STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155001	A. BUILDING 00 B. WING	12/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOOVERWOOD	7001 HOOVER RD INDIANAPOLIS, IN 46260

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit also included the Investigation of Complaints IN00394199, IN00382714, and IN00385997. Complaint IN00394199 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580. Complaint IN00382714 - Unsubstantiated due to lack of evidence. Complaint IN00385997 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Survey dates: December 12, 13, 14, 15, 19, 20, and 21, 2022. Facility number: 000001 Provider number: 155001 AIM number: 100275310 Census Bed Type: SNF/NF: 146 Residential: 14 Total: 160 Census Payor Type: Medicare: 9 Medicaid: 97 Other: 40 Total: 146 These deficiencies/deficiency reflect/reflects State Findings cited in accordance with 410 IAC	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 1/21/2023	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Voss	Administrator	01/21/2023

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

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	16.2-3.1. Quality review was completed on January 5, 2023.			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in			

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	paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review and interview, the facility failed to notify the physician and responsible party when a medication was not given or available for 1 of 1 resident reviewed for notification. (Resident 21) Finding includes: The record for Resident 21 was reviewed on 12/13/22 at 11:00 a.m. Diagnoses included, but were not limited to, kidney and pancreas transplant on 5/23/14. An administration note, dated 12/6/22 at 7:01 p.m., indicated the facility was awaiting delivery from pharmacy and Tacrolimus (a drug which suppresses the immune system and was used to prevent rejection of a transplant organ) was not given. An administration note, dated 12/7/22 through 12/9/22, indicated the medication was on order and Tacrolimus was not given.	F 0580	What corrective action will be accomplished for those resident found to be affected by the deficient practice ? Resident 21 physician and responsible party were notified of missing medication. 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 in the facility have the potential to be affected by the alleged deficient practice. A facility wide audit was conducted to determine if any other medications had not been given because of unavailability. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur?	01/21/2023

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	An administration note, dated 12/8/22 at 6:27 p.m., indicated the facility was awaiting delivery from pharmacy. A pharmacy document, received on 12/9/22 at 3:50 p.m., indicated the pharmacy needed transplant dates. An administration note, dated 12/10/22 at 10:39 a.m., indicated the medication was not available to give. A progress note, dated 12/11/22 at 10:35 a.m., indicated the facility contacted the Pharmacist to get Resident 21's Tacrolimus medication sent as soon as possible. The form was completed and sent back to the pharmacy. A progress note, dated 12/11/22 at 12:20 p.m., indicated the pharmacy brought the medication for Resident 21 and the medication was given. A facility document, with an effective date of 12/13/22, indicated Tacrolimus 0.5 mg (milligram) capsule for kidney transplant rejection prevention had been reordered for Resident 21 on 12/6/22. The record lacked indication Resident's 21 transplant physician, primary physician, or his representative was notified Tacrolimus was not given. During an interview, on 12/13/22 at 3:00 p.m., the Assistant Director of Nursing (ADON) indicated she was unsure if the physician, transplant coordinator, or family were notified the medication was not given or available to be administered to Resident 21. During an interview, on 12/13/22 at 3:45 p.m., the		Any time a medication is not given to a resident because of unavailability, the nurse will contact the pharmacy to determine when the medication will be available. If the medication is not available for more than 24 hours, the nurse will notify the physician, responsible party and the nurse manager. All unavailable medications will be discussed in morning meeting. The DON/designee will educate staff on the “Change of Condition” and “Medication Errors” policies. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place? An audit will be completed on all medications that were not administered due to unavailability on a daily basis Monday through Friday x 4 weeks, monthly x 2, then quarterly thereafter until compliance is 100%. The results of these audits will be reviewed by the Quality Assurance Committee. By what date will the systemic changes for each deficiency be completed. ? January 21, 2023	

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	Consulting Pharmacist indicated the insurance company required a transplant date which was missing so the medication could not be billed. The pharmacy contacted the facility on 12/9/22, requesting the date, and finally received a response back on 12/11/22. The Consulting Pharmacist indicated it was a communication error. During an interview, on 12/13/22 at 4:20 p.m., the ADON indicated the insurance company would not allow a cycle fill for transplant medication. Staff would need to request a refill of the medication two days before the resident was out of the medication. The family, physician, and transplant coordinator were not notified the medication was not given or available for administration. During an interview, on 12/14/22 at 1:04 p.m., a family member of Resident 21 indicated she had not been notified Resident 21's Tacrolimus medication was not given or available. It was important for him to receive his medication after his kidney and pancreas transplant. A facility policy, titled "Change of Condition," dated as revised 12/22, indicated the facility must inform the resident's physician and or notify the resident's family member when there was a change requiring such notification. The policy identified notification was required when a need to alter treatment and the inability to provide service, treatment, or medication occurred. A facility policy, titled "Medication Errors," indicated the attending physician shall be notified promptly of any error. This Federal tag relates to Complaint IN00394199.			

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	3.1-5(a)(3)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the			

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	community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview and record review, the facility failed to ensure a comprehensive care plan was developed for 1 of 3 residents reviewed for person centered care plans. (Resident 50) Finding includes: During an observation, on 12/15/22 at 8:11 a.m., Resident 50 was seated, in her wheelchair, in the dining room. Her eyes were closed. Her body leaned to the left side of her wheelchair with the left side of her back and shoulder pressing into the side support of her wheelchair. During the observation, no staff repositioned Resident 50. During an observation, on 12/15/22 at 11:56 a.m., Resident 50 was seated, in her wheelchair, in the dining room. Her eyes were closed. Her body leaned to the left side of her wheelchair with the left side of her back and shoulder pressing into the side support of her wheelchair. During the observation, no staff repositioned Resident 50 as they walked by her and through the dining room. The record for Resident 50 was reviewed on 12/15/22 at 10:00 a.m. Diagnoses included, but were not limited to, osteogenesis imperfecta,	F 0656	What corrective action will be accomplished for those resident found to be affected by the deficient practice ? Resident 50's care plan was updated to reflect the care needed to care for a resident with a diagnosis of osteogenesis imperfecta. 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 in the facility have the potential to be affected by the deficient practice. A facility wide audit was done to review all diagnoses and assure that appropriate care plans were in place. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? New admissions will be reviewed	01/21/2023

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	fracture, muscle weakness, pain, and dementia. A Significant Change Minimum Data Set (MDS) assessment, dated 11/16/22, indicated the resident had a moderate cognitive impairment, minimal depression symptoms, and demonstrated no behaviors. Resident 50 required extensive assistance of staff for all activities of daily living. A Care Area Assessment (CAA), dated 11/16/22, indicated the resident triggered for activities of daily living and required assistance from staff related to an unsteady gait and her diagnoses. The CAA indicated staff would assist with daily care, Resident 50 would participate in therapy programs, and her care plan would be developed to monitor for complications. A care plan, dated 12/6/19, indicated the resident had an alteration in comfort and pain related to osteogenesis imperfecta, fibromyalgia, left calcaneus fracture, and left radial nerve palsy. Interventions included, but were not limited to, administer pain medication as ordered, apply a walking boot to the left lower extremity, encourage rest periods as desired, and notify the physician if pain persists and interventions are unsuccessful. During an interview, on 12/13/22 at 4:00 p.m., Resident 50's family member indicated she had a concern the staff did not know how to properly care for her mom with her diagnosis of osteogenesis imperfecta. During an interview, on 12/15/22 at 9:42 a.m., Nursing Assistant (NA) 11 indicated Resident 50 had a diagnosis of brittle bone disease. The education provided did not specifically direct staff to provide activities of daily living care differently than other residents with her level of assistance.		in the daily morning meeting for diagnoses that may require further care plan development and education of staff. The DON/designee will educate the staff on the " Care Plan -Comprehensive" policy. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place? An audit of all new admissions and diagnoses with special considerations will be done on a daily basis Monday through Friday x 4 weeks, monthly x 2 and quarterly thereafter until compliance is 100%. The results of these audits will be reviewed by the Quality Assurance Committee. By what date will the systemic changes for each deficiency be completed ? January 21, 2023	

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	During an interview, on 12/15/22 at 9:50 a.m., Licensed Practical Nurse (LPN) 15 indicated nursing staff should provide assistant of one or two staff members. The resident's care sheet indicated she had fractures but was not specific how to provide care to Resident 50 in order to reduce the risk for fractures or injuries. During an interview, on 12/19/22 at 1:16 p.m., the Nurse Educator indicated staff were educated on how to handle and manage care for Resident 50 with her diagnoses of Osteogenesis imperfecta. She indicated the care plan did not specify how to provide care but did indicate staff were made aware of the diagnosis and to notify the physician. The care guide for the resident lacked indication and direction specifically on the care of Resident 50 and her brittle bone disease. The care plan and care guide should be specific to reflect the care needed with a specific diagnosis. Staff also should be educated on specific care and how to handle Resident 50 when providing care. A facility policy, titled "Care Plan - Comprehensive," dated 3/22, indicated the facility would develop and implement a comprehensive person-centered care plan for each resident which included measurable objectives and timeframes to meet the resident's medical, nursing, and mental and psychological needs which are identified in the comprehensive assessment. 3.1-35(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good			

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	nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to provide assistance with activities of daily living (ADL's), related to nail care, for 1 of 2 residents reviewed for ADL care. (Resident 21) Finding includes: During an observation, on 12/12/22 at 2:12 p.m., Resident 21was found in his room, lying in his bed, and an odor of urine filled the room. His hair was disheveled with a quarter inch long beard and mustache, and his fingernails extended past his fingertips. During an observation and interview, on 12/13/22 at 1:30 p.m., Resident 21 fingernails extended past his fingertips. An unidentified nursing assistant indicated Resident 21 was diabetic and the nursing staff needed to cut his nails. During an observation and interview, on 12/15/22 at 11:07 a.m., Resident 21 was found, in his room, lying in his bed. He was dressed and had fingernails extending past his fingertips. Licensed Practical Nurse (LPN) 15 indicated Resident 21's fingernails were long and needed to be trimmed. The record for Resident 21 was reviewed on 12/19/22 at 3:00 p.m. Diagnoses included, but were not limited to, urinary tract infection, cerebral infarction, diarrhea, aphasia, dementia, cognitive communication deficit, and neuromuscular dysfunction of bladder. A Minimum Data Set (MDS) assessment, dated 11/3/22, indicated he was totally dependent on staff for personal hygiene.	F 0677	What corrective action will be accomplished for those resident found to be affected by the deficient practice ? The nails of resident 21 were manicured and cleaned. 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 of the facility have the potential to be affected by the same deficient practice. A facility wide sweep of all residents fingernails was done. If the resident refused to have nails trimmed, a progress note was written to reflect that information. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? Nail checks of all residents will be done of the second Friday of the month to assure all are an appropriate length by the nurse/designee. Policies were developed for “Adl’s for Dependent Residents” and “Nail Checks” The DON/designee will educate the staff on appropriate ADL care and the new policies How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in	01/21/2023

