STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	09/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE KOKOMO	3518 S LAFOUNTAIN ST KOKOMO, IN 46902

(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. This visit included the Investigation of Complaint IN00443390. Complaint IN00443390-No deficiencies related to the allegations are cited. Survey dates: September 16, 17, 18, 19, 20 and 23, 2024. Facility number: 000025 Provider number: 155064 AIM number: 100274850 Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type: Medicare: 2 Medicaid: 36 Other: 14 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 2, 2024.	F 0000		
F 0567 SS=D Bldg. 00	483.10(f)(10(i)(ii) Protection/Management of Personal Funds Based on interview and record review, the facility failed to ensure a resident was able to receive personal funds when requested for 1 of 1 resident reviewed for personal funds. (Resident 36)	F 0567	F567 *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of*	10/04/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Markia Baker	Administrator	10/17/2024

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	Finding includes: During an interview, on 9/16/24 at 11:17 a.m., Resident 36 indicated she asked several times to get money from her account and she was not able to get money out of her account. An email, dated 9/17/24, from the Corporate Business Office Manager indicated she had deposited the resident's check into the AR side instead of her RFMS (Resident Fund Management Service) account. During an interview, on 9/23/24 at 9:27 a.m., the Administrator indicated the facility did not have a business office manager. The Corporate Business Office Manager was covering multiple facilities. During an interview, on 9/23/24 at 10:00 a.m., the Administrator indicated when the resident was discharged to another facility they cancelled Resident 36's funds. When the resident was readmitted, her funds were messed up. The resident's funds could take more than 30 days to get resolved. During an interview, on 9/23/24 at 12:07 p.m., the Corporate Business Office Manager indicated the RFMS (Resident Fund Management Service) rejected her funds. The resident's social security check was deposited into her account, and it was rejected. The facility had to reapply for her, and it took a while. They received a check for $333.00, and the Corporate Business Office Manager had deposited all the check into her facility patient liability billing account and did not deposit $50 to her personal account. During an interview, on 9/23/24 at 3:02 p.m., the Administrator indicated if the resident wanted the		*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. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **This facility request a desk review for this alleged allegation.** **1** What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident 36 was provided with personal funds on 9/24/2024. **2** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. **3** What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? Administrator/designee will train the BOM on the policy “Resident Rights” to include ensuring a resident has access to their personal funds. **4** How the corrective action will be monitored to ensure the	

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	funds today, she would take the money out of the Administrator's personal funds to give to the resident. The Administrator's funds would be reimbursed from the corporate office. A current policy, titled "Resident Funds," dated as revised 4/29/19 and received from the Administrator on 9/23/24 at 2:00 p.m., indicated "...This facility manages the personal funds of residents when such request is made by the resident...The resident may choose to have the facility hold, safeguard, and manage his/her personal funds...Resident funds are deposited into an interest bearing resident trust fund account...Residents should have access to petty cash on an ongoing basis and be able to arrange for access for larger funds...Resident requests for access to their funds should be honored by facility staff as soon as possible but no later than...Three banking days for amounts of $100.00 ($50.00 for Medicaid residents)...." A current policy, titled "Resident Rights," dated 8/23/17 and received from the Administrator on 9/23/24 at 9:00 p.m., indicated "...To promote the exercise of rights for each resident...These rights include the resident's right to: Exercise his or her rights...If he or she wishes, have the facility manage his personal funds...." 3.1-6(e) 3.1-6(f)(1)		deficient practice will not recur, what quality assurance program will be put into place? Administrator/designee will audit residents personal fund accounts to ensure they have access to their funds. Audits will be completed on 10 resident accounts a day x 4 weeks, then 5 resident accounts a week x 4 weeks, then 1 resident account weekly x 4 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of Compliance 10/4/2024	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on observation, interview and record review, the facility failed to ensure a care plan was reviewed and revised as appropriate for 1 of 4 residents reviewed for accidents. (Resident 23)	F 0657	**F727** *This Plan of Correction is the center's credible allegation of*	10/04/2024

