STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155254	A. BUILDING 00 B. WING	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE GREENFIELD	5430 W US 40 GREENFIELD, IN 46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included Investigation of Complaints IN00439061, IN00439795, and IN00440705. Complaint IN00439061- No deficiencies related to the allegations are cited. Complaint IN00439795- No deficiencies related to the allegations are cited. Complaint IN00440705- No deficiencies related to the allegations are cited. Survey dates: August 27, 28, 29, and 30, 2024 Facility number: 000157 Provider number: 155254 AIM number: 100274720 Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type: Medicare: 5 Medicaid: 43 Other: 4 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 6, 2024.	F 0000	**PLAN OF CORRECTION ON BEHALF OF APERION CARE GREENFIELD** **"This plan of correction constitutes the facility's written credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed solely because required by the provisions of the health and safety code section 1280 and 42 CFR 483". Facility operators reserve litigation rights of the truth of the facts alleged or the conclusion set forth in the Statement of Deficiencies".**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Adams	HFA	09/17/2024

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

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F 0558 SS=E Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences Based on observation, interview, and record review, the facility failed to ensure fluids were available at the bedside for 7 of 7 residents reviewed for accommodation of needs. (Residents 21,19, 30, 43, 41, 31, and 35) Findings include: 1. Resident 21's record, reviewed on 8/28/24 at 2:40 p.m., indicated diagnoses that included, but were not limited to, type 2 diabetes mellitus, schizoaffective disorder, bipolar, and dementia. During an observation and interview on 08/27/24 at 12:34 p.m., Resident 21 indicated no ice water was ever passed. Resident 21 indicated staff used to pass ice water at night, now if they wanted water, they got it themselves. A cup was located at Resident 21's bedside and was less than half full. Fresh ice water had not been passed, thus far, on 8/27/24. During an observation on 08/29/24 at 10:26 a.m., a Styrofoam cup was on the bedside table with "8/28" written on it. Another empty cup was sitting on the bedside table. An Admission Minimum Data Set (MDS) assessment, dated, 7/19/24, indicated Resident 21 was cognitively intact for daily decision making. Resident 21 had a care plan, dated 6/30/24, indicating to encourage fluids. 2. Resident 31's record, reviewed on 8/28/24 at 2:41 p.m., indicated diagnoses that included, but were	F 0558	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** **Residents 21, 19, 30,43,41,31, and 35 did not have any adverse effects related to this alleged deficient practice. Those residents were provided fluids at their bedsides.** **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** **All other residents have the potential to be affected by this alleged deficient practice.** **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** **All residents will be provided with fluids at their bedside unless contraindicated, such as NPO. Staff were in-serviced on the Hydration policy and procedure on 9/3/24.** **How The Corrective Action(s)**	09/17/2024

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	not limited to, chronic obstructive pulmonary disease, cerebral infarction, heart failure, and schizophrenia. During an observation on 8/28/24 at 10:47 a.m., Resident 31 did not have any water at the bedside. During an observation on 8/29/24 at 10:33 am., Resident 31 had no cup of water at the bedside. 3. Resident 35's record, reviewed on 8/28/24 at 2:43 p.m., indicated diagnoses that included, but were not limited to, fibromyalgia, alcoholic cirrhosis, chronic obstructive pulmonary disease, bipolar, anxiety, and hepatic encephalopathy. During an observation and interview on 8/27/24 at 1:31 p.m., Resident 35 had no water at the bedside. Resident 35 indicated, "we rarely ever get fresh ice water and definitely not daily". During an observation on 8/29/24 at 10:33 a.m., Resident 35 had no cup of water at the bedside. A Quarterly MDS assessment, dated 8/20/24, indicated Resident 35 was cognitively intact. 4. Resident 41's record, reviewed on 8/28/24 at 2:38 p.m., indicated diagnoses that included, but were not limited to, acute respiratory failure, encephalopathy, paraplegia, type 2 diabetes, anemia, and hypertension. During an observation and interview on 8/28/24 at 10:38 a.m., Resident 41 had no water at the bedside. They indicated there was never any drinking water brought in the room. Resident 41 indicated the only water in the room was the one to flush out the feeding tube.		**Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** DON/Designee will monitor fluids at bedside in resident rooms daily on scheduled workdays times 4 weeks, then 2 times per week times 4 weeks, then weekly times 4 weeks. **Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and/or 100% compliance and plan will be adjusted accordingly.**	

