STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155019	A. BUILDING 00 B. WING	10/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GARDEN VILLA - BLOOMINGTON	1100 S CURRY PK BLOOMINGTON, IN 47403

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00365367. Complaint IN00365367 - Unsubstantiated due to lack of evidence. Survey dates: October 21, 22, 25, 26, 27, and 28, 2021. Facility number: 000007 Provider number: 155019 AIM number: 100275040 Census Bed Type: SNF/NF: 70 Total: 70 Census Payor Type: Medicaid: 63 Other: 7 Total: 70 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on November 08, 2021.	F 0000	The filing of this plan of correction does not constitute an admission the alleged deficiencies did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirement and to continue providing quality care and services to all residents. Acceptance of this Plan of Correction (POC) provides the facility's credible evidence of compliance effective November 16, 2021. We respectfully request desk review and consideration for paper compliance of substantial compliance based on the Plan of Correction (POC) and supporting documents submitted.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the resident's status for 3 of 24 residents reviewed for accuracy	F 0641	**F641-Accuracy of Assessments** **This facility does ensure that assessments are accurate.** **Corrective actions taken:** In	11/09/2021

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

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	of assessments (Resident 20, 41, and 47). Findings include: 1.) On 10/25/21 at 11:35 a.m., Resident 20's clinical record was reviewed. Diagnoses included, but were not limited to: major depressive disorder, anxiety, delusional disorders, hallucinations, and unspecified psychosis. Resident 20's admission MDS assessment, dated 10/7/21, indicated the resident was administered an antipsychotic medication 7 times during the assessment period. A review of Resident 20's October, 2021, MAR (Medication Administration Record) indicated the resident did not have an antipsychotic medication ordered nor administered. During an interview, on 10/28/21 at 2:58 p.m., the Assistant Director of Nursing indicated she did not see an antipsychotic medication administered to Resident 20 on their October, 2021, MAR and their admission MDS assessment was not accurate. 2.) On 10/25/21 at 11:40 a.m., Resident 41's clinical record was reviewed. Diagnoses included, but were not limited to: traumatic brain injury and acute embolism and thrombosis of left subclavian vein. Resident 41's admission MDS assessment, dated 10/7/21, indicated the resident was administered an anticoagulant medication 7 times during the assessment period. A review of Resident 41's October, 2021, MAR (Medication Administration Record) indicated the		regard to the Minimum Data Set (MDS) admission assessments for the 3 of 24 residents reviewed for accuracy of Assessments. The MDS Coordinator corrected the deficiency when the surveyor identified the error. 1. **How other residents were identified:** All Residents who admit to the facility. 2. **Measures in place/system changes:** The DON/Designee will audit all new admission assessments for accuracy for a period of six months. **See attached audit form.** 3. **Monitoring of corrective actions taken:** The Quality Assurance and Improvement committee will review compliance of F641 Accuracy of Assessments and corrective actions as indicated at least quarterly during the scheduled quarterly meetings and as needed. Following two (2) quarterly quality assurance compliance reviews and no facility inaccuracies in admission assessments the committee will discuss revisions at that time.	

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	resident did not have an anticoagulation medication ordered, nor administered. During an interview, on 10/28/21 at 2:58 p.m., the Assistant Director of Nursing indicated she did not see an anticoagulant medication administered to Resident 41 on their October, 2021, MAR and their admission MDS assessment was not accurate. 3.) On 10/21/21 at 3:00 p.m., Resident 42 was observed to be edentulous (no natural teeth) and without dentures. On 10/25/21 at 11:45 a.m., Resident 42's clinical record was reviewed. Diagnoses included, but were not limited to: Alzheimer's disease, severe protein-calorie malnutrition, dementia, and dysphagia (difficulty swallowing). Resident 42's admission MDS assessment, dated 10/7/21, indicated the resident was not edentulous. During an interview, on 10/28/21 at 10:31 a.m., LPN 2 indicated Resident 42 is completely edentulous. A review of Resident 42's "Inventory of Person Effects," dated 10/5/21, indicated, "... Dentures [NO] ... Husband states does not wear dentures ..." During an interview, on 10/28/21 at 2:58 p.m., the Assistant Director of Nursing indicated Resident 42 was edentulous and the admission MDS assessment was incorrect. 3.1-31(d)			