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	Finding includes: During daily observations, on 9/16/24, 9/17/24, 9/18/24, 9/19/24 and 9/20/24, a mattress was noted on the floor on the right side of Resident 23's bed with the left side of the bed positioned against the half wall in the room. The clinical record for Resident 23 was reviewed on 9/17/24 at 3:22 p.m. The diagnoses included, but were not limited to, seizures, schizoaffective disorder, depression, pseudobulbar affect, dementia- moderate with behavioral disturbance, cerebellar ataxia, bipolar disorder, chronic kidney disease-stage 3, intellectual disabilities, and atrial flutter. A Minimum Data Set (MDS) assessment, dated 3/26/24, indicated Resident 23 was discharged to an inpatient psychiatric facility and was expected to return to the facility. The resident was readmitted to the facility on 4/4/24. A care plan, dated 6/10/24, indicated interventions included, but were not limited to, the resident was to be "1:1 with staff member at all times" and "Mattress against wall between wall and bed for resident safety." Both interventions were initiated on 3/22/24 with no revision date. The resident was not observed to be on 1:1 with a staff member or to have a mattress between the resident's bed and the wall. During an interview, on 9/20/24, the Director of Nursing (DON) indicated the care plan had not been updated to indicate the resident no longer needed to be 1:1 with a staff member and no longer needed a mattress against the wall beside		*compliance.* *Preparation and/or 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. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **This facility request a desk review for this alleged allegation.** 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: Resident 23 care plan was reviewed and updated. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents currently residing in the facility have the potential to be affected. Thus, this plan of correction applies to all residents. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: The interdisciplinary team will be educated on, but not limited to, care plan revisions.	

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	her bed, following the resident's stay at an inpatient psychiatric facility. A current policy, titled "Comprehensive Care Plan," dated as revised 11/17/17, indicated " ...A comprehensive care plan must be...reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments...The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving...." 3.1-35(d)(2)(B)		4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? . The interdisciplinary team will meet once a week to discuss care plans for the scheduled residnts during that week. MDS, or Social Service will review individual care plans during the actual meeting weekly and make necessary changes at that time. This audit will occur weekly x8 weeks, then monthly thereafter. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/04/2024	

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview and record review, the facility failed to administer oxygen at the correct flow rate as ordered by the physician for 2 of 3 residents reviewed for respiratory care. (Residents 32 and 43) Findings include: 1. During an observation, on 9/16/24 at 4:03 p.m., Resident 32 was receiving oxygen at a flow rate of 2 liters per minute (LPM) via a nasal canula. During an observation, on 9/17/24 at 9:15 a.m., Resident 32 was receiving oxygen at a flow rate of 2 LPM via a nasal canula. During an observation, on 9/18/24 at 11:35 a.m., the resident was receiving oxygen at a flow rate of 2 LPM via a nasal canula. During an observation, on 9/19/24 at 1:29 p.m., Resident 32 was receiving oxygen at a flow rate of 2 LPM via a nasal canula. The clinical record for Resident 32 was reviewed on 9/19/24 at 12:35 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia (not enough oxygen in the body), asthma, atrial fibrillation, dependence on supplemental oxygen, and anxiety disorder. A current care plan, dated as initiated and revised on 11/27/23, indicated to use oxygen therapy for altered respiratory status related to COPD, anxiety disorder, respiratory failure with hypoxia, and asthma. Interventions included, but were not	F 0695	**F695** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **This facility request a desk review for this alleged allegation.** 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: Resident 32 oxygen was set at the correct liter flow. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: All residents who receive oxygen therapy are at risk for respiratory care related to oxygen use have the potential to be affected by the alleged deficient practice. A	10/04/2024