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	During an observation on 8/29/24 at 10:36 a.m., Resident 41 had no water at the bedside. During an observation on 8/30/24 at 10:01 a.m., Resident 41 had no water at the bedside. An Admission MDS assessment, dated 7/16/24, indicated Resident 41 was cognitively intact. 5. Resident 43's record, reviewed on 8/28/24 at 2:37 p.m., indicated diagnoses that included, but was not limited to, hemiplegia and hemiparesis following a cerebral infarction, acute respiratory failure, aphasia, and hypertension. During an observation and interview on 8/27/24 at 1:48 p.m., Resident 43 indicated there was no water at the bedside. They hardly had any ice water brought into their room. During an observation on 8/29/24 at 10:31 a.m., Resident 43 had no water at the bedside. During an observation on 08/30/24 10:47 a.m., Resident 43 had no water cup at the bedside. Resident 43 indicated, "they did come in one time yesterday with a cup of fresh water, but no one has been in today". A MDS assessment, dated, 8/19/24, indicated Resident 43 was cognitively intact. During an interview on 08/29/24 at 10:37 a.m., Certified Nursing Assistant (CNA) 10 indicated she typically passed water to the residents in the morning, but it depended on how busy it was and how long showers took. If the staff don't pass ice water in the morning, they attempt to get it done after lunch or before the shift ended. 6. The clinical record for Resident 19 was reviewed			

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	on 8/30/2024 at 1:30 p.m. The medical diagnoses included stroke. A Quarterly MDS assessment, dated 7/26/2024, indicated Resident 19 was cognitively impaired and needed set-up assistance for daily tasks of eating. During an observation on 8/27/2024 at 11:45 a.m., Resident 19 was sitting in a wheelchair in his room. Resident 19 had no fluids available in the room. A clear plastic cup was on the floor under the bed. During an observation on 8/29/2024 at 1:46 p.m., Resident 19 was sitting in a wheelchair is his room. Resident 19 had no fluids available in his area of the room. 7. The clinical record for Resident 30 was reviewed on 8/31/2024 at 11:05 a.m. The diagnoses included Alzheimer's disease. An Annual MDS assessment, dated 7/26/2024, indicated Resident 30 was cognitively impaired and was dependent on staff for daily tasks of eating. During an observation on 8/27/2024 at 1:35 p.m., Resident 30 was sitting in a wheelchair in her room. Resident 30 had no fluids available in the room. During an observation on 8/29/2024 at 2:20 p.m., Resident 30 was sitting in a wheelchair in her room. Resident 30 had no fluids available in her area of the room. During an interview on 8/27/2024 at 2:05 p.m., CNA 17 indicated staff had no time to pass fluids			

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	this shift yet. Residents were able to get fluids with meals and if they requested it. During an interview on 8/30/2024 at 1:30 p.m., the Executive Director indicated all staff can pass fluids, but the direct care staff were primarily responsible to pass fresh fluids to residents' rooms every shift unless clinically contraindicated. A policy entitled, "Water Pass- Hydration", was provided by the Social Service Director on 8/30/2024 at 2:10 p.m. The policy indicated that fresh cold ice water would be provided to each resident at a minimum of three times a day. 3.1-3(v)(1)			
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment Based on observation, interview, and record review, the facility failed to provide a homelike environment for 2 of 12 residents reviewed for a clean environment. (Resident 43 and Resident 31) Findings include: 1. Resident 43's clinical record, reviewed on 8/28/24 at 2:47 p.m., indicated diagnoses that included, but were not limited to, type 2 diabetes mellitus, alcoholic cirrhosis of the liver, and schizophrenia. During an observation on 8/27/24 at 1:43 p.m., Resident 43's bathroom floor was sticky to walk on, a bedpan, uncovered, with an open bag of adult diapers were laying on the floor, and there was paint peeling off the walls behind the bed	F 0584	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** **Res 43 room has been painted. Res 31 and 43s bathroom was deep cleaned and organized.** **Residents 43 and 31 did not have any adverse effects related to this alleged deficient practice.** **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will**	09/17/2024