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F 0689 SS=E 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 interview, observation, and record review, the facility failed to ensure that a resident received adequate supervision to prevent a resident to resident altercation for 2 of 2 residents reviewed for accidents (Resident 17 and Resident 4), the failed to ensure hot water temperatures remained at a safe and comfortable level, below 120 degrees Fahrenheit for 7 of 33 residents whose rooms were assessed for safe water temperature (Residents 12, 13, 14, 17, 33, 44, and 58), and the facility failed to ensure a safe environment after janitor's closet was found to be unlocked and unattended with hazardous materials for 1 of 1 janitor's closet observed during a random observation. Findings include: 1. Resident 17's clinical record was reviewed on 10/25/21 at 2:25 p.m. Diagnoses included, but were not limited to: Alzheimer's disease with late onset and unspecified dementia without behavioral disturbance. The Admission Minimum Data Set assessment, completed on 10/14/2021, indicated Resident 17 was interviewable and cognitively intact.	F 0689	**F 689-Free of Accident Hazards/Supervision/Devices** **This facility does ensure unsecured housekeeping utility rooms are secured, water temperatures are safe, and residents are free from abuse.** **Corrective actions taken:** In regard to the janitors closet on the 400 hall it was ajar during a random observation as the environmental staff member did not ensure it was latched when exiting the closet. All environmental staff were in-serviced on ensuring doors are closed upon exit. **See attached in-service sheets.** Concerning the water temperature on unit 5. The facility has an invoice from the contracted plumbing company dated 10/21/2021, which indicated the water heaters for station 4 and 5 were serviced and the water temperatures were holding at 117 degrees Fahrenheit. The water heaters have thermostat regulators	11/16/2021

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	During an observation, on 10/21/21 at 9:43 a.m., Resident 17's room was observed with a Velcro white band across door at about chest height with a large red stop sign in the middle. During an observation, on 10/22/21 at 11:37 a.m., Resident 4 was observed to be walking in the hallway near the 500 hallway nursing station. Resident was attempting to go into an occupied room adjacent to dining room area. During an interview, on 10/21/21 at 11:47 a.m., Licensed Practical Nurse (LPN) 1 indicated the Velcro stop sign band was in place to help prevent other residents from wandering into Resident 17's room. Some residents do wander and are watched to prevent wandering into other residents' rooms. LPN 1 was not aware of any resident having wandered into Resident 17's room since the band had been put into use. During an interview, on 10/22/21 at 10:20 a.m., Resident 17 was observed with a scabbed laceration on her left forearm, the size of a dime, close to where she wears her wristwatch. Resident 17 indicated the laceration came from another female resident (Resident 4) who came into her room, held her arms, and scratched her. The laceration might have happened when she was trying to get out of the other resident's grip and said staff came in to help her. That same resident had entered her room at times. This causes her some anxiety, but she did not wish to move rooms or move hallways. A review of Resident 17's progress notes indicated the following: -Nursing note, 10/6/21 at 4:17 a.m., "Res [resident] heard calling out. Staff entered room to see res		that control the water temperature exiting the water heaters. These regulators were set to 117 degrees Fahrenheit and were shown to the surveyors. **See attached vendor invoice.** Concerning the resident to resident between Resident #17 and Resident #4 on October the 5th 2021. These residents reside on a secured dementia unit in which residents do wander. The night the altercation occurred the unit was staffed with 5 staff members 1 Registered nurse, 2 Licensed Practical Nurse and 2 Certified nursing assistants. This figures to an Hours per patient day of 4.85. We normally staff a 3.65 HPPD. Residents are rounded on above facility policy and procedures and standards of care. This was reported to the Indiana State Department of Health in a timely manner. Concerning Resident #17 this resident has a care plan focus “The resident has potential to demonstrate verbally abusive behaviors of yelling at others and increased irritability with others when others near her doorway or enter her room r/t diagnosis of MDD”. **See attached staffing sheet.** 1. **How other residents were identified:** There were no residents identified as affected, as no residents on this unit who ambulate independently are	