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	limited to, administering oxygen via nasal canula according to the physician's order. A physician's order, dated 2/2/24, indicated to administer oxygen at 3 LPM via nasal canula continuously every day and night shift for COPD. A physician's progress note, dated 9/16/24, indicated the resident was dependent on 3 LPM of oxygen with a plan to continue the supplemental oxygen at 3 LPM continuously for the resident's COPD, asthma, and respiratory failure with hypoxia. A Medication Administration Record (MAR), dated 9/1/24 through 9/30/24, indicated the resident was administered 3 LPM of oxygen continuously. During an observation and interview, on 9/19/24 at 1:40 p.m., the Assistant Director of Nursing (ADON) indicated the resident was on 2 LPM of oxygen rather than the ordered 3 LPM. The ADON indicated the oxygen should be at the rate ordered by the physician.2. During an observation, on 9/17/24 at 11:29 a.m., Resident 43 was receiving oxygen at a flow rate of 4 LPM via a nasal canula. During an observation, on 9/19/24 at 2:38 p.m., the resident was receiving oxygen at a flow rate of 4 LPM via a nasal canula. During an observation, on 9/23/24 at 11:28 a.m., the resident was receiving oxygen at a flow rate between 3 and 3.5 LPM via a nasal canula. The clinical record for Resident 43 was reviewed on 9/17/24 at 4:24 p.m. The diagnoses included, but were not limited to, acute respiratory failure		facility wide audit on all residents with oxygen use to ensure oxygen is set to correct flow rate. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: DON, or designee, will re-educate nursing staff on, but not limited to, oxygen use and ordered liter flow rate. Oxygen orders were reviewed for accuracy. 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? . DON, or designee, will check 5 oxygen flow rates daily (M-F) X 4 weeks, then 5 oxygen flow rates three times a week X 4 weeks, then 5 oxygen flow rates twice a week X 2 weeks. Any discrepancies will be corrected and MD/NP notified. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or	

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	with hypoxia, chronic obstructive pulmonary disease (COPD), anxiety, chronic kidney disease (CKD), and arteriosclerotic heart disease. A care plan, dated 6/20/23, indicated the resident was at risk for altered respiratory status/difficulty breathing related to morbid obesity, COPD, congestive heart failure (CHF), and a history of embolism and thrombosis. Approaches included, but were not limited to, O2 via NC (nasal cannula) per MD order. A physician's order, dated 6/20/24, indicated O2 at 3 LPM every day and night shift. A MAR, dated 9/1/24 to 9/30/24, indicated the resident received O2 at 3 LPM every day and night shift. During an interview, on 9/23/24 at 10:20 a.m., LPN 6 indicated the oxygen should have been at 3 LPM per the physician's order. A current policy, titled "Oxygen Safety," undated and received from the Director of Nursing on 9/20/24 at 3:24 p.m., indicated "...Oxygen is a prescribed drug and must have a Physician's order which outlines...liter flow...All changes in an order (liter flow...) must be verified by physician BEFORE changes are made." 31-47(a)(6)		greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance 10/4/24	
F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was in the facility at least 8 consecutive hours a day, 7 days a week for 5 of the days reviewed during the	F 0727	**F727** *This Plan of Correction is the center's credible allegation of*	10/17/2024

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	third quarter for RN coverage. (8/10, 8/11, 8/31, 9/1 and 9/14/24) Finding includes: A Payroll-Based Journal (PBJ) staffing report, for the third quarter of 2024, indicated the facility had failed to have licensed nursing coverage for 24 hour/day. During a record review, on 9/23/24 at 11:20 a.m., the actual worked staffing schedule indicated there was no RN coverage for 8/10, 8/11, 8/31, 9/1 and 9/14/24. During an interview, on 9/19/24 at 11:18 a.m., the Director of Nursing (DON) indicated RN 2 was on call for 8/10, 8/11, 8/31, 9/1 and 9/14/24. The nurse was not in the building on those days. During an interview, on 9/23/24 at 2:20 p.m., the Scheduler indicated other than management staff, the facility had one RN who worked every other weekend. The facility followed the state regulations and guidelines and did not have a policy for staffing. 3.1-17(b)(3)		*compliance.* *Preparation and/or 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. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **This facility request a desk review for this alleged allegation.** 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: No residents were affected. 2 How will the facility identify other residents having the potential to be affected by the same deficient practice: No residents will be affected. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: On 9/23/24, the Director of Nursing and the Executive Director met with the scheduler to ensure education on, but not limited to, scheduling of RN hours (8 hours a day, seven days a week). Reeducation was completed on	

