P.M., the Dietary Manager indicated the meatloaf was cooked in a big pan and cut into four sections. They had obtained temperatures in two of the four sections. During an interview on 03/04/24 at 12:27 P.M., Cook 2 indicated Resident 4 had shown him his meatloaf, it had looked a little raw. He told him not to eat it and had informed the other kitchen staff. He got the resident a grilled cheese sandwich. It didn't look like much of the meat was raw. He didn't see any other resident's meatloaf that looked raw.		completed education with facility staff regarding hand sanitation policy with meal service. 2 Current residents receiving facility meals have the potential to be affected by the alleged deficient practice. The Dietary Manager observed meals to ensure food was tempted and documented correctly. Any identified concerns were immediately addressed. The Administrator/Director of Nursing observed dining room and hall room trays at various times to ensure appropriate hand sanitation was completed. Any identified concerns were immediately addressed. 3 Administrator/Director of Nursing/Dietary Manager completed an in-service with all staff regarding “General Food Preparation and Handling”, “Hand Washing”, and “Assisting the resident with In-room meals” as it relates to obtaining food temperatures and completing hand sanitation between meal trays both in the dining room and room trays. 4 The Dietary Manager will audit temperature logs and validate accuracy on varying days and meals as follows: 5 meals per week x 4 weeks, then 3 meals per week x 4 weeks, then 1 meal per week x 4 weeks. Any identified concerns will be	

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	During an interview on 03/04/24 at 12:35 P.M., the DON (Director of Nursing) indicated there had not been any residents sick from a food borne illness in the building. The current facility policy titled, "GENERAL FOOD PREPARATION AND HANDLING", with a revision date of 7/2023, and provided by the DON on 03/07/24 at 3:03 P.M. The policy indicated, "...All meats are to be cooked or heated to a safe minimum internal temperature..." 1.b. During an observation in the Main Dining Room on 03/04/24 at 11:47 A.M., CNA 9 had rubbed her nose with her left hand, opened a cabinet door by the sink using her left hand, retrieved a cup from inside the opened kitchen door, and used her left hand to get sugar packets from the drink station. She held the cup in her left hand and filled it with ice from the ice chest and served it to Resident 42. CNA 9 took a menu to Resident 19 and asked her what she wanted for lunch. She took the menu back to the kitchen. She scratched her chin with her left hand then asked Resident 7 what he would like to drink. She went to the ice chest and opened it with her left hand, retrieved a cup, held it in her left hand, placed ice and the resident's drink choice in the cup and served it to the resident. CNA 9 then got Resident 4 two glasses of tea, scratched her face with her right hand, took dirty cups to the dirty dish side of the kitchen door, and then sanitized her hands. During an interview on 03/08/24 at 1:14 P.M., CNA 10 indicated when serving resident trays she would wash her hands, give residents' drinks, and sanitize between every couple of residents. Staff shouldn't touch any part of their selves and if they did, they should wash their hands. 1.c. On 03/04/24 at 11:43 A.M., in the Main Dining		immediately addressed. This will continue for no less than 3 months and compliance is met. The Director of Nursing/Designee with observe meal service in the dining room and on the halls for varying days and shifts as follows: 5 meals per week x 4 weeks, then 3 meals per week x 4 weeks, then 1 meal per week x 4 weeks. Any identified concerns will be immediately addressed. This will continue for no less than 3 months and compliance is met. The Dietary Manager/Director of Nursing/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	155728	A. BUILDING 00 B. WING	03/08/2024

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	Room, the following was observed: Cook 2 served a meal plate to Resident 15 and opened their ice cream cup, served a meal plate to Resident 9 and opened their ice cream cup, served a meal plate to Resident 30, removed rolled silver ware and a clothing protector from a cabinet, opened Resident 30's ice cream cup, then washed his hands with soap and water, turning on the water with his bare hands. He shut the water off with his bare hands then dried his hands on paper towels. He served a plate to Resident 9's family member, grabbed rolled silverware out of a drawer, put the silverware back in the drawer, passed a stack of black napkins from a staff member through the kitchen door to a kitchen staff member, served a meal plate to Resident 19 and opened their ice cream cup, dropped the lid on the floor, picked it up, threw it away, then washed his hands with soap and water, shutting the water off with paper towels. 2. On 03/04/24 at 12:46 P.M., meal trays were being passed to rooms on the 300 Hall by DA (Dietary Aide) 6 and the following was observed: DA 6 served Resident 6 their meal, touched and moved their over the bed table, went into another room, served Resident 10 their meal, touched their over the bed table, opened their ice cream, went into another room, served Resident 27 their meal, touched items on their over the bed table, opened a straw for them, then used hand sanitizer. During an interview on 03/08/24 at 1:11 PM., the DM (Dietary Manager) indicated when staff took meals to residents' rooms, they should sanitize their hands after delivering each tray served. When serving in the dining room, staff should sanitize their hands after serving each meal as			