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	A Care Area Assessment (CAA), dated 5/18/22, indicated Resident 21 triggered for activity for daily living (ADL) and required extensive assistance for ADLs, transfers, and mobility. A Care Plan would be developed to monitor for complications related to ADLs. A care plan, dated 9/26/22, indicated Resident 21 required staff to provide assistance with personal hygiene. The record lacked an indication Resident 21 refused or was offered to have his fingernails trimmed. During an interview, on 12/14/22 at 2:15 p.m., Resident 21's family member indicated the facility was responsible for ensuring he was groomed including cutting his nails when they were long. During an interview, on 12/15/22 at 3:30 p.m., the Assistant Director of Nursing (ADON) indicated nursing staff should provide nail care as needed. A policy on ADLs for Dependent Residents was requested and the Risk Managment Nurse indicated the facility did not have one. This Federal tag relates to Complaint IN00385997. 3.1-38(a)(3)(E)		place? A random sampling of all residents will be done on a daily basis Monday through Friday x 4 weeks, monthly x 2 and quarterly thereafter until compliance is 100%. The results of the audits will be reviewed by the Quality Assurance Committee. By what date will the systemic changes for each deficiency be completed. ? January 21, 2023	
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 facility residents. Based on the comprehensive assessment of a resident, the			

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	facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to provide the necessary care and services for a resident who had a change of condition and required hospitalization, failed to follow physician's orders to administer Tacrolimus (an antirejection medication), and failed to implement the bowel protocol for a resident experiencing constipation for 2 of 2 residents reviewed for bowel and bladder elimination. (Resident 21 and 9) Findings include: 1. The record for Resident 21 was reviewed on 12/15/22 at 8:35 a.m. Diagnoses included, but were not limited to, a kidney and pancreas transplant on 5/23/14. Resident 21's hospital progress note indicated he was hospitalized on 5/12/22 related to sepsis (life-threatening complication of an infection), pneumonia, and UTI (Urinary Tract Infection). Resident 21's hospital discharge summary, dated 5/26/22, indicated he was hospitalized from 5/20/22 to 5/26/22, related to sepsis, UTI, positive for Methicillin-resistant Staphylococcus aureus (MRSA), and impacted stool. A Hospital history and physical, dated 10/23/22, indicated Resident 21 had been hospitalized multiple times this year for sepsis. Most recently he was discharged in May 22 for aspiration pneumonia and UTI. He had cultures which had been positive for VRE. On 5/20/22, he had a diagnosis of Systemic inflammatory response	F 0684	What corrective action will be accomplished for those resident found to be affected by the deficient practice ? Resident 21's MD orders have been reviewed to ensure the Tacrolimus is being administered as ordered. Resident 9's chart was reviewed to ensure the bowel protocol is being followed per policy. 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 deficient practice. All residents receiving Tacrolimus were reviewed to ensure that the medication was being given without omission. A facility audit was completed for any resident who had not had a bowel movement for Three days. Orders were checked to ensure that the bowel protocol was in place.	01/21/2023

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	syndrome (SIRS), sepsis, UTI with a chronic foley catheter. The UTI was positive for VRE. A progress note, dated 10/27/22, indicated Resident 21 had been hospitalized from 10/23/22 to 10/27/22, for altered mental status. Physician's orders included, but were not limited to, on 3/11/22, staff were to give Tacrolimus capsule 0.5 mg by mouth two times a day for transplant rejection prevention related to kidney transplant. On 11/24/21, an order indicated to fax Tacrolimus transplant medication labs to the transplant coordinator every four weeks. A review of Resident 21's Medication Administration Record (MAR), dated 12/22, indicated he did not receive his Tacrolimus antirejection medication on the following 9 occasions: a. On 12/6/22 at 5:00 p.m. b. On 12/7/22 at 7:30 a.m., and 5:00 p.m. c. On 12/8/22 at 7:30 a.m., and 5:00 p.m. d. On 12/9/22 at 7:30 a.m., and 5:00 p.m. e. On 12/10/22 at 7:30 a.m., and 5:00 p.m. f. On 12/11/22 at 7:30 a.m. An administration note, dated 12/6/22 at 7:01 p.m., indicated the facility was awaiting delivery from pharmacy and Tacrolimus was not given. An administration note, dated 12/7/22 through 12/9/22, indicated the medication was on order and Tacrolimus was not given. An administration note, dated 12/8/22 at 6:27 p.m., indicated the facility was awaiting delivery from pharmacy. A pharmacy document, received on 12/9/22 at 3:50		What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? Anytime a resident with an order for Tacrolimus is admitted and does not have the medication available for administration, the nurse shall contact the pharmacy and obtain a date that it will be available. If there is a delay of more than 24 hours, the nurse needs to contact the physician, responsible party ,the transplant coordinator and the nurse manager. The nurse manager will continue with follow up to ensure the resident receives the medication in a timely manner. MD orders for Tacrolimus will be reviewed in the daily meeting. A list of residents who have not had a bowel movement in 3 days will be reviewed in the morning meeting and the bowel protocol will be put in place. The DON/designee will educate staff on the “Bowel Protocol “ , “Physician orders” and “Prevention of Hospitalizations” How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place?	

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	p.m., indicated the pharmacy needed transplant dates. An administration note, dated 12/10/22 at 10:39 a.m., indicated the medication was not available to given. A progress note, dated 12/11/22 at 10:35 a.m., indicated the facility contacted the Pharmacist to get Resident 21's Tacrolimus medication sent as soon as possible. The form was completed and sent back to the pharmacy. A progress note, dated 12/11/22 at 12:20 p.m., indicated the pharmacy brought medication for Resident 21 and the medication was given. A facility document, with an effective date of 12/13/22, indicated Tacrolimus 0.5 mg capsule for kidney transplant rejection prevention was reordered for Resident 21 on 12/6/22. During an interview, on 12/13/22 at 3:00 p.m., the Assistant Director of Nursing (ADON) indicated she was unsure if the physician, transplant coordinator, or family were notified the medication was not given or available to be administered to Resident 21. During an interview, on 12/13/22 at 3:45 p.m., the Consulting Pharmacist indicated the insurance company required a transplant date which was missing so the medication could not be billed. The pharmacy contacted the facility on 12/9/22, requesting the date and finally received a response back on 12/11/22. The Consulting Pharmacist indicated it was a communication error. During an interview, on 12/13/22, at 4:20 p.m., the ADON indicated the insurance company would		An audit of all residents will be done on all new admissions who have an order for Tacrolimus, on a daily basis Monday through Friday x 4 weeks, monthly x 2, then quarterly thereafter until compliance is 100%. The results of these audits will be reviewed by the Quality Assurance Committee. An audit of all residents will be done on all residents who have not had a bowel movement in 3 days and if the bowel protocol is in place on a daily basis Monday through Friday x 4 weeks, monthly x 2 then quarterly thereafter until compliance is 100%. The result of these audits will be reviewed by the Quality Assurance Committee. By what date will the systemic changes for each deficiency be completed. ? January 21, 2023	

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	not allow a cycle fill for transplant medication. Staff would need to request a refill of the medication two day before the resident was out of medication. The family, physician, and transplant coordinator were not notified the medication was not given or available for administration. During an interview, on 12/14/22 at 1:04 p.m., a family member indicated she had not been notified Resident 21's Tacrolimus medication was not given or available. It was important for him to receive his medication after his kidney and pancreas transplant. During an interview, on 12/19/22 at 9:00 a.m., the Transplant Coordinator indicated she had not received notification Resident 21 had missed doses of his Tacrolimus medication. Tacrolimus was important to take daily as scheduled to reduce the risk of rejecting the organ transplant. During an interview, on 12/19/22 at 11:45 a.m., the Nurse Practitioner indicated she was not notified when Resident 21 was not given his Tacrolimus medications or concerns with sediment in his catheter tubing. The physician should be notified with concerns about any order or change of condition a resident may have. Resident 21 had a history of kidney and pancreas transplant and needed his medication daily without a missed dose. The medication was needed for the resident to not reject his transplant organs, and he will need it for the rest of his life. 2. During an interview, on 12/20/22 at 3:32 p.m., Resident 9 indicated she had been taking narcotics to help with pain management of her wounds on her legs and she had been suffering from constipation. It had been more than a week since her last bowel movement. She had informed			

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	the Hospice staff of her concerns for constipation and still had no treatment or medications administered to help relieve her pain in her stomach from the constipation. The record for Resident 9 was reviewed on 12/20/22 at 1:30 p.m. Diagnoses included, but were not limited to, constipation, chronic pain, diabetes, muscle weakness, and spinal enthesopathy (inflammation of a ligament, cartilage, or tendon at the point it inserts into a bone which forms part of the spine). A Significant Change in Status Minimum Data Set (MDS) assessment, dated 11/21/22, indicated she had no bowel toileting program and no bowel patterns or constipation. She required extensive assistance of two staff for transfers, toilet use, and one-person physical assist for personal hygiene. A Care Area Assessment (CAA), dated 11/21/22, indicated she triggered the CAA because she required assistance with toileting, and she was incontinent. Staff were to assist her with toileting and incontinence care as needed. A review of Resident's 9 Bowel Elimination Task Record, dated 12/8/22 to 12/20/22, indicated she had no bowel movements. A physician's order indicated staff could administer Miralax Powder 17 grams. One scoop every 24 hours as needed for constipation. Resident 9's Medication Administration Record (MAR), dated 12/22, lacked indication Miralax was administered. During an interview, on 12/20/22, at 12:02 p.m., the			

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	Nurse Educator indicated Resident 9 had no bowel movements documented and the MAR lacked indication Miralax was given. Her expectation for staff when caring for a resident who was taking narcotics which could make constipation worse was to ensure a bowel program was in place, to document bowel movements, and to administer medications as needed for relief. A facility policy, titled "Physician Orders," dated 3/22, indicated no orders shall be changed or discontinued by anyone other than the physician. Nursing shall follow all orders as written. The physician would be contacted for any concerns, questions, or for clarification. A facility policy, titled "Prevention of Hospitalizations," dated 12/22, indicated an effort to avoid hospitalizations of the resident, monitoring of abnormal symptoms, assessment on an ongoing basis, consultation with the physician shall be standard practice. A facility policy, titled "Bowel Protocol," dated 3/22, indicated the facility should monitor the frequency of residents' bowel movements in order to prevent constipation, fecal impaction, or possible complication. Resident bowel shall move on a regular basis at least every three days. 3.1-37(a)			
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-			