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	attempting to move away from [Resident 4's medical record number] who was holding both wrists. Residents separated by staff. When asked what happened res stated 'She just walks in like she owns the place. I told her to get out when she grabbed me and wouldn't let go.' 1 cm x 1.2 cm skin tear noted to left wrist, blood noted on wristwatch." -Social services note, 10/6/21 at 7:53 p.m., "SSD [Social Service Director] met with resident to follow up on any distress due to altercation with another resident. Resident reported the other female resident had entered resident's room and grabbed resident's wrist. Resident reported she then called for staff. Resident said the other resident was 'bossy.' Resident denied any fear, anger or tearfulness due to altercation. Resident was appreciative of the follow up. Staff reported no changes in resident's daily routine." -Nursing note, 10/22/21 at 11:39 a.m., "While providing medications this AM, resident spoke of scratches on left arm from an incident that occurred 'shortly after we came home.' Resident was referring to the move from Garden Villa Bedford to Garden Villa Bloomington on the 5th of October. Scratches continue to heal well, no s/s of infection observed. Resident denies pain/discomfort and exhibits no distress. When asked if the stop sign banner across her door is helpful, resident states 'I'll reserve judgement for the future.' Res clarified that she's glad to have it up to 'hopefully discourage [Resident 13] and others.' Resident rests quietly in her room with call light in reach." Resident 4's clinical record was reviewed on 10/25/21 at 2:51 p.m. Diagnoses included, but were not limited to: Alcohol dependence with		cognitively impaired. All Residents on station 5 are at risk as the unit is a secured dementia unit. 2. **Measures in place/system changes:** The ED/ designee will complete water temperatures checks on 5 rooms daily on station 5 for four weeks, three times weekly for four weeks and then monthly for six months. The ED/designee with complete audit to ensure closets are closed and locked daily for four weeks, three times weekly for four weeks and then monthly for six months. Resident #17 will have 15-minute checks for 7 days and then 15-minute checks on night shift for 7 days, then hourly rounding for two weeks, then every two rounding for four weeks, then every two-hour rounding on night shift for an additional four months. **See attached audit tools, staffing sheet.** 3. **Monitoring of corrective actions taken:** The Quality Assurance and Improvement committee will review compliance of F689-Free of Accident Hazards/Supervision/Devices and corrective actions as indicated at least quarterly during the scheduled quarterly meetings and as needed. Following two (2) quarterly quality assurance compliance reviews and no facility	

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	alcohol-induced persisting dementia, other recurrent depressive disorders, psychotic disorder with delusions due to known physiological condition, and major depressive disorder recurrent mild. Clinical record indicated that Resident 4 had known history of intrusive wandering. Resident 4 resided in the secure unit of the facility. The Admission Minimum Data Set assessment, completed on 10/6/2021, indicated Resident 4 was non-interviewable and severely cognitively impaired. This same assessment further indicated that Resident 4 had delusions (misconceptions or beliefs that are firmly held, contrary to reality), behavioral symptoms including verbal behavioral symptoms (e.g., threatening others, screaming at others, cursing at others), wandering behaviors, and that she was coded at a 1 (requires supervision, oversight, encouragement, or cueing) for her functional status for walking in room, walking in corridor, and locomotion on unit. A review of Resident 4's care plans indicated the following: -A care plan, initiated on 12/3/2018 and current through 1/3/2022, for Resident 4 indicated, "Resident has episodes of intrusively wandering and socially inappropriate behavior of rummaging through others belongings and climbing into bed with others r/t dx [diagnosis] of dementia and anxiety." -A care plan, initiated on 2/25/2019 and current through 1/3/2022, for Resident 4 indicated, "Resident has episodes of physical aggression towards others and staff during care activities. Resident can become easily annoyed, slap others, slap staff, grabbing others and threw a cup of liquid on staff." Resident goal is will have no		safe and/or sanitary environmental issues/concerns are identified, the committee will discuss audit frequency decrease. 4. Date of Compliance: November 16, 2021.	