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	frames. During an interview on 8/30/24 at 2:00 p.m., the Executive Director (ED) indicated she was aware of the paint peeling on the wall. The ED indicated the two residents in the room kept moving their beds around and [scuffing] up the paint on the wall. The ED indicated maintenance had been in the room to repaint it several times. 2. Resident 31's clinical record, reviewed on 9/30/24 at 12:46 p.m., indicated diagnoses that included, but were not limited to, chronic obstructive pulmonary disease, cerebral infarction, heart failure, and hypertension. During an observation on 8/28/24 at 10:48 a.m., Resident 31's bathroom floor had a Styrofoam cup, lid, straw, wash basin and toilet paper on it. During an observation on 08/30/24 at 12:00 p.m., Resident 31's toilet bowl lid was off the toilet and sitting on the bathroom floor. An open toilet paper roll and a wash basin were laying on the floor. During an interview on 08/30/24 at 02:11 p.m., the ED indicated the resident had just taken the toilet bowl lid off and it was now back in place. A care plan, revised 3/7/24, indicated Resident 31 will be provided with a homelike environment. An admission packet included resident rights provided by the ED, on 8/28/24 at 10:45 a.m., indicated, "...you have the right to a safe, clean, comfortable, and homelike environment..." 3.1-19(f)(5)		**Be Taken:** **All other residents have the potential to be affected by this alleged deficient practice.** **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** **Res 43 room has been painted. Res 31 and 43s bathroom was deep cleaned and organized.** **Maintenance Director and housekeeping staff were in-serviced over Quality of Life-Homelike Environment policy and procedure on 9/3/24.** **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** **Housekeeping Supervisor/Designee will monitor cleanliness and Maintenance Director/Designee will monitor general condition of 3 different rooms 3 times a week times 3 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QAPI**	

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			committee monthly for minimum of 6 months and/or 100% compliance and plan will be adjusted accordingly.	
F 0600 SS=E Bldg. 00	483.12(a)(1) Free from Abuse and Neglect Based on interview and record review, the facility failed to ensure residents were free from physical abuse for 5 of 5 residents reviewed for abuse. (Residents 2, 13, 31, 33, and 45) Findings include: 1. The clinical record for Resident 45 was reviewed on 8/28/24 at 12:15 p.m. Her diagnoses included, but were not limited to, dementia and major depressive disorder. She was admitted to the facility on 11/6/23 from another facility. The 8/1/24 Quarterly Minimum Data Set (MDS) assessment indicated she was severely cognitively impaired. An interview was conducted with Family Member 2 on 8/28/24 at 12:29 p.m. She indicated Resident 45 was transferred to her current facility from another facility. Family Member 2 received a voicemail from the previous facility that Resident 45 was being transferred the following day. By the time Family Member 2 received the voicemail, Resident 45 was already transferred to her current facility. Resident 45 had behaviors daily. She was combative and hallucinated. Another male resident smacked her at the facility about a month ago.	F 0600	**F600** **What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice?** **R**esidents 2, 13, 31, 33, and 45 were not affected by this alleged deficient practice. Psychosocial assessments completed on 9-17-24 showing no signs/symptoms of psychosocial distress. **How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken?** **All residents have the potential to be affected by this alleged deficient practice.** **What measures will be put into place or systemic changes will be made to ensure that the**	09/17/2024