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	(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to ensure a resident at risk for development of pressure ulcers received the necessary care, treatment, and services, consistent with professional standards of practice, to prevent a pressure ulcer and promote healing and failed to ensure the correct dose of Dakin's (an antimicrobial cleanser) was used during wound care for 3 of 7 residents reviewed for pressure ulcers. (Resident 299, 21, 112) Resident 299 acquired a stage 3 presure ulcer while in the facility. Findings include: 1. The record for Resident 299 was reviewed on 12/19/22 at 3:00 p.m. Diagnosis included, but were not limited to, end stage renal disease, diabetes, and heart failure. An Admission Summary, dated 11/26/22 at 6:35 p.m., indicated Resident 299 was admitted to the facility for rehabilitation due to altered mental status. She ambulated with an assist of two with a gait belt, walker, and wheelchair. A nurse-to-nurse report, dated 11/26/22, indicated Resident 299 had a red area to the coccyx which was blanchable.	F 0686	What corrective action will be accomplished for those resident found to be affected by the deficient practice ? Resident 299 has been assessed and interventions are in place. Resident 21 has been assessed to ensure MD orders are being followed. Resident 112 has deceased (1/3/23) 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 deficient practice. All residents at high risk for skin breakdown have been evaluated for skin irregularities. Any irregularities found were reported to the physician and treatment orders and interventions put in place. Responsible party was contacted.	01/21/2023

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	A skilled evaluation, dated 11/27/22 to 11/29/2022 at 5:04 p.m., indicated Resident 299's skin was warm, dry, normal skin color and turgor. A Braden Scale was conducted, on 11/27/22, and indicated Resident 299 was at risk for skin breakdown. A progress note, dated 11/30/22 at 4:26 p.m., indicated a family member had concerns regarding a cushion patch on Resident 299's coccyx was soiled which was applied at the hospital prior to her discharging to the facility on 11/26/22. The patch was removed, and the skin was intact beneath. A wound progress note, dated 12/2/22, indicated Resident 299 had a stage 3 pressure wound on her coccyx which measured 1 cm by 1.3 cm by 0.1 cm with 100 percent granulation, and a small amount of serosanguinous drainage. Treatment indicated to cleanse wound with wound cleanser or normal saline, apply collagen, cover with foam, and secure. Change every Monday, Wednesday, Friday, and as needed. The wound progress notes indicated therapy would be notified to upgrade the wheelchair cushion for Resident 299. A communication progress note, dated 12/2/22, indicated family member was notified of treatment orders to coccyx. A progress note, dated 12/2/22, indicated a coccyx wound was observed, and was facility acquired. The progress note indicated epithelial tissue was present and pink in color. The wound measured 3.2 cm by 3.4 by 0.1 cm. Wound care included applying triad cream and to cover with Duoderm every three days.		What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? A skin sweep will be conducted on a monthly basis throughout the facility for those residents at high risk for skin breakdown. DON/designee will educate staff on “Skin Management Program”, “Medication Errors”, And “Physician’s orders” The nurse involved in using the wrong medication was counselled. Any new skin breakdown will be discussed in morning meeting. The nurse manager will assess the wound and document findings. Nurse managers will evaluate the resident upon admission and document. New skin breakdown will be referred to the wound team for evaluation How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place? All new admissions will be reviewed for skin breakdown ensuring treatments are in place and being completed. Current pressure ulcers on a daily basis Monday through Friday x 4 weeks, monthly x 2, then quarterly thereafter until	

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	A care plan, dated 12/6/22, indicated Resident 299 had acquired a stage one pressure ulcer on her coccyx. Interventions included, but were not limited to, administer treatments as ordered, follow facility policies and protocols for prevention and treatment of skin breakdown, monitor nutritional status and serve diet as ordered, monitor intake, and record, and use a pressure relieving device on the bed and in the wheelchair. An Admission MDS assessment, dated 12/7/22, indicated Resident 299 was at risk for pressure ulcers and she currently had a stage 2 pressure wound which was not present upon entry and required extensive assistance from staff for all activities of daily living. She had a pressure relieving device to the chair and bed, was not receiving pressure care and was not on a turning and repositioning schedule. A Care Area Assessment, dated 12/7/22, indicated Resident 299 triggered the CAA due to requiring assistance with bed mobility, incontinence, impaired skin integrity. A care plan would be developed to monitor complications and the risk of developing pressure ulcers. A physician progress note, dated 12/7/22 at 4:00 p.m., indicated it was his first visit for the wound. The pressure wound on the coccyx was due to pressure and classified as a stage 3. A small layer of fat was exposed and measured 1 cm by 1.3 cm by 0.1 cm. A small amount of serosanguineous drainage was noted and a large area of pink granulation within the wound bed. The wound care order included to clean the wound with wound cleanser, or normal saline, apply collagen, cover with foam dressing, and secure. Change Monday through Friday, and as needed. Provide		compliance is 100%. The results of these audits will be reviewed by the Quality Assurance Committee. By what date will the systemic changes for each deficiency be completed. ? January 21, 2023	

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	offloading to Resident 299, do not sit for long periods of time, turn, and reposition per policy, and upgrade cushion in her wheelchair. A wound care note, dated 12/15/22, indicated Resident 299 was seen on wound rounds for a stage 3 pressure wound on coccyx which was acquired on 12/2/22. The pressure wound area measured 0.9 cm by 1.2 cm by 0.1 cm and had 100 percent granulation tissue with a small serosanguinous drainage. Treatment to the area included to cleanse with wound cleanser or normal saline, apply collagen powder followed with Triad daily. The facility would notify therapy to upgrade wheelchair cushion. Resident 299's Kardex indicated she required assistance by staff to turn and reposition in bed and as necessary. Physician orders included, but were not limited to: a. On 12/2/22 at 7:00 a.m., to clean area of coccyx, apply triad, and cover with Duoderm change every three days for open area. b. On 12/9/22, to cleanse with wound cleanser or normal saline, apply collagen, cover with foam, and secure. Change one time a day every Monday, Wednesday, Friday, and as needed for pressure wound. c. On 12/15/22 at 3:00 p.m., to cleanse the wound with wound cleanser or normal saline, apply collagen powder, and a layer of triad daily for a pressure wound. A review of Resident 299's Treatment Administration Record, dated 12/22, lacked indication wound care was provided on 12/7/22. A review of Resident 299's Occupational Therapy progress note, dated 11/29/22 to 12/19/22, lacked			

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	indication a pressure relieving device for her wheelchair was requested or needed to be upgraded. A review of Resident 299's Physical Therapy progress note, dated 11/30/22 to 12/19/22, lacked indication a pressure relieving device for her wheelchair was requested or needed to be upgraded. During an interview, on 12/14/22 at 2:30 p.m., a family member indicated she came into the facility to visit Resident 299 and she could smell an odor. She observed her back and coccyx area she noticed her bandage was soiled and she had concerned the bandage was the same one when she was discharged from the hospital. During an interview, on 12/20/22 at 3:53 p.m., the ADON indicated no measurement of the redness was documented when Resident 299 was admitted to the facility for the coccyx. The pressure wound was found on 12/2/22. During an interview, on 12/21/22 at 11:12 a.m., the ADON indicated the nurse did not document an accurate assessment and finding of the pressure wound. 2. The record for Resident 21 was reviewed on 12/14/22 at 10:55 a.m. Diagnoses included, but were not limited to, cerebral infarction (stroke), urinary tract infection, kidney transplant, pancreas transplant, diabetes, dementia, and pressure ulcer (injury which breaks down the skin). A care plan, dated 2/28/22, indicated Resident 21 was at high risk for pressure ulcer development related to decreased mobility, nutritional status, and a history of pressure ulcers. Interventions			

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	included, but were not limited to, administer treatments as ordered and monitor for effectiveness, educate the resident, family, and caregivers as to causes of skin breakdown, including transfer, positioning, importance of taking care during ambulating, mobility, good nutrition, and frequent repositioning, and if the resident refused treatment, discuss with the resident, Interdisciplinary team, and family to determine why, and try alternative methods to gain compliance. Document alternative methods. Inform Resident 21, family, and caregivers of any new area of skin breakdown, provide a low air loss mattress to the bed with settings as ordered by physician, monitor nutritional status, and serve diet as ordered, monitor and record intake, monitor, document, and report as needed any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length by width by depth), and stage. Obtain and monitor lab or diagnostic work as ordered. Report results to physician and follow up as indicated. Teach Resident 21 and family the importance of changing positions for prevention of pressure ulcers and encourage small frequent position changes. The care plan indicated he had an unstageable pressure ulcer to the right heel and right ankle. Interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness, and assess, record, and monitor wound healing as ordered. A Care Area Assessment (CAA), dated 5/18/22, indicated Resident 21 triggered for pressure injury and required extensive assist with ADL's, transfers, and mobility, which could lead to or contribute to increased risk of developing pressure ulcers. A care plan would be developed			

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	to monitor for complications related to the pressure ulcer risk. A Braden Scale was conducted, on 6/3/22, and indicated Resident 21 was at a high risk for skin breakdown. A quarterly Minimum Data Set (MDS) assessment, dated 11/3/22, indicated Resident 21 was at risk for pressure injuries and had no pressure wounds at the time of assessment. Current treatments were pressure reducing device for the chair, and pressure reducing device for bed. Resident 21 required extensive assistance of two staff to provide physical assist for locomotion, dressing, eating, toilet use, bed mobility. He was totally dependent on staff for personal hygiene and bathing. During an observation, on 12/15/22 at 11:07 a.m., Licensed Practical Nurse (LPN) 15 and LPN 12 entered Resident 21's room to provide wound care to his right heel. Resident 21 was lying in his bed as LPN 15 removed his Prevalon boot (a cushioned bottom boot which floats the heel off the surface of the mattress) from his right lower extremity. Resident 21 made a grunting noise and pointed to his right foot. LPN 15 continued to remove the bandage from his right foot, cleanse the foot, and applied the ointment to the back of the heel/ankle. She placed a foam pad, wrapped with gauze, and secured with that had the date 12/15/22. The Prevalon boot was than replaced on the right foot. Resident 21 begun to grunt out and point to his right foot and shake his head with the look of frustration. During an interview, on 12/15/22 at 11:20 a.m., LPN 15 indicated she performed wound care to Resident 21's left heel. When asked what the order			

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	indicated for wound care she did not respond. Resident 21's Medication Administration Record (MAR), dated 12/22, indicated: a. On 12/8/22 to 12/14/22, start betadine solution to his right heel every day related to changes in skin texture. b. On 12/15/22, apply Santyl ointment to right heel wound for dislodgement. c. On 12/16/22 to 12/19/22, apply Santyl ointment to Resident 21's right heel for a pressure ulcer. Physician orders included, but were not limited to, a. On 12/15/22, staff were to apply Santyl ointment 250 unit/gram (Collagenase.) Apply to the right heel wound bed topically, cover and secure one time a day and as needed. A skin/wound progress note, dated 11/24/22 at 1:36 p.m., indicated Resident 21 had a 3.0 cm (centimeter) by 2.5 cm intact firm eschar noted to his right ankle. No signs or symptoms of pain or discomfort. He had a low air loss mattress and utilized Prevalon boots while in bed. A progress note, dated 11/24/22 at 1:40 p.m., indicated Nurse Practitioner gave an order for betadine ointment to right ankle wound and leave open to air. A progress note, dated 11/30/22, indicated Resident 21 presented with an unstageable pressure wound to the right heel measuring 1.8 by 1.6 by 0.1, and 100 percent necrotic tissue with no drainage. Treatment would be betadine daily and pressure reducing boot. A progress note, dated 12/7/22, indicated Resident 21 had an unstageable pressure wound to the right heel measuring 1.7 cm by 1.5 cm by 0.1			

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cm, and 100 percent necrotic tissue with no drainage. The pressure wound was facility acquired on 11/24/22.