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	further episodes of verbal aggression or physical aggression toward others through next review. Interventions indicated, but were not limited to, "15 minutes checks as needed ... observe for increased signs or symptoms of confusion, agitation, and any signal leading to verbal aggression...." A review of Resident 4's progress notes indicated the following: -Nurses note, on 10/6/21 at 4:28 a.m., "Staff heard yelling from [Resident 17's room]. Res seen holding [Resident 17] by both wrists. Residents separated. 15 min checks initiated x 3 days (for three days). POA (Power of Attorney) and NP (Nurse Practitioner) notified. When asked what happened res stated 'I don't know what she's yelling about'." -Social services note, on 10/6/21 at 8:46 p.m., "...care plans for delusions, exit seeking, physical aggression towards others and staff during care, irritability, intrusive wandering/rummaging, code status, long term placement, affectionate behavior towards others, impaired cognition and psychosocial well-being ... will be developed." -Nurses note, on 10/9/21 at 2:34 a.m., "resident intrusively wandering into other resident's rooms which in turn upset that resident." -Nurses note, on 10/11/21 at 2:46 a.m., "Intrusive wandering noted. Staff able to redirect." -Social services note, on 10/11/21 at 4:53 p.m., "...Be aware at times that [Resident 4] can have aggressive behaviors with other residents." -Nurses note, on 10/11/21 at 6:37 p.m., "Resident			

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	intrusive but easily directed." -Nurses note, on 10/12/21 at 6:25 p.m., "...Awake all afternoon and intrusive mostly after supper meal. Redirects easily this shift..." -Nurses note, on 10/13/21 at 11:14 p.m., "...Intrusive wandering noted..." -Nurses note, on 10/14/21 at 5:54 a.m., "...has been wandering around the unit, attempting to go in other resident's rooms." -Nurses note, on 10/17/21 at 6:30 p.m., "Resident took another residents flowers that was brought in today and throwed [sic] the jar and the flowers on the floor and glass went every where..." -Nurses note, on 10/18/21 at 11:35 p.m., "Intrusive wandering noted. Able to redirect. Res seen by staff pulling decorations and name plate off walls." -Nurses note, on 10/19/21 at 6:31 a.m., "Res found laying in bed with another resident. Staff able to get res to her own bed." -Nurses note, on 10/23/21 at 10:38 p.m., "Intrusive wandering noted. Argumentative at times with redirection." -Nurses note, on 10/24/21 at 11:38 p.m., "Intrusive wandering noted. Able to redirect." -Nurses note, on 10/25/21 at 6:36 p.m., "Resident intrusive into rooms but easily re-directed..." On 10/27/21 at 2:45 p.m., the Assistant Director of Nursing provided the facility policy, "Resident Rights," with a revised date of December 2016,			

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	and indicated it was the policy currently being used by the facility. A review of the policy indicated, " ...1. Federal and state laws guarantee certain basic rights to all residents of the facility. These rights include the resident's right to: ... c. be free from abuse ..." 2. During an observation, on 10/22/21 at 10:35 a.m., of resident rooms the following was observed: -Room 516's hot water was observed to be hot to the touch, unable to keep hand under for more than a few seconds. -Room 517's hot water was observed to be hot to the touch, unable to keep hand under for more than a few seconds. During an observation, on 10/22/21 at 11:23 a.m., the following hot water temperatures were observed: -Room 515 had a hot water temperature of 123.6 degrees Fahrenheit. -Room 516 had a hot water temperature of 121.6 degrees Fahrenheit. -Room 517 had a hot water temperature of 124.3 degrees Fahrenheit. -Room 518 had a hot water temperature of 120.4 degrees Fahrenheit. During an observation, on 10/22/21 at 12:24 p.m., with the Director of Environmental Services present, the following was observed: -Room 516 had a hot water temperature of 126.0 degrees Fahrenheit. -Room 517 had a hot water temperature of 125.4 degrees Fahrenheit.			