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	The potential for aggressive behaviors care plan, revised 7/29/24, indicated the goal was for Resident 45 to not harm herself, residents, or others. 2. The clinical record for Resident 31 was reviewed on 8/30/24 at 12:00 p.m. Her diagnoses included, but were not limited to, bipolar disorder, depression, psychotic disorder, and schizophrenia. The behavior care plan, revised 2/29/24, indicated she had behaviors directed towards others. The goal was for her to not show behaviors of yelling, hitting, and throwing items. The investigative file into a resident to resident altercation between Resident 45 and Resident 31 was provided by the DON (Director of Nursing) on 8/30/24 at 8:40 a.m. The file included an incident report dated 3/11/24. The report indicated, on 3/11/24, Resident 45 was sitting at the dining room table drinking her coffee when Resident 31 wheeled up behind Resident 45 in her wheelchair hitting Resident 45 with open hand on her back. Resident 45 then stood up and they both began swinging at each other making contact with each other's face and arms. Head to toe assessments were completed on both residents. Both residents were placed on one to one supervision. The file included three, undated, documented interviews conducted by the Executive Director (ED) with the (ADON) Assistant Director of Nursing, (QMA) Qualified Medication Aide 3, and (CNA) Certified Nursing Assistant 4. The undated, documented interview with the		**alleged deficient practice does not occur?** **Staff were in-serviced on Abuse and Abuse prevention and behavior monitoring on 9-4-24. Staff will receive on going education on observing residents with increased agitation and aggression and interventions to assist with redirection.** **4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur?** **DON/designee will complete staff questions and education on 5 staff members weekly x 3 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan will be adjusted accordingly**	

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	ADON read, "I was the nurse on duty. I immediately separated the residents, assessed, notified families. Admin [Administrator] present made aware." The undated, documented interview with QMA 3 read, "I heard a lot of noise in the hallway. When I ran around the corner ADON was taking care of the problem. I assisted with getting [name of another resident] out the dining room. Admin came and asked what happened so was made aware." The undated, documented interview with CNA 4 read, "I seen the two women swinging at each other. I ran and helped pull them away from each other. Admin and ADON present and helped." 3. The clinical record for Resident 2 was reviewed on 8/30/24 at 12:02 p.m. His diagnoses included, but were not limited to, dementia and schizophrenia. The behavior care plan, revised 5/25/24, indicated he had physical aggression towards others. The goal was for him to have a decrease in episodes of physical abuse or yelling out towards others with redirection from staff. The investigative file into a resident to resident altercation between Resident 2 and Resident 45 was provided by the DON (Director of Nursing) on 8/30/24 at 8:40 a.m. The file included an incident report dated 7/1/24. The report indicated, on 6/30/24, Resident 2 was sitting in his wheelchair trying to get outside to smoke and Resident 45 was sitting in her wheelchair in the way. Resident 2 attempted to move Resident 45 and when Resident 45 asked			

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him to leave her alone, Resident 2 swung with an open hand making contact with her left eye. Head to toe assessments were completed on both residents. Resident 2 was placed on one to one supervision.

The file included two undated, documented interviews conducted by the ED with LPN (Licensed Practical Nurse) 5 and LPN 6.

The undated, documented interview with LPN 5 read, "I was the nurse on duty. I yelled for help to separate the residents, assessed, notified families. Admin [Administrator] just left so I called her to inform. She came back and started talking to residents and staff."

The undated, documented interview with LPN 6 read, "I was standing in the dining room, assisting the staff for smoke break. I helped [name of LPN 5] separate and assess the residents. I was standing next to [name of LPN 5] when he called Admin."

4. The clinical record for Resident 13 was reviewed on 8/30/24 at 12:04 p.m. Her diagnoses included, but were not limited to, schizoaffective disorder, major depression, and anxiety.

The investigative file into a resident to resident altercation between Resident 13 and Resident 45 was provided by the DON (Director of Nursing) on 8/30/24 at 8:40 a.m.

The file included an incident report dated 7/25/24. The report indicated, on 7/25/24, Resident 13 was in her wheelchair rolling down the hallway where she got too close to Resident 45. Resident 45 reacted by swinging with an open hand making contact with the back of Resident 13's head. Both residents were separated and assessed. Resident