A progress note, dated 12/14/22, indicated Resident 21 had an unstageable pressure to right heel measuring 1.4 cm by 1.5 cm by 0.1 cm, and 100% necrotic tissue with no drainage.3. During an observation, on 12/20/22 at 10:12 a.m., RN 5 was observed to put two 3 milliliter (ml) containers of normal saline into a medication cup. She then poured a one-quarter concentration of Dakin's solution into the cup for a total of 10 ml of fluid. She placed a gauze dressing into the cup and once finished cleaning the wound, packed the wound with the Dakin's and normal saline soaked gauze.

The record for Resident 112 was reviewed on 12/19/22 at 2:36 p.m. Diagnoses included, but were not limited to, Alzheimer's disease with late onset, disorder of the skin and subcutaneous tissue and muscle weakness.

A physician's order, dated 12/1/2022, indicated to use Dakin's (1/4 strength) 0.125 % Solution; cleanse wound with wound cleaner or normal saline and pack lightly with fluffed gauze moistened with 1/4 strength Dakin's, cover and secure daily.

During an interview, on 12/20/22 at 1:43 p.m., RN 5 indicated she did add 6 ml of normal saline to the Dakin's because it was to be at 1/4 strength per the order. RN 5 reviewed the label of the solution which indicated the solution was 1/4 strength. She indicated she was not aware the solution (in the bottle) was 1/4 strength.

During an interview, on 12/21/22 at 10:25 a.m., the

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	Assistant Director of Nursing indicated she expected nursing to follow the physician's orders and check medications prior to using/administering. A facility policy, titled "Skin Management Program," dated 6/22, indicated the facility would ensure each resident received care consistent with the professional standards of practice to prevent pressure ulcers and did not develop a pressure ulcer. The policy described a stage 3 pressure ulcer as a full thickness skin loss were fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. A facility policy, titled "Physician Orders," dated as revised in 03/2022 was provided by the Assistant Director of Nursing on 12/20/22 at 2:30 p.m., indicated "...No orders shall be changed...by anyone other than the physician...Nursing shall follow all orders as written...." 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure kitchenettes cleaning chemicals were locked and secured away in a cabinet for 1 of 5 units reviewed for accident	F 0689	What corrective action will be accomplished for those resident found to be affected by the deficient practice ?	01/21/2023

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	hazards. (Unit 2B) Findings include: During an observation, on 12/12/22 at 2:20 p.m., of the 2B Unit Kitchenette, a container of Diversity Descaler detergent, a container of Keystone Liquid Rinse Additive, and a spray bottle of glass cleaner was in the kitchenette, under the two-compartment sink, in a cabinet unlocked and unsecured. Five residents were observed seated in the dining room with no staff present. During an observation, on 12/12/22 at 2:35 p.m., a Nursing Assistant (NA) indicated the chemicals were under the kitchen sink, in a cabinet, unsecured and unlocked. He indicated it was difficult to observe residents in the dining room, near the kitchen, because a wall blocked the view when staff were seated at the nurse's station. He did not remove the chemicals, secure the cabinet, or block the entrance to the kitchen when residents were observed in the dining room within 10 feet of the opening to the kitchen. He indicated the residents did have some cognitive impairment and were able to propel themselves. During an interview, on 12/12/22 at 2:44 p.m., the Dietary Aide indicated she did not have the key to the cabinet and the chemicals should not be in the cabinet unsecured. During an observation and interview, on 12/12/22 at 2:44 p.m., the Registered Dietitian indicated the chemicals were unsecured and unlocked in the kitchenette on Unit 2B. She indicated quite a few residents on the unit had cognitive impairment, were able to propel themselves, and could get in the kitchenette.		Immediately, staff placed the unsecured chemicals in the cabinet and locked it. 2B kitchenettes cleaning chemicals are locked and secured away in a cabinet 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 deficient practice. Staff was in serviced on proper procedure for chemical storage What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? Staff was in serviced on proper procedure for chemical storage Facility will implement daily rounds provided each business day by Environmental services/designee, to ensure chemicals are locked and secured away in cabinet. -Facility to provide on going education on the chemical storage policy, as needed. How the corrective action will be monitored to ensure the deficient	

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	During an observation and interview, on 12/12/22 at 2:46 p.m., the Registered Dietitian indicated two bottles of Diversity Descaler, and a bottle of mechanical detergent was observed under the kitchenette two compartment sink with the door jarred open. In a cabinet directly across from the sink was a bottle of glass cleaner. The chemicals should be kept secured in a cabinet when not in use. During an interview, on 12/13/22 at 8:45 a.m., the Corporate Environmental Service and Maintenance Director indicated all chemicals should be secured in a locked cabinet or cart away from access to residents. During an interview, on 12/13/22 at 9:03 a.m., the Kitchen Manager indicated he would expect the chemicals be locked up and secured for resident safety related to accidental ingestion of chemicals. During an interview, on 12/15/22 at 12:23 p.m., the Corporate staff indicated chemicals should remain secured in a locked cabinet for resident's safety. The Diversey Glass and Multi Surface Cleaner Safety Data Sheet (SDS), dated 7/25/18, indicated the Glass and Multi Surface Cleaner was hazardous to a person's health. The SDS indicated to avoid contact with skin, eyes, or ingestion. The Diversey Suma Calc D5 Descaler SDS, dated 3/21/18, indicated the Descaler was hazardous to a person's health. The SDS indicated to avoid contact with skin, eyes, or ingestion. The Diversey Suma Klear A10 Mid-range Rinse Aide SDS, dated 1/28/15, indicated the Descaler was hazardous to a person's health. The SDS indicated to avoid contact with skin, eyes, or		practice will not recur; what quality assurance program will be put in place? Dining Services Director, Executive Chef, Dietitian, and/or designee will conduct audits daily for 30 days and then weekly for 90 days until a score of 100% is achieved. Audits include monitoring of chemical usage and storage.	

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	ingestion. A facility policy, titled "Chemical Storage," dated as revised 10/1/18, indicated the inventory of cleaning chemical supplies shall be properly stored at all times. The policy highly recommended all storage areas always remain locked and opened only by a manager or supervisor to allow supplies to be issued. 3.1-45(a)(1)			
F 0690 SS=G Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to			

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	restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 2 of 2 residents reviewed for catheter care. (Resident 21 and 86) Resident 21 and Resident 86 was not provided care to address concerns which developed after a urinary catheter was not changed for multiple months. Findings include: 1. During an observation, on 12/12/22 at 2:12 p.m., when entering Resident 21's room a strong odor of urine was in the room. He was lying in his hospital bed and his catheter bag hung from the side with dark amber colored urine. The clear extension catheter tubing was lined inside with sediment. During an observation, on 12/13/22 at 1:31 p.m., Resident 21's room had an odor of strong urine as you entered the room. The clear extension catheter tubing was lined inside with sediment and amber colored urine was in the Foley bag. During an observation, on 12/14/22 at 2:30 p.m., Resident 21's urine appeared amber in colored, and sediment lined the inside of the catheter extension tubing. During an observation, on 12/15/22 at 9:33 a.m., Resident 21's room had a strong urine odor. The	F 0690	What corrective action will be accomplished for those resident found to be affected by the deficient practice ? Resident 21's catheter has been changed per MD order. Resident 86's catheter has been changed 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 deficient practice. All residents with a catheter were evaluated for daily care, appropriate orders and orders for when to change the catheter. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? All new admissions with orders for a catheter will be checked in the morning meeting for the	01/21/2023

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	clear extension catheter tubing was lined inside with sediment and dark amber colored urine was in the Foley bag. During an observation and interview, on 12/15/22 at 9:40 a.m., nursing assistant (NA) indicated she did not smell urine in Resident 21's room and had no concerns to report to the nurse. She indicated maybe the tubing needs to be changed because of the white build up. During an observation and interview, on 12/15/22 at 9:49 a.m., Licensed Practical Nurse (LPN) indicated she had not had any report of concerns for Resident 21's catheter tubing or the odor in his room. The LPN entered his room and indicated there was a strong odor of concentrated urine and Resident 21 may need more fluids. The LPN indicated the catheter extension tubing was coated on the inside with white sediment and the tubing should be changed. The record for Resident 21 was reviewed on 12/14/22 at 10:55 a.m. Diagnoses included, but were not limited to, cerebral infarction (stroke), urinary tract infection, kidney transplant, pancreas transplant, diabetes, dementia, and pressure ulcer (injury which breaks down the skin). A care plan, dated 4/13/21, indicated Resident 21 had an indwelling catheter related to a neuromuscular dysfunction of bladder. Interventions included, but were not limited to, position catheter bag and tubing below the level of the bladder and away from entrance room door, monitor and document intake and output as per facility policy, monitor for signs and symptoms of discomfort on urination and frequency, and monitor and document for pain or discomfort due to catheter. Monitor, record, report to the medical		appropriate orders for care and maintenance of a catheter. Orders for when to change the catheter will also be checked. Catheter changes will be reviewed in the morning meeting to ensure they are done on a timely basis. The DON/designee will educate staff on Urinary Catheter-Insertion and Removal and Urinary Catheter How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place? An audit of daily catheter care, appropriate orders and change orders of all residents with a catheter, on a daily basis Monday through Friday x 4 weeks, monthly x 2, then quarterly until compliance is 100%. The results of these audits will be reviewed by the Quality Assurance Committee. By what date will the systemic changes for each deficiency be completed. ? January 21, 2023	

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	doctor signs and symptoms of urinary tract infection such as pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. A Care Area Assessment, dated 5/18/22, indicated Resident 21 triggered for catheter, and diagnoses of UTI, neuromuscular dysfunction of the bladder, and status post kidney transplant. He required extensive assist with activities of daily living, transfers, and mobility, which could lead to or contribute complications related to catheter. Resident 21's CAA indicated his care plan would be developed to monitor for complications related to a Foley catheter. A Quarterly Minimum Data Set (MDS) dated 11/3/22, indicated he had an indwelling catheter and was totally dependent on staff for personal hygiene. Physician's orders, included, but were not limited to, a. On 4/13/21, change catheter as needed for leakage or decreased output. b. On 4/13/21, provide catheter care daily. c. On 6/11/21, change catheter on the 8th day of every month one time a day every 30 days related to chronic kidney disease. The order was entered as a diagnostic order. d. On 9/23/21, irrigate the Foley catheter with 60 milliliters (ml) of sterile water as needed every 8 hours as needed for hematuria. e. On 9/24/21, Resident 21 had an order indicating he may have a Foley catheter. The catheter size was a 16 French with a 10 ml bulb for neuromuscular dysfunction of bladder. Staff were			