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During an interview, on 10/22/21 at 12:35 p.m., the Director of Environmental Services indicated the water temperatures were too hot.

During an interview, on 10/22/21 at 12:37 p.m., the Director of Environmental Services indicated he had turned the main water heater down and it was observed to read at 117 degrees Fahrenheit.

The following residents resided in the identified rooms:

Resident 33's clinical record was reviewed on 10/27/21 at 2:05 p.m. Diagnoses included, but were not limited to: Unspecified dementia, depression, and unspecified psychotic disorder.

The Admission Minimum Data Set assessment, completed on 10/16/21, indicated Resident 33 was non-interviewable and severely cognitively impaired. Resident was coded as not independently ambulatory and required extensive assistance with ambulation, mobility, and personal hygiene.

Resident 58's clinical record was reviewed on 10/27/21 at 2:15 p.m. Diagnoses included, but were not limited to: Unspecified dementia and anxiety disorder. The Admission Minimum Data Set assessment, completed on 10/12/21, indicated Resident 58 was non-interviewable and severely cognitively impaired. Resident was coded as not independently ambulatory and required extensive assistance with ambulation, mobility, and personal hygiene.

Resident 12's clinical record was reviewed on 10/27/21 at 2:30 p.m. Diagnoses included, but were not limited to: Aphasia (loss of ability to

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	understand or express speech), unspecified dementia, depression, and unspecified psychotic disorder. The Admission Minimum Data Set assessment, completed on 10/14/21, indicated Resident 12 was non-interviewable and severely cognitively impaired. Resident was coded as not independently ambulatory and required extensive assistance with ambulation, mobility, and personal hygiene. Resident 44's clinical record was reviewed on 10/27/21 at 2:40 p.m. Diagnoses included, but were not limited to: Unspecified dementia and depression. The Admission Minimum Data Set assessment, completed on 10/8/21, indicated Resident 44 was non-interviewable and severely cognitively impaired. Resident was coded as independently ambulatory with supervision (oversight, encouragement, or cueing) for walking in room and in corridor and required extensive assistance with personal hygiene. Resident 13's clinical record was reviewed on 10/27/21 at 2:50 p.m. Diagnoses included, but were not limited to: Alzheimer's disease, aphasia, unspecified dementia, anxiety disorder, depression, and unspecified psychotic disorder. The Admission Minimum Data Set assessment, completed on 10/14/21, indicated Resident 13 was non-interviewable and severely cognitively impaired. Resident was coded as independently ambulatory for walking in room and in corridor and required extensive assistance with personal hygiene. Resident 14's clinical record was reviewed on 10/27/21 at 3:00 p.m. Diagnoses included, but were not limited to: unspecified dementia, anxiety disorder, and depression. The Admission Minimum Data Set assessment, completed on			

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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
	10/14/21, indicated Resident 14 was non-interviewable and assessment could not be completed. Resident was coded as not independently ambulatory and required extensive assistance with ambulation, mobility, and personal hygiene. Resident 17's clinical record was reviewed on 10/25/21 at 2:25 p.m. Diagnoses included, but were not limited to: Alzheimer's disease with late onset and unspecified dementia without behavioral disturbance. The Admission Minimum Data Set assessment, completed on 10/14/21, indicated Resident 17 was interviewable and cognitively intact. Resident was coded as not independently ambulatory and required extensive assistance with ambulation, mobility, and personal hygiene. During an observation, on 10/22/21 at 11:33 a.m., Resident 17 was observed to sit on side of her bed, put on her shoes, and ambulate independently to the restroom in her room with the use of a rolling walker. During an observation, on 10/26/21 at 11:55 a.m., Resident 17 was observed exiting her room. Resident ducked under the Velcro stop sign band across her door and ambulated out into the main dining room independently with the use of a rolling walker. During an observation, on 10/27/21 at 10:50 a.m., Resident 17 was observed out at activities in the dining room and ambulated independently back to her room with the use of a rolling walker. On 10/27/21 at 2:33 p.m., the Assistant Director of Nursing provided the facility policy, "Safety of Water Temperatures," with a revised date of December 2009, and indicated it was the policy currently being used by the facility. A review of the policy indicated, " ...Tap water in the facility shall be kept within a temperature range to			