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	well. Staff should not touch their person before serving a meal. If they did, they should wash their hands before serving another tray. When washing their hands, staff should turn the water on, get some soap, wash their hands, rinse their hands, dry their hands with paper towels, then shut the water off with the paper towel. The current "Hand Washing" policy, with a revised date of 07/2023, was provided by the DM on 03/08/24 at 1:34 P.M. The policy indicated, "...When to Wash Hands...After touching bare human body parts other than clean hands...How to Wash Hands...Turn on the faucet using a paper towel to avoid contaminating the faucet...Wet hands and forearms with warm water...apply...soap...Scrub...Rinse...Dry hands with paper towel. Turn the faucet off with the towel..." The current "Assisting the Resident with In-Room Meals" policy, with a revised date of December 2013, was provided by the DM on 03/08/24 at 1:34 P.M. The policy indicated, "...Employees must wash their hands before serving food to residents...if there is contact with...the resident's personal effects, the employee must wash his/her hands before serving food to the next resident..." 3.1-21(i)(3)			
F 0919 SS=D Bldg. 00	483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-			

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	§483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. Based on observation, interview, and record review, the facility failed to provide a functioning call light for 1 of 16 residents reviewed for functioning call lights. (Resident 26) Findings include: During an observation and interview on 03/04/24 at 1:10 P.M., Resident 26 was sitting on the side of his bed. He turned the call light on and indicated it should turn a light on in the hallway. The light in the hallway did not turn on. CNA (Certified Nurse Aide) 7 indicated the call lights were battery operated and if the batteries were dead then the call light stopped working. The resident would just yell for staff when they walked by if he needed something. During an observation and interview on 03/05/24 at 9:07 A.M., Resident 26's call light was not working. There was no bell or other staff-alerting device in the resident's room. The resident indicated there were no concerns overnight and he would yell for help if he needed something. During an observation on 03/05/24 at 12:10 P.M., Resident 26 was sitting on the bedside commode inside his room with the door open. He was asking for help and if the call light was on in the hallway. He indicated he needed help. The resident's call light was not on, and the staff were summoned for the resident. The staff immediately went to the resident room to assist the resident. During an interview on 03/05/24 at 1:40 P.M., Resident 26 was sitting on the side of the bed. He indicated his call light had come unplugged and that staff had come by and easily fixed it. The	F 0919	**F919 Resident Call System** 1 Resident #26 was allegedly affected by the deficient practice. Resident #26 call bell was immediately repaired by the Maintenance Director. A manual call bell was also provided to the resident. A new call light system has been installed in Resident #26 room. 2 Current residents residing in the facility have the potential to be affected by the alleged deficient practice. The Administrator and Maintenance Director immediately completed 100% audit of call lights to ensure they were functioning appropriately. Any identified concerns were immediately addressed. 3 The Administrator/Director of Nursing held and in-service regarding “Call light, use of” related to proper function of the resident’s call light. 4 The Maintenance Director/Designee will audit call lights for proper function as follows: 3 rooms on each hall per week x 4 weeks, then 2 rooms on each hall per week x 4 weeks, then 1 room on each hall x 4 weeks. Any identified concerns will be immediately addressed. This will continue for no less than	04/01/2024

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	resident pushed the call light. The light in the hallway was on. During an interview and observation on 03/05/24 at 1:43 P.M., the Maintenance Supervisor indicated the resident's call light system was a wireless system that worked with a computer at the nurse's station. If the resident's call light was not coming on, then the battery or bulb would be checked first. The computer system would let them know if the batteries were running low. The staff should let him know right away that a call light was not working. If it was during the middle of the night, they could call him to come in or write it on his clipboard that he reviewed daily. He had checked on the resident that morning, but he was asleep and laying on his call light, so he didn't wake him up. The staff could give the resident a bell to use if their call light was not working. The resident's call light was observed with the Maintenance Supervisor, and he indicated the cord was broken and needed to be replaced. The current, undated, facility policy titled, "Call Light, Use of" was provided by the DON (Director of Nursing) on 03/06/24 at 8:45 A.M. The policy indicated, "...To assure call system is in proper working order...Check all call lights daily and report any defective call lights to the charge nurse immediately...Log defective call lights with the exact location in a facility maintenance log..." 3.1-19(u)		3 months and compliance is met. The Director of Nursing/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	