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	to document urine output. Resident 21's hospital progress note, indicated he was hospitalized on 5/12/22 related to sepsis (life-threatening complication of an infection), pneumonia, and UTI. A physician's progress note, dated 5/13/22, indicated he was seen for a readmission visit after having an UTI. A hospital history and physical, dated 5/20/22, indicated he was diagnosed with sepsis related to aspiration pneumonia and urinary tract infection possible Foley associated. He had a recent Serratia (bacteria in urine) UTI, history of klebsiella (bacteria in urine) UTI, and Enterobacter aerogenes (bacteria in urine) UTI. Resident 21's hospital discharge summary, dated 5/26/22, indicated he was hospitalized from 5/20/22 to 5/26/22, related to sepsis, UTI, positive for Methicillin-resistant Staphylococcus aureus (MRSA), and impacted stool. A hospital history and physical, dated 10/23/22, indicated the resident was treated for sepsis, UTI with a chronic foley catheter. Resident 21 had also had a history of UTI on 5/5/20, and 5/20/22 with hospitalizations. During an interview, on 12/15/22 at 3:54 p.m., the Assistant Director of Nursing (ADON) indicated Resident 21's catheter order was entered as a diagnostic order, nursing staff would not see this, and it would not direct staff to change the order which had been entered 6/11/21. During an interview, on 12/15/22 at 4:34 p.m., the ADON indicated Resident 21 last had his catheter			

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	changed when he was admitted in the hospital in 10/22, when he was treated for sepsis related to UTI. Staff should have changed the catheter per the physician's order, and there was no order to specify the frequency to change the catheter. She had observed the catheter tubing and indicated the significant amount of sediment caked on the tubing and this put Resident 21 at risk for urinary tract infection. During an interview, on 12/15/22 at 5:30 p.m., the Director of Nursing (DON) indicated Resident 21 did not have his catheter changed since his last hospitalization in 10/22, when he had been hospitalized for sepsis related to UTI. He had multiple UTI since 5/22, and indicated the catheter not being change put Resident 21 at risk for another hospitalization and UTI. During an interview, on 12/16/22 at 8:57 a.m., the ADON and Risk Management Nurse indicated the nurse should clarify with the Physician upon admission or as needed the frequency of the catheter change if not indicated in the orders. Nursing staff should follow standing orders for on how and when catheter care should be provided. Nursing staff should report concerns immediately when they discover concerns regarding with the catheter such as strong odor or buildup of sediment in the urine. The ADON indicated she was unsure if the provider was notified of the concerns of the buildup in the extension tubing. Resident 21 had been hospitalized for UTI with sepsis and been treated for UTI which put him at risk. During an interview, on 12/19/22 at 9:00 a.m., the Transplant Coordinator indicated Resident 21 was at an increased risk for UTI which could cause an infection in his transplant kidney. She			

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	recommended good catheter care was provided including changing the catheter as ordered. During an interview, on 12/19/22 at 11:45 a.m., the Nurse Practitioner indicated she was notified, on 12/15/22, concerns regarding the catheter. Her recommendations for Resident 21 were to have monthly catheter changes because of chronic urinary retention and with his history of UTI with sepsis. She was not made aware Resident 21 had not had monthly catheter changes and his hospitalizations related to UTI and sepsis could have been from not having routine catheter changes. It was a concern for him not having routine catheter care. Staff should notify her if they were made aware of, or observed concerns related to odorous urine, blood in the urine, and sediment. 2. During an observation, on 12/12/22 at 1:30 p.m., upon exiting the second-floor elevator on Unit 2A, a strong foul smell of urine permeated into the hallway. The smell of urine became stronger as you walked towards Resident 86's room. During an observation, on 12/13/22 at 9:49 a.m., a strong foul smell of urine permeated into the hallway outside Resident 86's room. During an observation, on 12/13/22 at 1:30 p.m., a strong foul smell of urine permeated Resident 86's room. During an observation and interview, on 12/13/22 at 2:00 p.m., Resident 86 was observed lying her bed with the Foley catheter bag attached on the left side of the bed facing the door. The strong foul urine smell filled the room. Resident 86 indicated she notified the nurse the			

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	other day when staff emptied her catheter the urine had smelled strong. The resident had a history of urinary tract infections and required antibiotics. The record for Resident 86 was reviewed on 12/14/22 at 10:55 a.m. Diagnoses included, but were not limited to, urinary retention, chronic kidney disease, heart failure, urinary tract infections, and diabetes. Physician's orders, included, but were not limited to, a. On 8/12/22, provide catheter care daily. b. On 8/12/22, place a dignity bag. c. On 8/12/12, the order indicated Resident 86 may have a Foley catheter, 16 French bulb size 10 ml, every shift for retention of urine. d. On 12/14/22, give Ciprofloxacin HCL (antibiotic to treat urinary tract infection) by mouth two times a day until 12/21/22. e. On 12/16/22, change catheter as needed. A review of Resident 86's physician orders lacked indication staff were directed to change her catheter from 8/12/22 to 12/16/22. A Care Area Assessment, dated 1/17/22, indicated Resident 86 triggered for catheter and had a diagnosis of UTI and urinary retention. She required extensive assist with activities of daily living, transfers, and mobility, which could lead to or contribute complications related to Foley catheter. Her care plan would be developed to monitor for complications related to Foley catheter. Resident 86's care plan lacked indication she had an indwelling catheter for urinary retention or direction to staff to provide catheter related care.			

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	A Treatment Administration Record (TAR), dated 1/22, indicated Resident 86 had her catheter changed on 1/3/22. A TAR, dated 2/22, indicated Resident 86 had refused her catheter change on 2/2/22 and staff did not change of offer any other days in the month. A progress note, dated 2/2/22, indicated Resident 86 refused to have her catheter changed. A progress note, dated 2/24/22, indicated Resident 86 had a catheter inserted related to dislodgement. A TAR, dated 3/22, indicated Resident 86 had a catheter change on 3/18/22. A TAR, dated 5/22, indicated Resident 86 had been hospitalized on 5/1/22, and no catheter changed was completed. A urine culture, dated 5/9/22, indicated she had a positive urine culture for urinary tract infection. A urine culture, dated 5/26/22, indicated she had a positive urine culture for urinary tract infection. A progress note, dated 7/4/22 at 8:23 p.m., indicated Resident 86 had her catheter changed while in the hospital. A progress note, dated 7/6/22 at 6:16 p.m., indicated Resident 86 was to have her Foley catheter changed once a month. She indicated to staff she had just got back from the hospital where the catheter was changed.			

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	A progress note, dated 7/10/22 at 10:02 p.m., indicated Resident 86 had her catheter changed while at the hospital. A progress note, dated 7/13/22 at 10:35 p.m., indicated Resident 86 had her catheter changed while at the hospital. A Long-Term Care Evaluation, dated 7/16/22, indicated Resident 86 last had her catheter changed on 6/27/22. A progress note, dated 7/26/22 at 10:35 p.m., indicated Resident 86 refused to have her catheter changed due to having it changed when she was in the hospital. A Hospital History and Physical, dated 8/9/22, indicated Resident 86 had a Foley catheter related to urinary retention and facility staff indicated it was changed monthly. The progress notes indicated it was unclear when the catheter was last changed. A progress note, dated 9/1/22 at 6:04 a.m., indicated Resident 86 had her catheter changed due to low urine output. A urine culture, dated 9/8/21, indicated she had a positive urine culture for urinary tract infection. A TAR, dated 10/22, indicated she had a catheter changed on 10/14/22, related to leukocytosis. A communication progress note, dated 12/16/22 at 11:11 a.m., indicated the resident was notified she had her catheter changed on 12/13/22, when the nurse sent out a laboratory sample of urine to obtain an analysis, culture, and sensitivity.			

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	A TAR, dated 12/22, indicated Resident 86 had a Foley catheter and to document urine output every shift. On four different occasions, the TAR lacked documentation of urine output. An order was placed for staff to change the Foley catheter on 12/16/22. During an interview, on 12/15/22 at 5:04 p.m., the ADON indicated Resident 86 had not had a catheter change since 10/14/22. Resident 86's order did not indicate the frequency of when the catheter should be changed. During an interview, on 12/15/22 at 5:38 p.m., the Director of Nursing indicated the catheter should be change per physician order's and going two months was probably too long not to have the catheter changed. The facility policy, titled "Urinary Catheter Insertion and Removal," dated as revised 7/18, indicated an indwelling urinary catheter shall be inserted only, when necessary, based upon physician's order. 3.1-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			

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	Based on observation, interview and record review, the facility failed to ensure oxygen tubing was changed weekly and failed to ensure a resident received the correct amount of oxygen per liter as ordered by the physician for 2 of 3 residents reviewed for respiratory care. (Resident 24 and 48) Findings include: 1. During an observation, on 12/20/22 at 10:01 a.m., Resident 24's nasal cannula tubing was found to be dated 12/07/22. The record for Resident 24 was reviewed on 12/21/22 at 8:57 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, obstructive sleep apnea and chronic obstructive pulmonary disease. A physician's order, dated 05/17/21, indicated to provide oxygen at 3 liters/minute via nasal cannula to maintain oxygen saturation at greater than 90 percent. During an interview, on 12/20/22 at 12:10 p.m., the Quality Assurance Coordinator indicated oxygen lines were to be changed weekly on Sunday.2. During an observation, on 12/12/22 at 12:05 p.m., Resident 48 was receiving oxygen at 3L (liters) a minute via nasal cannula. During an observation, on 12/13/22 at 12:11 p.m., Resident 48 was receiving oxygen at 3L a minute via nasal cannula. During an observation, on 12/19/22 at 4:20 a.m., Resident 48 was receiving oxygen at 3L a minute via nasal cannula.	F 0695	What corrective action will be accomplished for those resident found to be affected by the deficient practice ? Resident 24 O2 tubing was changed and dated to reflect the change. Resident 48 O2 level was checked for the correct setting according to physician orders. 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 who used O2 therapy had their tubing checked to assure tubing had been changed and physician orders were compared to the setting being used to assure that the correct order was in place. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? All residents with O2 therapy will have their tubing and setting checked every Monday to assure compliance with the physician's orders. The DON/designee will educate staff on "Physician's orders" and "O2 Therapy" policies How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place? An audit of tubing change and O2	01/21/2023