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	45 was placed on one to one supervision. The 7/29/24 follow up section indicated both residents were seen by their physicians. The file included three, undated, documented interviews conducted by the ED with QMA 7, the ADON, and CNA 8. The undated, documented interview with QMA 7 read, "I heard [names of Resident 45 and Resident 13] got into it but I was down getting report so I didn't see anything. I didn't assist with anything. Admin [Administrator] was present and handling situation." The undated, documented interview with the ADON read, "I was walking past the MDR [main dining room] when I saw [name of Resident 45] swing and hit [name of Resident 13.] I separated them with the help of admin and staff. Notified M.D. [Medical Director], families, and completed assessments. Assisted with 1:1s [one to one supervision]..." The undated, documented interview with CNA 8 read, "I heard a lot of noise coming from the dining room, as soon as I turned the corner the ADON was already there. I helped get [Resident 13] out of the dining room. Admin was also in the dining room helping." 5. The clinical record for Resident 33 was reviewed on 8/30/24 at 12:06 p.m. His diagnoses included, but were not limited to, traumatic brain injury, bipolar disorder, and depression. The 7/29/24 investigative file into a resident to resident altercation between Resident 31 and Resident 33 was provided by the Housekeeping Supervisor on 8/30/24 at 8:55 a.m.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE GREENFIELD	5430 W US 40 GREENFIELD, IN 46140

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	The file included an incident report dated 8/5/24. The report indicated, on 7/29/24, both residents were in the hallway in their wheelchairs. Resident 33 was passing by Resident 31 when Resident 31 reached over and slapped Resident 33 in the face and back of the head. Both residents were immediately separated and assessed. Neurological checks were initiated on Resident 33. The 8/5/24 follow up section indicated Resident 31 was seen by her physician and medications were adjusted. The file included three, undated, documented interviews conducted by the ED with LPN 6, Staff Member 50, and CNA 9. The undated, documented interview with LPN 6 read, "I heard a lot of noise so I can [sic] around the corner. I didn't witness it but was made aware by staff and admin [Administrator.] I assessed resident and made notifications to families and M.D. Admin was present so I didn't report to anyone." The undated, documented interview with Staff Member 50 read, "I was in the dining room when it happened. I got [name of Resident 33] while another staff member got [name of Resident 31.] Admin came around the corner and asked what happened and I told her." The undated, documented interview with CNA 9 read, "I hurried up and grabbed [name of Resident 31] and got her out the dining room. Admin came around the corner and assisted with the incident." An interview was conducted with the ED on 8/30/24 at 9:52 a.m. She indicated after investigating, she substantiated resident to resident abuse for all four altercations, as she was			

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	present for most of them, and all four of them were witnessed by staff. The Abuse Prevention and Reporting policy was provided by the SSD (Social Services Director) on 8/29/24 at 12:23 p.m. It read, "This facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services by staff or mistreatment. This facility therefore prohibits abuse, neglect, exploitation, misappropriation of property, and mistreatment of residents....Abuse: Abuse means any physical or mental injury or sexual assault inflected upon a resident other than by accidental means. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish to a resident....Physical Abuse is the infliction of injury on a resident that occurs other than by accidental means and that requires medical attention. Physical abuse includes hitting, slapping, pinching, kicking, and controlling behavior through corporal punishment." 3.1-27(a)(1)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on interview and record review, the facility failed to maintain documentation Resident 5's representative was provided with a bed hold policy for 1 of 1 resident reviewed for hospitalization. Findings include: The clinical record for Resident 5 was reviewed on	F 0625	**F625** **What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice?** **Res 5 was not affected by this alleged deficient practice. SSD went over the bed hold policy**	09/17/2024

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	8/29/24 at 2:34 p.m. The diagnoses included stroke. A Quarterly Minimum Data Set (MDS) assessment, dated 6/28/24, indicated Resident 5 was cognitively intact. The census flowsheet for Resident 5 indicated a therapeutic leave from 7/22/24 to 7/26/24. During an interview on 8/30/24 at 1:45 p.m., Resident 5 indicated he did not know what a bed hold policy was and did not receive any paperwork prior to going to the hospital in July of 2024. During an interview on 8/30/24 at 3:20 p.m., the Executive Director indicated the staff could not find the bed hold policy for Resident 5's July hospitalization. The expectation was nursing staff would provide the bed hold policy at the time of transfer to the resident or their representative. A blank copy of the "Bed Hold Policy Notice" was provided, on 8/30/24 at 3:20 p.m., by the Executive Director. The policy contained the availability to indicate when a resident was unable to sign, copy mailed to representative, and a place for resident signature. 3.1-12(a)(25)(A) 3.1-12(a)(25)(B)		**with resident 5 on 9-12-24.** **How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken?** **All residents have the potential to be affected by this alleged deficient practice** **How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken?** **An audit was completed on residents who transferred to the hospital.** **Nursing staff and SSD were in-serviced on 9-12-24 on the bed hold policy.** **How will the corrective action be monitored to ensure the alleged deficient practice will not occur?** **SSD/designee will audit all residents who are transferred to the hospital weekly x 4 weeks, then biweekly x 2 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan will be adjusted accordingly.**	