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	155019	A. BUILDING 00 B. WING	10/28/2021

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	prevent scalding of residents. 1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 120 degrees Fahrenheit, or the maximum allowable temperature per state regulation..."3. On 10/21/21 at 10:10 to 10:15 a.m., during entrance tour of the facility, the janitor's closet at the end of the hallway, where residents resided, was found to be unlocked and unattended. Inside the janitor's closet were bleach, urinal/drain treatment, and disinfectant which indicated not to drink. During an interview, on 10/21/21 at 10:15 a.m., Housekeeper 1 indicated the door should be locked. On 10/28/21 at 3:59 p.m., the Assistant Director of Nursing (ADON) provided the facility policy titled, "Safety and Supervision of Residents," revision date July, 2017, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "...Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide..." priorities..." 3.1-45 (a)(1) 3.1-45(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			

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	professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure a resident was administered oxygen as indicated by the physician order for 1 of 1 resident reviewed for respiratory care. (Resident 29) Findings include: On 10/21/2021 from 12:15 p.m. through 12:26 p.m., Resident 29 was observed to be sitting in the dining room in a Broda chair with oxygen nasal cannula (N/C) tube positioned in her nose. The oxygen tank dial was observed to be set at 0. During an interview, on 10/21/2021 at 12:26 p.m., Unit Manager (UM) 1 indicated the oxygen should be set at 2 liters (L) The UM was observed to turn the dial on the oxygen tank to 2 L. During an interview, on 10/21/2021 at 12:29 p.m., UM 1 indicated the MD (Medical Doctor) order was for oxygen 2.5 L at all times. She was observed to turn the oxygen dial to 2.5 L. On 10/28/2021 at 10:30 a.m., Resident 29's clinical record was reviewed. Diagnoses included, but were not limited to acute and chronic respiratory failure with hypoxia. Physician orders, dated October, 2021, indicated, "... O2 [oxygen] at 2.5 L per N/C every shift ..." A care plan, initiated on 2/8/2021, and current through target date 1/14/2022, for Resident 29 indicated, "... Focus: acute and chronic respiratory failure with hypoxia, oxygen dependent ... Goal:	F 0695	**F695-Respiratory Care** **This facility does ensure residents who use oxygen have it turned on.** **1. Corrective actions taken:** Regarding resident #29, the resident had no respiratory distress and oxygen saturation was within normal limits. In-servicing was completed with all nursing staff on proper procedure for applying oxygen. ***See attached oxygen audit form and in servicing.*** **2. How other residents were identified:** All residents were audited for the use of oxygen. A facility report was utilized to determine all residents with physician orders for the use of oxygen. **See attached DON/Designee oxygen reports.** **3. Measures in place/system changes:** The Director of Nursing (DON)/designee(s) will audit all residents in the facility who use oxygen to ensure the oxygen is on. The DON/designee audits will be ongoing for all residents per unit. Audits will be completed every day for two weeks, then three days a week for two weeks and the monthly for a period of (6) months. **See attached**	11/16/2021