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	The record for Resident 48 was reviewed on 12/15/22 at 3:00 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), dementia, and anxiety. A current physician's order, dated 12/05/22, indicated Resident 48 was to receive oxygen at 2L via nasal cannula. During an interview, on 12/19/22 at 6:31 a.m., LPN 1 indicated Resident 48 should have received oxygen at 2L as ordered by the physician. During an interview, on 12/19/22 at 7:30 a.m., the Assistant Director of Nursing indicated it was her expectation for nursing to follow physician's orders. A current policy, titled "Physician Orders," dated 3/2022 and provided by the Assistant Director of Nursing on 12/19/22 at 11:00 a.m., indicated "...Nursing shall follow all physician orders as written...." A facility policy, titled "Oxygen Therapy," dated as revised 05/2022 and provided by the Quality Assurance Coordinator on 12/20/22 at 12:10 p.m., indicated "...The oxygen tubing needs to be changed weekly on Sunday night shift...." 3.1-47(a)(6)		settings will be completed on all O2 therapy being administered on a daily basis Monday through Friday x 4 weeks, monthly x 2, then quarterly thereafter until compliance is 100%. The results of these audits will be reviewed by the Quality Assurance Committee. By what date will the systemic changes for each deficiency be completed. ? January 21, 2023	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-			

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	§483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review, the facility failed to ensure a resident's blood sugar was taken and insulin was given per physician's orders and failed to ensure a resident's pain was assessed by a licensed nurse prior to a QMA (qualified medication aide) administering an as needed pain medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 120) Finding includes: The record for Resident 120 was reviewed on 12/15/22 at 1:30 p.m. Diagnoses included, but were not limited to, depression, mood disorder, DM (diabetes mellitus), and pain in the joints. A current physician's order, dated 12/07/22, indicated the resident was to receive 5 units of Novolog insulin (medication used to lower the blood sugar within 15 minutes) after meals for DM.	F 0757	What corrective action will be accomplished for those resident found to be affected by the deficient practice ? Resident 120 medication record was reviewed for completion and documentation was reviewed for acknowledgment that a nurse had assessed the residents before receiving a prn medication from a QMA and that blood sugars were done according to the MD order and that insulin was administered when indicated. 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 deficient practice. A facility wide audit was	01/21/2023

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	A current physician's order, dated 12/07/22, indicated the resident was to have her blood sugar checked with each meal. A current physician's order, dated 12/07/22, indicated the resident was able to receive 10 mg (milligram) of oxycodone (a medication used to treat pain) every four hours as needed for pain. The resident's Medication Administration Record, for December 2022, was reviewed and the following was noted: a. There was no documentation the resident received 5 units of Novolog insulin as ordered on 12/09/22 after lunch and 12/14/22 after dinner. b. There was no documentation the resident's blood sugar was checked on 12/13/22 with her dinner. c. The resident received 10 mg of oxycodone on 12/09/22 at 11:12 a.m., and 6:03 p.m., on 12/12/22 at 7:38 a.m., on 12/14/22 at 7:56 p.m., and on 12/15/22 at 8:30 a.m., by QMA 10. A current care plan, dated 7/25/22, indicated the resident had DM and was at risk for alterations in her blood sugar. Interventions included, but were not limited to, give DM medications as ordered. A current care plan, dated 12/08/22, indicated the resident was receiving pain medication related to her knee replacement. Interventions included, but were not limited to, report to nurse when the resident complaints of pain or requests pain treatment. During an interview, on 12/19/22 at 1:40 p.m., the Assistant Director of Nursing indicated she could not find documentation the resident received 5 units of Novolog insulin on 12/09/22 and 12/14/22 or documentation the resident's blood sugar was		done of all medication records. Omissions of insulin being given was addressed with the nurse and any prn medications without a corresponding note from a nurse was addressed with the QMA. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? In the morning meeting, a review of all insulin administration, blood glucose testing in the past 24 hours will and a random sampling of PRN medications administered by QMA will be reviewed for assessment by a nurse. DON/designee will educate staff regarding " Physician orders" and the " QMA" Policy. Both instances will be considered a medication error and will be addressed accordingly. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place? An audit will be completed on all insulin administrations and blood glucose testing assuring they are given in accordance with the physician order on a daily basis Monday through Friday x 4 weeks, monthly x 2, then quarterly thereafter until compliance is 100%. The results of these audits will be reviewed by the Quality Assurance Committee. By what date will the systemic	

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	checked on 12/13/22. She could also not provide documentation QMA 10 reported the resident's pain medication request to the nurse so the resident pain level could be assessed prior to administering the resident's as needed pain medication. A licensed nurse should be notified, and the resident assessed prior to any as needed medication be administered by a QMA. If a medication or treatment was not documented in the resident's medication and treatment administration record, then it was not completed. A current policy, titled "Physician Orders," dated 3/2022 and provided by the Assistant Director of Nursing on 12/19/22 at 11:00 a.m., indicated "...Nursing shall follow all physician orders as written...." A current policy, titled "Qualified Medication Assistants," dated as revised on 5/2022 and provided by the Assistant Director of Nursing on 12/19/22 at 4:00 p.m., indicated "...The QMA will have a nurse assess the resident before giving any prn [as needed] medication...." 3.1-48(a)(3)		changes for each deficiency be completed. ? January 21, 2023	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic			

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	Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview and record review, the facility failed to ensure there was an appropriate diagnosis for the use of an	F 0758	What corrective action will be accomplished for those resident found to be affected by the	01/21/2023

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	anti-psychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 50) Finding includes: During an observation and interview, on 12/14/22 at 1:45 p.m., Resident 50 was observed lying in her bed with her eyes closed. An Occupational Therapist (OT) entered her room and asked her to participate in therapy, Resident 50 shook her head side to side indicated no. The OT indicated she had been working with Resident 50 for a while and had noticed her sleeping more during the day. During an observation, on 12/15/22 at 8:11 a.m., Resident 50 was observed in her wheelchair at the dining room table. She was leaning to the left side of her wheelchair and her head and chin were positioned down to her chest. Her eyes were closed, and she appeared to be sleeping. During an observation, on 12/15/22 from 11:55 a.m., to 12:17 p.m., she was observed in her wheelchair at the dining room table. She was leaning to the left side of her wheelchair and her head and chin were positioned down to her chest. Her eyes were closed, and she appeared to be sleeping. The record for Resident 50 was reviewed on 12/15/22 at 10:00 a.m. Diagnoses included, but were not limited to, dementia and mood disorder with depressive features. Resident 50's physician's orders included, but were not limited to, a. Olanzapine tablet 5 milligrams (mg), one tablet by mouth in the evening related to unspecified dementia without behavioral disturbances.		deficient practice ? Resident 50s psychotropic medications were reviewed by the physician. 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 deficient practice. A facility wide audit of all residents who are on psychotropic medications was done to assure that all have the appropriate diagnoses. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? All new orders for psychotropic medications will be reviewed in morning meeting on a daily basis to assure that an appropriate diagnosis is listed. DON/designee will educate staff on “Unnecessary Medications” policy How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place? An audit of all new or revised psychotropic medications will be done on a daily basis Monday through Friday x 4 weeks, monthly x 2, then quarterly thereafter until compliance is 100%. The results of these audits will be reviewed by	

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	b. Zoloft tablet 25 mg, one tablet by mouth once a day related to mood disorder due to known physiological condition with depressive features. Resident 50's behavior task record, dated from 11/16/22 to 12/15/22, indicated she had no behaviors or behavior symptoms. Resident 50's Kardex, dated 12/15/22, indicated she required staff to monitor, document, and report as needed any adverse reactions of psychotropic and antidepressant medications. Resident 50's Significant Change in Status Minimum Data Set (MDS) assessment, dated 11/16/22, indicated she had moderate cognitive impairment, minimal depression symptoms, and demonstrated no behaviors. Resident 50 required extensive assistance of staff for all activities of daily living. She took antipsychotic and antidepressant medications. Resident 50's Care Area Assessment (CAA), dated 11/16/22, indicated she triggered for dementia and psychotropic drug use. Due to the use of psychotropic medications and diagnosis placed Resident 50 at risk for medication side effects and falls. Her care plan would be developed to monitor for complications associated with psychotropic medication. Resident 50's care plan indicated she had a mood disorder and reported feeling tired during the day. Interventions included, but were not limited to, administer medications as ordered, monitor and document for side effects and effectiveness, assist the resident, family, and caregivers to identify strengths, positive coping skills and reinforce these, monitor, record mood to determine if problems seem to be related to external causes		the Quality Assurance Committee. By what date will the systemic changes for each deficiency be completed. ? January 21, 2023	

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	such as medications, treatments, or concern over diagnosis, monitor, record, and report to physician as needed acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite or eating habits, or change in sleep patterns, and monitor, record, and report to physician as needed mood patterns, sign and symptoms of depression, anxiety, sad mood as per facility behavior monitoring protocols. Resident 50's nurse progress notes were reviewed and indicated she refused her medications on 11/11/22 and 11/14/22 and demonstrated no other behaviors. During an interview, on 12/14/22 at 4:00 p.m., Resident 50's family member indicated she had a concern with consistent solomonce and sleepiness throughout the day. She reported her concerns to the nursing staff and did not feel Resident 50 should be on an antipsychotic medication since she did not have a diagnosis to support the medication use. During an interview, on 12/19/22 at 9:54 a.m., the Consulting Pharmacist indicated sleepiness could be a side effect from the Olanzapine and should continue to be monitored. The diagnosis of dementia was not the appropriate diagnosis for the use of olanzapine as an FDA approved medication use and should be reviewed by the facility and Resident 50's provider. A current facility policy, titled "Unnecessary Mediations," with a revised date of 4/22, indicated every effort should be made to avoid residents receiving any unnecessary medication by checking orders, evaluating for side effects, and having pharmacy consultation or evaluation on a			

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	regular basis. 3.1-48(a)(4)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure oral medications were stored separately from eye and ear medications, failed to ensure medications were stored in their packaging and failed to label medications with an open date in 3 of 5 medication carts reviewed for medication storage and	F 0761	What corrective action will be accomplished for those resident found to be affected by the deficient practice ? The medication carts on 1A, 2B, and 2A were all checked for vials without an open date, any	01/21/2023