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F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility failed to accurately encode Minimum Data Set (MDS) information for 2 of 19 residents reviewed from MDS accuracy. (Resident 5 and Resident 19) Findings include: 1. The clinical record for Resident 5 was reviewed on 8/29/24 at 2:34 p.m. The diagnoses included bipolar disorder. An Admission MDS assessment, dated 2/1/24, indicated that Resident 5 did not have a PASARR (Preadmission Screening and Resident Review) Level II. A PASARR Level II, dated 6/21/19, indicated Resident 5 had a serious mental illness but did not need specialized services. During an interview on 8/30/24 at 11:45 a.m., the Social Services Director indicated Resident 5 had a serious mental illness and the most current Level II was the one dated 6/21/19. 2. The clinical record for Resident 19 was reviewed on 8/30/2024 at 1:30 p.m. The medical diagnoses included chronic obstructive pulmonary disease. A Quarterly MDS assessment, dated 7/26/24, indicated Resident 19 did not have a prognosis of six months or less but received hospice services. A hospice care plan, revised on 3/13/24, indicated	F 0641	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** **Residents 5 and 19 were not affected by this alleged deficient practice. MDS for resident 5 dated 2/1/24 has been modified to reflect PASARR level II and MDS for resident 19 dated 7/26/24 has been modified to show correct hospice status.** **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** **All other residents have the potential to be affected by this alleged deficient practice.** **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** **MDS audit was completed**	09/17/2024

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	Resident 19 received hospice care. A certification of terminal illness for Resident 19 provided, on 8/30/24 at 10:45 a.m., by the Executive Director indicated a terminal diagnosis with a life expectancy of six months or less if the disease runs its projected course. During an interview, on 8/30/24 at 12:45 p.m., the MDS Nurse indicated the aforementioned assessments for Resident 5 and Resident 19 were coded incorrectly due to oversight. A policy entitled, "Resident MDS Assessment and Care Planning Standard", was provided by the Social Services Director on 8/30/24 at 2:10 p.m. The policy indicated all assessments are to be completed timely and accurately for the Resident Assessment Instrument Manual.		**9/12/24** **MDS Coordinator, and SSD were in-serviced on 9/3/24 over MDS policy and procedure with focus on checking accuracy of assessment before signing their responsible MDS section.** **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** **MDS Coordinator/Designee will monitor assessment accuracy quarterly with each MDS assessment prior to submitting the MDS on-going. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan will be adjusted accordingly.**	
F 0645 SS=D Bldg. 00	483.20(k)(1)-(3) PASARR Screening for MD & ID Based on interview and record review, the facility failed to ensure Resident 11 had a completed Preadmission Screening and Resident Review	F 0645	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient**	09/17/2024