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			9/23/24. 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? . Beginning 9/25/24, the Director of Nursing, or designee, will audit the daily staffing to ensure adequate RN coverage is schedule if applicable. This audit will be M-F X 8 weeks, then daily (M-F) going forward. The Executive Director, or designee, will meet with Human Resource Director, Director of Nursing and the scheduler weekly to monitor applicants and staffing needs. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance: ongoing	

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F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure medications were available and a resident received her scheduled medication as ordered for 1 of 1 resident reviewed for pharmacy services. (Resident 4) Finding includes: During an interview, on 9/16/24 at 11:42 a.m., Resident 4 indicated she had missed 2 days of her Oxybutynin (used for overactive bladder) and she had several incontinent episodes. She was told by staff the pharmacy was slow and had not delivered the medication. During an interview, on 9/18/24 at 11:29 a.m., Resident 4 indicated she did not receive her morning dose of Oxybutynin. The staff told her the pharmacy had not delivered it yet. The resident indicated she had not received her Oxybutynin for 3 days and had increased incontinence episodes. The clinical record for Resident 4 was reviewed on 9/18/24 at 8:49 a.m. The diagnoses included, but were not limited to, overactive bladder, rheumatoid arthritis, emphysema, and hypertension. A care plan, dated 12/24/22, indicated Resident 4 had an alteration in urinary elimination. Interventions included, but were not limited to, bladder assessments completed upon admission, quarterly and when needed and to monitor for	F 0755	**F755** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **This facility request a desk review for this alleged allegation.** 1 How the corrective action will be accomplished for those residents found to be affected by the deficient practice: On 9/21/24, Resident 4 medications were audited to ensure all medications were available per physician orders. Any identified discrepancies were corrected immediately, and the MD notified. 2 How will the facility identify other residents having the	10/04/2024

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	incontinence and change as needed. A care plan, dated 12/24/22, indicated Resident 4 was incontinent of bowel and bladder. Interventions included, but were not limited to, monitor any possible causes of bladder incontinence. A physician's order, dated 6/20/24, indicated to give 1 tablet of Oxybutynin Chloride ER (Extended Release) 10 mg (milligrams) daily. A pharmacy signed delivery invoice indicated the resident received 14 tablets of Oxybutynin 10 mg ER tablets from the pharmacy on 8/24/24, and did not receive additional tablets until 9/18/24. During an interview, on 9/18/24 at 11:32 a.m., QMA 3 indicated the resident did not have the Oxybutynin 10 mg tablets in the drawer with the rest of her other pills. The medication was not available in the Emergency Drug Kit (EDK). QMA 3 looked in the bottom of the medication cart and found a card of Oxybutynin 10 mg ER containing 14 tabs which were received on 9/18/24. During an interview, on 9/19/24 at 1:24 p.m., the Director of Nursing (DON) indicated the pharmacy documentation indicated the resident went 7 days without her medication. The staff should have documented the medication was unavailable and contacted the pharmacy. During an interview, on 9/19/24 at 2:20 p.m., the resident indicated she received her medication, on 9/18/24 and 9/19/24, and her incontinent episodes were a lot less. A current policy, titled "Medication Administration General Guidelines," undated and		potential to be affected by the same deficient practice: On 9/23/24, a full house audit was completed to ensure medications were available for all residents. Any discrepancies were corrected, and the MD was notified. 3 What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: On 9/23/24, the DON and ADON provided education to the floor nurses and Qualified Medication Assistants (QMA's) on the process of reordering medications, with emphasis on the use of the EDK and notification to the pharmacy to request and determine delivery time of medications and if back up pharmacy is needed, and notification to provider and responsible party if applicable. Reeducation was completed on 9/25/24. Beginning 9/25/24, the DON or ADON will pull the eMAR administration compliance report each day in clinical whiteboard meeting to review for medications documented not administered due to unavailability. The DON or ADON will audit the report to ensure all medications are available per physician orders. If medications are not available, the medication will be retrieved from	

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	155064	A. BUILDING 00 B. WING	09/23/2024