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	labeling. (1A East, 2B, and 2A medication carts) Findings include: 1. During an observation of the 1A East medication cart with QMA 10, on 12/15/22 at 3:21 p.m., one 5 milliliter bottle of atropine oral drops for Resident 48 was found stored in a top-drawer compartment with Neomycin, polymyxin B ear drops for Resident 120. Also found loose and unpackaged in the drawers of the cart were a small white rectangular tablet, a medium sized round white tablet, a small round yellow tablet, a large white oblong tablet, a white capsule with a green band and a medium sized round white tablet. At that time, QMA 10 indicated the night shift was responsible for cleaning the medication carts and there should not have been any medications out of their packaging. 2. During an observation of the 2B medication cart with QMA 11, on 12/20/22 at 8:08 a.m., one Novolog insulin flex pen for Resident 21 was found open and without a date stored in the top drawer along with a 10-milliliter bottle of Lantus insulin for Resident 75. It was also found open without a date. During an interview, on 12/20/22 at 8:10 a.m., LPN 12 indicated if the insulins were found open without a date opened, she would get new insulin and put a date on it when she opened it. 3. During an observation of a 2A medication cart with LPN 13, on 12/20/22 at 8:17 a.m., a container of Neomycin Polymyxin Dexamethasone eye ointment for Resident 28 was found stored, in the same compartment, with prednisolone eye drops for Resident 4 and Debrox ear drops for Resident		unpackaged medications, and that all ear and eye medications were stored separately. 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 deficient practice. A facility wide audit on all medication carts was done to determine if any issues were present. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? At the end of each shift the nurse/QMA signing off on the cart will check for undated open vials, any unpackaged medications in the drawer and the appropriate storage of eye and ear medications. The DON/designee will educate nurses and QMAs on the appropriate labelling and storage of medications and policies “Medication Storage” and “Medication Labelling” How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place? An audit of all will be done on all medication carts on a biweekly basis Monday through Friday x 4 weeks, monthly x 2, then quarterly	

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	299. During an interview, on 12/20/22 at 8:19 a.m., LPN 13 indicated eye and ear medications need to be stored separately and to label all medications with the date they are opened. A facility policy, titled "Medication Labeling," dated as revised in 05/2022 and provided by the Assistant Director of Nursing on 12/19/22 at 11:16 a.m., indicated "...The facility shall maintain accurately labeled medications to assure safe and effective medication administration to the residents...." A facility policy, titled "Medication Storage," dated as revised in 04/2022 and provided by the Assistant Director of Nursing on 12/19/22 at 11:16 a.m., indicated "...Drugs shall be stored in a clean and orderly manner in cabinets, drawers or carts...Oral medications are stored separately from other medications. Eye drops are stored separately from ear drops...." 3.1-25(j)		thereafter until compliance is 100%. The results of these audits will be reviewed by the Quality Assurance Committee. By what date will the systemic changes for each deficiency be completed. ? January 21, 2023	
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			

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	facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to properly handle and store potentially hazardous foods in a manner which was intended to prevent the spread of food borne illnesses, maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination, and label and date containers of refrigerated products when opened in the main kitchen and 2 of 4 kitchenettes. Findings include: 1. During the initial tour of the main kitchen, on 12/19/22 at 10:24 a.m., the following were observed: During an observation, the walk-in freezer had a built up of ice around the left fan and fan cage. The area of built-up ice was from the 6 o'clock position to the 12 o'clock position and measured 4 inches wide by 2 inches thick. a. A bag labeled liver was freezer burnt with chunks of ice throughout and dated 11/8/22. b. A carton of mighty shake was found under the metal rack shelf on the floor of the freezer. During an observation and interview, of the dry storage room: a. A large blue 17-liter plastic container was sitting	F 0812	What corrective action will be accomplished for those resident found to be affected by the deficient practice ? 1) Immediately, work orders were created, and maintenance contacted regarding the following: A. Ice buildup in the freezer. B. Black induction heat surface tops had large cracks run through from side to side. C. Gasket on refrigerator door in pantry to be cleaned and/or replaced. D. No grate over drain in dishroom Dietary staff was in serviced on proper procedure for reporting physical defects and malfunctioning equipment. Immediately, the food items were removed from freezer, refrigerator, pantry area and/or dry storage and discarded: Labels and pens are available in	01/21/2023

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	on the bottom shelf next to containers of oil. The blue container had a greasy appearance to the outside and was undated and unlabeled. The Corporate Chef indicated the blue container had used oiled in it and should not be put on the shelf unlabeled and undated. The used oil should be stored away from the new oil. b. A 105-ounce container of mustard on the shelf with a 2-inch-long area of dried mustard on the outside of the container. c. A container of shelled sunflower seeds was found undated and unlabeled. d. An open bag of pancake mix was found undated and unlabeled. During an observation and interview, in a drain to the left side of the dishwasher on the floor was a hard plastic cup, a disposable plastic cup, and a white straw. No grate was found over the drain. The Corporate Chef indicated the staff should ensure no debris was in the drains. During an observation and interview, the walk-in cooler had the following: a. A cardboard box, half filled with red bell peppers which were wrinkled and had fluffy white and gray colored mold in multiple spots. More than 75 percent of the peppers left in the box had mold on them. b. Two 5-gallon buckets of kosher dill pickles had black colored mold on the outside container and on the handle. c. A pan of red marinara sauce unlabeled and undated. d. Half of an onion undated. e. A plastic container of pineapple was undated and unlabeled. f. A container of pumpkin puree dated 12/11. g. A container of cheese sauce undated. h. Two containers of sour cream dated 12/8/22.		all food storage areas for label and dating. Dietary staff was in serviced on proper procedures for labeling and dating items with an opened and discard date 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 deficient practice. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? · Dietary staff was in serviced on proper procedure for reporting physical defects and malfunctioning equipment. · Assign designated personnel to monitor food preparation and storage areas to ensure all food items are labeled and dated. · Re-establish cleaning assignments to include monitoring of all kitchen and pantry surfaces, physical defects, and malfunctioning equipment. · Designate personnel to monitor and clean the food preparation, pot washing areas,	

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	During an interview, on 12/12/22 at 12:04 p.m., the Corporate Chef indicated the red bell peppers and the containers of pickles had mold on them. The last time the red bell peppers were used was on 12/11/22. The facility received the peppers on 11/27/22. All open items should be labeled and dated when it was placed in the cooler. 2. During an observation with the Registered Dietitian, on 12/12/22, at 2:40 p.m., of the kitchenette on Unit 2B the following was observed: a. The cabinets had greasy and white stained fingerprints and smeared marks all around the handles. b. The cooler had greasy and white stained fingerprints and smeared marks all around the handle and door. c. A container of brown sugar in the cupboard with the plastic wrap half covered was undated and unlabeled. d. In the refrigerator were small plastic cups with lids with white colored cream. The containers were undated and unlabeled. e. 2 black induction heat surface tops had large cracks run through from side to side. Inside the cracks was dirt and food crumbs. f. The gray colored gasket on the inside of the refrigerator door had black colored mold. 3. During an observation and interview, on 12/12/22 at 2:47 p.m., the Registered dietitian indicated the kitchenette on Unit 2A and Unit 2B had cabinets which were greasy with white stained fingerprints and smeared marks all around the handles, the cooler had greasy and white stained fingerprints and smeared marks all around the handle and door, a container of brown sugar in the cupboard with the plastic wrap half covered		and storage areas within the daily/weekly cleaning log and assigned job duties. · Cleaning and sanitation check logs to be initialed each day by personnel and reviewed by manager at the close of each day. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place? Dining Services Director, Executive Chef, Dietitian, and/or designee will conduct audits daily for 30 days and then weekly for 90 days until a score of 100% is achieved. Audits include label and dating, food storage, cleaning, and function of food service equipment.	

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	was undated and unlabeled, and the gray colored gasket on the inside of the refrigerator door had black colored mold. During an interview, on 12/12/22 at 2:48 p.m., the Registered Dietitian indicated there was undated and unlabeled food items, black colored mold on the gasket, cracked induction heat surfaces, and dirty cabinets. It was the responsibility of the dietary department to ensure the area was clean and in good repair. During an interview, on 12/13/22 at 9:03 a.m., the Kitchen Manager indicated the staff were expected to ensure the kitchenettes were kept clean and in good repair. The staff should report concerns for any equipment which may need to be fixed. During an interview, on 12/15/22 at 12:23 p.m., the Corporate Kitchen Support indicated vegetables were good for 10 to 14 days and if mold was visible on food items it must be discarded. During an interview, on 12/19/22 at 11:00 a.m., the Culinary Director indicated the dietary staff should be monitoring and reporting concerns regarding the freezer or equipment repair. If dishes fall in the drain, they should be picked up and the drain kept free of debris. Staff should throw out items with mold on them and all items should be dated and labeled to keep residents from getting sick. A facility document, titled "Refrigerated Storage Life of Food," dated 1/18, indicated sour cream was good once opened for six days, pickles was good for two months once opened, and canned fruit was good for three days.			

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	3.1-21(i)(3)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based			

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	precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent and/or minimize the risk of transmission of Methicillin-resistant Staphylococcus aureus (MRSA) (a cause of a staph infection difficult to	F 0880	What corrective action will be accomplished for those resident found to be affected by the deficient practice ?. Resident 9 had an infection control bin placed outside her door with	01/21/2023

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	treat because of resistance to some antibiotics), to ensure the implementation of infection control practices and precautions on the proper use of Personal Protective Equipment (PPE), failed to follow the CDC guidance for contact precautions to ensure infection control practices during a meal service for resident who had an active cough and tested positive for Influenza A, and failed to ensure the proper disinfection and cleanup of a blood spill within a residents room who was at risk for the spread of blood borne pathogens for 3 of 3 residents reviewed for infection control. (Resident 9, 4, 41 and 47) Findings include: 1. During an observation, on 12/19/22 at 3:40 p.m., Resident 9 was observed in her room lying in bed with the door open. No precautions bin was outside the door of the resident room or a sign on the door indicating Resident 9 was on precautions. During an observation, on 12/20/22 at 9:45 a.m., Resident 9 was observed in her room lying in bed with the door open. No precautions bin was outside the door of the resident room or a sign on door indicating Resident 9 was on precautions. During a wound care observation and interview, on 12/20/22 at 3:20 p.m., a large amount of yellow green colored drainage was noted soaked through the dressing onto the pillowcase were her leg rested. Licensed Practical Nurse (LPN) 19 indicated she had not observed Resident 9 was on precautions for MRSA until 12/20/22. A care plan, dated as revised 5/26/22, indicated the resident was at risk for infection due to an open area from her left lower leg venous ulcer, and		appropriate signage on the door. Resident 4's floor was cleaned and disinfected of the blood stains. Resident 41 was placed in isolation after being found positive for influenza. All meals were then served in her room. 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 deficient practice. All residents with identified infections were reviewed for appropriate isolation if needed. All other residents were routinely monitored for any signs and symptoms of infection. Staff was directed that whenever there are blood spills of any kind or amount, they need to request housekeeping to assist in the clean up. Resident 4's floor was monitored for any further blood spills. All other residents were assessed for any abnormal signs and symptoms. All were encouraged to use masks and social distance. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur?	