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	(PASARR) prior to admission to the facility for 1 of 3 residents reviewed for PASARR. Findings include: The clinical record for Resident 11 was reviewed on 8/30/24 at 12:15 p.m. The diagnoses included schizophrenia. An Admission Minimum Data Set (MDS) assessment, dated 2/1/24, indicated Resident 11 did not have a PASARR Level II. Per the Indiana State Department of Family and Social Services Administration, all applicants to Medicaid-certified nursing facilities in Indiana are entered in the state's web-based PASARR system, and a Level I screen is completed to initiate the PASARR process. If indicated, a PASARR Level II evaluation is performed to identify the specialized needs of individuals with mental illness (MI), intellectual or developmental disability ID/DD, or both (MI/ID/DD). A PASARR Level I for Resident 11, dated 1/24/19, indicated that Resident 11 needed an on-site Level II review. During an interview on 8/30/24 at 12:55 p.m., the Social Service Director (SSD) indicated the facility did not have documentation for a Level II completed for Resident 11 after 1/24/2019. The SSD indicated the facility received an influx of residents around the time Resident 11 admitted and that the Level II was not completed due to oversight. A policy entitled, "Preadmission Screening and Annual Resident Review (PASARR)", was provided by the Director of Nursing on 8/30/24 at		**Practice:** **Resident 11 did not have any adverse effects related to this alleged deficient practice. Level II PASARR was completed for resident 11 on 9/12/24** **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** **All other residents have the potential to be affected by this alleged deficient practice.** **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** **An audit was completed on all residents currently residing at the facility for Level I and Level IIs.** **SSD was in-serviced on 9/3/24 over Level I and Level II PASARR policy and procedure. SSD will be responsible for completing Level I and Level II PASARR's for current residents and all new admissions.** How The Corrective Action(s) Will Be Monitored To Ensure The	

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	8:40 a.m. The policy indicated, " ...The facility will participate in or completed the Level I screen for all potential admissions regardless of payer source ...Based on the Level I, if an individual is determined to meet the above criterion, the facility will not admit and individual, the facility will refer the potential admission to the State PASARR representative for a Level II screening process ..." 3.1-16(d)(1)		Deficient Practice Will Not Recur: /b>	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review, the facility failed to hold regularly scheduled care plan meetings for 1 of 2 residents reviewed for care planning. (Resident 45) Findings include: The clinical record for Resident 45 was reviewed on 8/28/24 at 12:15 p.m. Her diagnoses included, but were not limited to, dementia and major depressive disorder. She was admitted to the facility, on 11/6/23, from another facility. The 11/6/23 nursing note read, "Resident is a new admit from [name of previous facility,] came to the facility via facility van. Resident is alert to name but confused with place where she is and time of day..." The 8/1/24 Quarterly Minimum Data Set (MDS) assessment indicated she was severely cognitively impaired. An interview was conducted with Family Member 2 on 8/28/24 at 12:29 p.m. She indicated Resident 45 was transferred to her current facility from	F 0657	**What corrective Action will be accomplished for those residents found to have been affected by the alleged deficient practice?** **Resident 45 had a care plan meeting on 9-12-24 was invited but declined to attend.How will other residents having the same potential to affected by the alleged deficient practice be identified and what corrective action will be taken?** **All other residents have the potential to be affected by this alleged deficient practice.What measures will be put into place or systemic changes will be made to ensure that the alleged deficient practice does not occur?An audit was completed on care plan invitations/meetingsSSD was in-serviced on 9/4/24 the need to provide and invite residents/family to care plan**	09/17/2024

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	another facility. Family Member 2 received a voicemail from the previous facility that Resident 45 was being transferred the following day. By the time Family Member 2 received the voicemail, Resident 45 was already transferred to her current facility. Family Member 2 received several phone calls about missed appointments from a local hospital provider regarding missed oncology, optometry, and diabetic clinic appointments. She hadn't had any scheduled care plan meetings with the current facility to discuss these things. The electronic health record (EHR) indicated Resident 45 had a, 11/14/23, Admission MDS assessment and, 5/1/24, Quarterly MDS assessment, but no corresponding care plan meetings were found. The 4/29/24, 3:12 p.m. care plan invite note indicated there would be a care plan meeting held, on 5/23/24, and that Family Member 2 was planning on attending. There was no information in the clinical record indicating the, 5/23/24, care plan meeting ever took place. An interview was conducted with the Social Services Director (SSD) in the presence of the ADON (Assistant Director of Nursing) on 8/30/24 at 11:08 a.m. The SSD indicated they held care plan meetings for residents quarterly. The meetings were documented in the EHR under a care plan meeting note. He was out of the facility in May 2024, so he couldn't speak as to whether the, 5/23/24, care plan meeting was held. He reviewed Resident 45's clinical record and indicated he did not see actual verification the, 5/23/24, care plan meeting was held, and there was no verification of a, November 2023, care plan		**meetings.MDS/DON/ADON/SSD was in-serviced on 9/4/24 over the comprehensive Care plan policy to include the importance of documentation of meeting within residents charts.4. How will the corrective action be monitored to ensure the alleged deficient practice will not occur? SSD/designee will audit up to 5 care plan invitations and documentation of care plan meetings weekly x 3 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan will be adjusted accordingly.**	