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	symptoms of shortness of breath daily ... Interventions: oxygen as ordered by MD or as a nursing measure ..." On 10/28/2021 at 2:34 p.m., the Administered provided the facility's policy, "Oxygen Administration" with a revised date of 10/2020, and indicated this was the policy currently being used by the facility. A review of the policy did not indicated following MD orders when administering oxygen ..." 3.1-47(a)(6)		**DON/designee oxygen audit tool.** **4. Monitoring of corrective actions taken:** The Quality Assurance and Improvement committee will review compliance of F 695 for oxygen use and corrective actions as indicated at least quarterly during the scheduled quarterly meetings. Following two (2) quarterly quality assurance compliance reviews and no resident oxygen usage without physician order concerns, the committee will discuss revisions to the oxygen audit frequency. **5.** Date of Compliance: November 16, 2021.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-			

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	(i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must			

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	contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review, the facility failed to ensure staff accurately documented in the clinical record a pressure ulcer skin assessment for a resident with an identified pressure ulcer for 1 of 4 resident reviewed for pressure ulcer/injury. (Resident 9) Findings include: On 10/25/21 at 12:29 p.m., Resident 9's clinical record was reviewed. Diagnoses included but were not limited to: Alzheimer's disease, osteoarthritis, hemiplegia (weakness of one side of body) and hemiparesis (paralysis of one side of body), and dementia. Resident 9's admission evaluation, dated 10/5/21, indicated the resident was admitted with a stage 3 (full thickness skin loss) pressure ulcer to their right heel. Resident 9's skin assessment, dated 10/13/21, indicated the resident had a stage 3 pressure ulcer to their right heel. Resident 9's skin assessment, dated 10/21/21, indicated the resident had a stage 3 pressure ulcer	F 0842	**F842-Residents Records-Identifiable Information** **The facility does ensure staff accurately document in the clinical record a pressure ulcer assessment.** **1. Corrective action taken:** Regarding Resident #9. The Residents right heel wound began at another facility and started as a DTI (Deep Tissue Injury). The wound had downgraded to a stage 3 pressure injury prior to discharge. The resident's care plan had not been updated yet as the facility just reopened, and care plans were being reviewed. The Director of Nursing had identified this discrepancy and was awaiting the assessment to be updated. This deficiency did not affect the resident's treatment as it was treated as a stage 3 pressure ulcer.	11/16/2021

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	to their right heel. Resident 9's skin assessment, dated 10/28/21, indicated the resident had a stage 3 pressure ulcer to their right heel. An undated care plan for Resident 9 indicated, "Pressure ulcer to right heel. DTI [Deep Tissue Injury]." A review of progress notes indicated the resident the resident had a DTI wound to the right heel upon admission. Resident 9's Progress notes indicated the following: -On 10/5/21, "...Skin issue: Deep Tissue Pressure Injury (DTPI). Skin Issue Location: rt [right] heel ..." -On 10/13/21, "...Skin issue: Deep Tissue Pressure Injury (DTPI). Skin Issue Location: right medial heel pressure ulcer ..." -On 10/21/21, "...Skin issue: Deep Tissue Pressure Injury (DTPI). Skin Issue Location: right medial heel ..." -On 10/27/21, "...Skin issue: Deep Tissue Pressure Injury (DTPI). Skin Issue Location: right medial heel ..." Resident 9's admission MDS (Minimum Data Set) assessment, dated 10/6/21, indicated the resident was admitted with a stage 3 pressure ulcer. During an interview, on 10/28/21 at 12:58 p.m., the Assistant Director of Nursing indicated the resident did not have a deep tissue injury, and		**2. How other residents were identified:** All residents with pressure ulcers will be audited for assessment accuracy. **3. Measures in place/system changes:** The Director of Nursing (DON)/designee(s) will audit all residents in the facility who have pressures ulcers weekly for a period of six months. **4. Monitoring of corrective actions taken:** The Quality Assurance and Improvement committee will review compliance of F 842 for accuracy of assessments and corrective actions as indicated at least quarterly during the scheduled quarterly meetings. Following two (2) quarterly quality assurance compliance reviews and no concerns with inaccuracy of assessments, the committee will discuss revisions to the pressure ulcer audit frequency. **5.** Date of Compliance: November 16, 2021.	

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	documentation which indicated the stage 3 pressure ulcer was a DTI was inaccurate. 3.1-50(a)(2)			