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	she was being treated for MRSA with oral antibiotics. Interventions included, but were not limited to, maintain universal precautions when providing resident care. A Discharge Report, printed date 11/11/22, indicated Resident 9 had a resistant organism MRSA per lab result on 11/4/22. A Wound Clinic progress note, dated 12/7/22, indicated Resident 9 was prescribed cefuroxime 500 mg by mouth twice a day for 10 days. A physician's order, dated 12/13/22, indicated Resident 9 was on Doxycycline 100 milligrams by mouth twice a day for MRSA in the wound for 12 days. A Weekly Non-Pressure Skin Condition Report, dated 12/14/22, lacked indication Resident 9 had MRSA and needed to be on precautions. A Medication Administration Record (MAR), dated 12/22, lacked indication Resident 9 was on precautions for MRSA. Resident 9's Treatment Administration Record (TAR), dated 12/22, indicated Resident 9 received the following wound care orders: a. On 12/15/22, to cleanse wound to left posterior calf. b. On 11/16/22, to cleanse wound to right posterior calf. c. Resident's 9 TAR lacked indication she was on precautions for MRSA. During an interview, on 12/20/22 at 11:49 a.m., the Infection Preventionist indicated the resident was not placed on precautions for MRSA and should have once the facility was made aware she was		All new admissions or any resident placed on antibiotic treatment will be discussed in morning meeting to ensure the appropriate PPE and signage ins in place in a timely manner. Assessment forms indicating diagnoses and other pertinent information will be completed pre-admission to ensure nurses receive the information they need. Report sheet updated to prompt nurse to ask for any new diagnoses. Staff was directed to report any blood spills they observed so appropriate cleaning can be done. Any resident demonstrating signs and symptoms of infection will be assessed to ensure there is no potential of conveying infection from one individual to another. The DON/designee will educate staff on “Blood Borne Pathogens” Infection Prevention and Control” , “Isolation”, PPE and social distancing, and “Hazardous Spills” and utilizing direct lightening when rendering resident care. How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place? All new admission and residents placed on antibiotic therapy will be audited for appropriate equipment and signage on a daily basis	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	positive for MRSA. The Center for Disease Control and Prevention article, titled "Healthcare Settings - Preventing the Spread of MRSA," dated 2/28/19, indicated MRSA was usually spread by direct contact with an infected wound or from contaminated hands, usually those of healthcare providers. 2. During an observation, on 12/15/22 at 8:41 a.m., multiple areas in Resident 4's room were observed to have dry red blood stains on the floor in her room and bathroom. a. An area of a red blood smear was located to the left exit side of her bed measured one foot long by 6 inches wide. b. Two areas of red blood smear were in front of the door to the bathroom measured 2 inches by 3 inches. c. An area on the green mattress draw sheet had a two inch by one inch blood stain on the left edge. d. An area in front of the garbage can measured a four inch by three-inch red blood smear. e. Directly in front of the toilet, on the floor was an eight inch by eight-inch red blood smear. The record for Resident 4 was reviewed on 12/15/22 at 8:35 a.m. Diagnoses included, but were not limited to, pulmonary hypertension, anemia, heart failure, atrial fibrillation, and chronic ulcer. During an observation and interview, on 12/15/22 at 8:45 a.m., Licensed Practical Nurse (LPN) 13 indicated there was blood on the floor of Resident 4's bedroom and bathroom and it was an infection control problem. Nursing staff should have notified housekeeping to clean up the blood immediately when it was observed on the floor. The night nursing staff changed the bandage on Resident 4's foot because it bled last night.		Monday through Friday x 6 weeks, monthly x 2, then quarterly thereafter until compliance is 100%. The results of these audits will be reviewed by the Quality Assurance Committee. A random audit will be done of the floors on the unit to ensure no blood spills are present on a daily basis Monday thru Friday x 6 weeks, monthly x2, then quarterly until compliance is 100%. All audits will be reviewed by the Quality Assurance Committee. A random audit of all residents will be done on those demonstrating signs and symptoms of infection to ensure the appropriate assessment and follow up has been accomplished on a daily basis Monday through Friday x 6 weeks, monthly x 2, the quarterly until compliance is 100%. All audits will be reviewed by the Quality Assurance Committee. By what date will the systemic changes for each deficiency be completed. ? January 21, 2023	

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	155001	A. BUILDING 00 B. WING	12/21/2022

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	During an observation and interview, on 12/15/22 at 8:49 a.m., the Nurse Educator indicated dry red blood was on the floor of Resident 4's bedroom and bathroom. Nursing staff should have notified housekeeping to clean up blood immediately when it was observed on the floor. During an interview, 12/14/22 at 2:07 p.m., the Infection Preventionist indicated there was a concern for infection control and staff should have reported the blood stains to housekeeping to clean up immediately. 3. During an observation of the lunch meal service of Unit 2B, on 12/15/22 from 12:10 p.m., to 1:10 p.m., Resident 41 was seated at a table facing the windows with no mask on. To the right of Resident 41 was an unidentified resident within 4 feet of each other. To the left of Resident 41 was Resident 47 who was facing the opposite direction. Resident 41 had a dry tight sounding cough with flushed red colored cheeks throughout the whole meal service. Multiple residents were within 6 feet of Resident 41. No staff were observed to space residents away from each other more as Resident 41 had an active cough. During an observation of the 2B unit, on 12/20/22 at 9:01 a.m., three resident had signs for Droplet precautions with precautions bin outside the door. Staff were observed to bring in breakfast meals to residents using Styrofoam boxes and disposable dishware. A nurse progress note, dated 12/19/22 at 10:00 a.m., indicated Resident 41 had a positive influenza test.			

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	A physician's order, dated 12/19/22, indicated staff were to administer Tamiflu 30 mg capsules by mouth two times a day. During an interview, on 12/15/22 at 12:59 p.m., Licensed Practical Nurse (LPN) 12 indicated Resident 41 had a cough for a little while but it appeared to be getting worse as the day went on. During an interview, on 12/15/22 at 2:30 p.m., the Infection Preventionist indicated staff should attempt to space residents six feet apart when an active cough or sign of infection was possible. During an interview, on 12/20/22 at 9:03 a.m., LPN 12 indicated three residents total tested positive with Influenza A on Unit 2B. During an interview, on 12/21/22 at 9:30 a.m., the Infection Preventionist indicated Resident 41, Resident 47, and another resident had tested positive for Influenza A and was started on precautions. A facility policy, titled "Infection Prevention and Control Program," dated as revised on 2/22, indicated the facility would monitor and identify occurrence of infection and implement control measures to prevent outbreaks. A facility policy, titled "Blood Borne Pathogens," dated 7/22, indicated contaminated work surfaces should be decontaminated with the facility approved disinfectant after completion of the procedure immediately after any spill of blood. 3.1-18(b)			
F 0883 SS=D	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations			

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Bldg. 00	§483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is			

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	medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on record review and interview, the facility failed to ensure a resident received the pneumococcal immunization after the responsible party had consented for the pneumococcal immunization to be given for 1 of 5 residents reviewed for influenza and pneumococcal immunizations. (Resident 303) Finding includes: The record for Resident 303 was reviewed on 12/20/22 at 9:24 a.m. The admission date into the facility was 11/28/22. The immunization was complete for the COVID -19 vaccine but lacked indication she had received the Pneumococcal or Influenza vaccination. During an interview, on 12/21/22 at 10:55 a.m., the Infection Preventionist indicated the pneumococcal and influenza vaccination had not been given or offered to Resident 303. The Center for Disease Control recommended one	F 0883	What corrective action will be accomplished for those residents found to be affected by the deficient practice ? Resident 303 was offered the influenza and pneumococcal immunizations. 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 deficient practice. A facility wide audit on all residents and the status of their immunizations was completed. Any residents who did not have the appropriate immunizations or had a consent signed to receive them and had not received them were offered the appropriate immunization. What measures will be put in	01/21/2023

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	dose of Pneumococcal vaccine for all adults aged 65 years or older and annual influenza vaccination. The facility policy, titled "Influenza Immunization Residents," dated as revised 7/19, indicated the influenza vaccine will be routinely offered annually to residents to aid in the previous prevention and control of infections from influenza. The facility policy, titled "Pneumococcal Vaccine," dated as revised 7/19, indicated the facility would offer pneumococcal vaccine in accordance with the current CDC guidelines and recommendations. 3.1-18(b)(5)		place and what systemic changes will be made to ensure that the deficient practice does not recur? All new admissions will be checked in morning meeting for appropriate consents for immunization and subsequent administration if requested. The DON/designee will educate staff on " Influenza" and "Pmeumococcal " immunization policies How the corrective action will be monitored to ensure the deficient practice will not recur; what quality assurance program will be put in place? An audit of all will be done on all new admissions on a weekly basis Monday through Friday x 4 weeks, monthly x 2, then quarterly thereafter until compliance is 100%. The results of these audits will be reviewed by the Quality Assurance Committee. By what date will the systemic changes for each deficiency be completed. ? January 21, 2023	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. This visit also included the Investigation of Nursing Home Complaint IN00394199, IN00382714, and IN00385997. Complaint IN00394199 - Substantiated.	R 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests	

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	Federal/State deficiencies related to the allegations are cited at F580. Complaint IN00382714 - Unsubstantiated due to lack of evidence. Complaint IN00385997 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Survey dates: December 12, 13, 14, 15, 19. 20, and 21, 2022. Facility number: 000001 Residential Census: 14 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on January 5, 2023.		that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 1/21/2023	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted			

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	between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to provide documentation to show the fire department had been invited or involved in fire dills every six months. This deficient practice has the potential to effect 14 of 14 residents residing in the facility. Finding includes: The fire drills for the past 12 months were reviewed on 12/15/22. There was no documentation to show the fire department had been invited to participate in 1 or 2 fire/emergency drills after February 2022. During an interview, on 12/15/22 at 11:29 a.m., the Quality Assurance Coordinator indicated the facility had lost their Maintenance Director in May 2022 and they were unable to locate the documentation to show the fire department had been invited to take part in the fire drills after the loss of the employee. A facility policy, titled "Fire Safety/Drills," dated 08/2018 and provided by the Director of Nursing on 12/15/2022, indicated "...Every 6 months, the facility shall attempt to hold a fire and disaster drill in conjunction with the local fire department. Documentation will be maintained...."	R 0092	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Maintenance Director/designee will make sure to do fire drills per policy moving forward **How other residents having the potential to be affected by the same deficient practice will be identified and who corrective action(s) will be taken?** ·No residents were affected by the alleged deficient practice. ·All residents have the potential to be affected by the alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** ·The Maintenance Supervisor will put the Fire Drills in TELS as a requirement biannually with documentation ·Maintenance Supervisor completes preventative	01/21/2023

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			maintenance tasks via TELs system which includes fire drills, and submits completion to the ED during monthly QAPI meeting ·Maintenance Director/designee will make sure to do fire drills per policy moving forward ·The ED contacted the Fire Department and they were invited to participate in a fire drill on 1/20/23 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** ·Maintenance will complete TELS monthly, to ensure the fire drills are completed per policy and the results of the monitoring will be reviewed during the Quality Assurance Performance Improvement (QAPI) monthly meeting for 6 months, QAPI is overseen by the Executive Director. Any non compliance with staff will result in staff education and up to disciplinary action.	