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	received from the DON on 9/18/24 at 4:27 p.m., indicated "...If a medication with a current active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g., other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted, or medication removed from the emergency kit...If a dose of regularly scheduled medication is...not available...the space provided on the front of the MAR for that dosage administration is initialed and circled. 3.1-25(a) 3.1-25(g)(3)		the Ekit (if applicable) and the pharmacy and provider will be notified. This audit will be M-F X 8 weeks, then daily (M-F) going forward. 4 How will the facility monitor its performance to make sure that solutions are sustained; the plan is implemented, and the corrective action evaluated for its effectiveness; and the plan of correction is integrated into the quality assurance system? . Beginning 9/25/24, the DON or ADON will pull the eMAR administration compliance report each day in clinical whiteboard meeting to review for medications documented not administered due to unavailability. The DON or ADON will audit the report to ensure all medications are available per physician orders. If medications are not available, the medication will be retrieved from the Ekit (if applicable) and the pharmacy and provider will be notified. This audit will be M-F X 8 weeks, then daily (M-F) going forward. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or	

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			greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5 Date of compliance - 10/4/2024	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and record review, the facility failed to ensure eye drops were dated when opened and medication drawers were free of loose unidentified medications for 1 of 2 medication carts reviewed for medication storage. (walnut hall) Findings include: During an observation, on 9/23/24 at 3:04 p.m., 2 bottles of eye drops for Resident 49 were opened and in the top drawer of the medication cart. No open dates were on the bottle or plastic bag containing the bottles. The second drawer of the medication cart had 6 loose medications: 1 large green, 2 round white, 2 oval white and 1 small round yellow pill. A physician's order, dated 9/19/24, indicated to administer 1 drop of prednisolone acetate ophthalmic suspension to Resident 49 in both eyes. During an interview, on 9/23/24 at 3:07 p.m., QMA	F 0761	F761 *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or 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. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **This facility request a desk review for this alleged allegation.** **1** What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Residents eye drops were	10/04/2024

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	3 indicated the eye drops should have had open dates on the package or bottle and the loose medications should have been removed and destroyed. A current policy, titled "Storage of Medications," not dated and received from the Administrator on 9/23/24 at 1:57 p.m., indicated "...certain medications or package types, such as I.V. solutions, multiple dose, injectable vials, ophthalmic, nitroglycerin tablets, once opened, required an expiration date shorter that the manufacturer's expiration date to insure medication and potency...when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated...the nurse shall place a "date opened" sticker on the medication and enter the date opened...." 3.1-25(m) 3.1-25(o)		discarded and new eye drops ordered. Any loose pills were removed from the cart. **2** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All medications that are stored in separate packages were checked on 9/23/24 by the DON and ADON to all med carts were audited to ensure medications that required date opened were labeled with such, and the carts were free from loose pills. **3** What measures will be put into place and what systematic changes will be made to ensure that the deficient practice does not recur? On 9/23/24, the DON began re-educating licensed nurses and Qualified Medication Assistants on proper medication storage to include dating medications and removing any loose pills in med carts. and loose pills in medication carts. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? DON/designee will audit med carts to ensure meds are dated (when applicable) and there are not loose pills in carts.	

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			Beginning 9/24/24, the DON or ADON will verify proper labeling of medications in separate packages and assessment of the medication carts for any loose pills 3 times a week X 4 weeks, then 2 times a week X 4 weeks, then weekly X 4 weeks. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of Compliance 10/4/2024	
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview and record review, the facility failed to ensure food was served at the proper temperature, menus were followed, or residents were offered a substitution of nutritional value of their choice, and to ensure puree recipes were followed to ensure residents received nutritional adequacy for 1 of 1 resident and 2 of 2 cooks reviewed for food and diet.	F 0804	F804 *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the*	10/04/2024

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	(Resident 32, Cook 4 and Cook 5) Findings include: 1. During an interview, on 9/17/24 at 10:07 a.m., Resident 32 indicated the food tasted terrible because they kept decreasing the budget and the food was often served cold. During an interview, on 9/18/24 at 12:05 p.m., Resident 32 indicated the fish was served very cold last evening, he was not sure if it was cooked all the way because it still seemed a little frozen in the middle, and the coleslaw was served at room temperature. During an interview, on 9/20/24 at 10:07 a.m., Resident 32 indicated according to the menu last evening he was to be served a bacon, lettuce, tomato (BLT) wrap with a salad but instead he received a grilled cheese sandwich with mashed potatoes and gravy. Resident 32 indicated this menu substitution happened routinely without them ever asking him what he would like as a substitute for his selection when they ran out of the menu items or had to serve something different because they did not have the correct ingredients. During an observation, on 9/20/24 at 12:36 p.m., the room tray cart with the 300 hall room trays were being passed out and a test tray was received at 12:51 p.m. During an observation and interview, on 9/20/24 at 12:51 p.m., the Dietary Manager (DM) tested the temperature of the items on the food tray. The temperature of the fish was 118.9. She indicated the temperature for the fish should be 145 degrees.		*facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **This facility request a desk review for this alleged allegation.** **1** What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident 32 has no adverse outcomes related to the alleged deficient practice. **2** How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Cook #4 and cook #5 were educated on following recipes. **3** How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Dietary manager/designee to educate all cooks on the policy "Pureed Food Preparation" to include following the correct pureed recipe, ensuring food is at the correct temperature, and honoring a residents food choice.	

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	The clinical record for Resident 32 was reviewed on 9/19/24 at 12:35 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, other asthma, bipolar disorder current episode hypomanic, recurrent major depressive disorder, atrial fibrillation, and anxiety disorder. A Minimum Data Set (MDS) assessment, dated 6/9/24, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he was cognitively intact. A current care plan, dated as initiated and revised on 11/27/23, included the problem of having the potential for a nutritional problem.2. During an observation, on 9/17/24 at 11:12 a.m., the facility menu indicated garlic bread was to be served for lunch. Cook 4 indicated the facility had one resident on a puree diet. The cook retrieved two slices of garlic bread from a metal pan and placed the garlic bread in the robot coupe (blender). She then added two Tablespoons of melted butter. The cook then added two and half cups of milk and started the blender. She looked inside the blender and stated the bread was too runny. The cook then added two slices of white bread. The Dietary Manager (DM) asked Cook 4 if she followed the recipe and had noticed Cook 4 used a four-cup measuring cup instead of a one cup measuring cup to measure the milk. The DM told Cook 4 the recipe called for 3/4 cup of milk, and she measured two and half cups instead. The extra milk made the bread too runny. 3. During an observation, on 9/17/24 at 11:05 a.m., Cook 5 placed a bowl of unmeasured cake into the robot coupe. She then took a gallon of milk and		**4** How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place? Dietary manager/designee will audit cooks preparing pureed foods to ensure they are following recipe. Dietary manager/designee will perform food temps to ensure they are in the correct temp range. Audits will be completed on 3 pureed recipes and 3 trays a week x 4 weeks, then 1 pureed recipe and 1 tray temp a week x 5 months. Dietary manager/designee will conduct random tray audits to ensure residents were given the correct food choice. Audits will be completed on 3 residents a week x 4 weeks, then 1 resident a week x 5 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of Compliance 10/4/2024	

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	poured an unmeasured amount of milk into the blender. She blended the cake and milk and indicated it was still too thick. Cook 5 then added another unmeasured amount of milk and poured it into the robot coupe. She blended the mixer and scrapped the edges of the inside of the robot coupe. She indicated it was still too thick and added more milk. Cook 5 indicated she should have measured the ingredients and followed the recipe. During an interview, on 9/17/24 at 11:35 a.m., the DM indicated Cook 4 and Cook 5 were supposed to follow the recipes and they did not. A current policy, titled "Pureed Food Preparation," dated 2020 and received from the DM on 9/17/24 at 1:35 p.m., indicated "...Pureed foods will be prepared using standardized recipes to ensure quality, flavor, palatability, and maximum nutritive value...Standardized recipes will be used to prepare all pureed foods...Serve with appropriate scoop number or divide equally to provide an equal number of portions. All of the pureed food must be used in order to deliver correct nutrient density to each resident...Review altered pureed recipes with the facility Registered Dietitian. Pureed foods will be the consistency of applesauce or smooth, mashed potatoes...Staff will be in-serviced on proper preparation of pureed foods...." 3.1-21(a)(1) 3.1-21(a)(2) 3.1-21(a)(3) 3.1-21(a)(4)			