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	meeting held, or verification of family invitation to a meeting after Resident 45's, 11/6/23, admission to the facility. He'd spoken to Family Member 2 on the phone previously, but he had no knowledge of any missed appointments. The Comprehensive Care Plan policy was provided by the (DON) Director of Nursing on 8/30/24 at 10:30 a.m. It read, "A comprehensive care plan must be...Prepared by an interdisciplinary team that includes but is not limited to...To the extent practicable, the participation of the resident and the resident's representative(s). An explanation should be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan....The resident and/or resident representative shall be invited to review the plan of care with the interdisciplinary team either in person, via telephone or video conference (if available) at least quarterly. As a best practice, thee interdisciplinary team should attempt to schedule an initial meeting with the resident and/or resident representative within 5 days of admission to review the baseline plan of care and make updates or revisions as indicated based on feedback and input of the resident and/or representative prior to the development of the comprehensive care plan." 3.1-35(d)(2)(B)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident Based on observation, interview, and record review, the facility failed to follow scheduled activities calendar or provide outside activities for	F 0679	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient**	09/17/2024

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	3 of 3 residents reviewed for activities. (Resident 34, Resident 41, and Resident 35). Findings include: 1. Resident 35's record, reviewed on 8/28/24 at 2:43 p.m., indicated Resident 35 had diagnoses that included, but were not limited to, fibromyalgia, type 2 diabetes, alcoholic cirrhosis, chronic obstructive pulmonary disease, and alcohol abuse. A Quarterly Minimum Data Set (MDS) assessment for Resident 35, dated 8/20/24, indicated he was cognitively intact for daily decision making. During an interview on 8/27/24 at 1:16 p.m., Resident 35 indicated that the activities director did not offer a variety of activities. "We were supposed to play cards one day, which it was on the activities calendar, but no one had any cards, so we couldn't play". Resident 35 had requested to go on outings with the facility, but the facility told him no, because they do not have enough transportation for all the residents. 2. Resident 41's clinical record, reviewed on 8/28/24 at 2:38 p.m., indicated diagnoses that included, but were not limited to, acute respiratory failure, encephalopathy, major depressive disorder, and hypertension. An Admission MDS assessment, dated 7/16/24, indicated Resident 41 was cognitively intact for daily decision making. During an interview on 8/28/24 at 10:30 a.m., Resident 41 indicated he wanted to leave the facility for outings, but they did not provide it. Resident 41 indicated they do not get to go		**Practice:** **Residents 34,35, and 41 were not affected by this alleged deficient practice. Residents will have an ongoing activity program that meets their needs. Psychosocial assessments were completed on 9-17-24 showing no signs/symptoms of psychosocial distress. How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** **All residents have the potential to be affected by this alleged deficient practice** **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:Activity Director and activity staff were in-serviced on 9/4/24 over Activities policy and procedure.Activities director will ensure that the monthly calendar is being followed and outside activities has been added to the calendar. How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:Activity Director/Designee will monitor activity program calendar on scheduled workdays weekly times 4 weeks, then every 2**	

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	anywhere, and it was upsetting to him. Resident 41 had a care plan, dated 2/3/24, and indicated he enjoyed anything outdoors and enjoyed going outside when the weather was nice. During an interview on 8/30/24 at 10:52 a.m., the Activities Director (AD) indicated the facility had not been able to leave or go on outings because they only had a small van that held three to four people and one wheelchair. The AD indicated the facility had not been out in the community since February 2024. The AD indicated the residents can go outside during smoking hours. 3. The clinical record for Resident 34 was reviewed on 8/28/24 at 1:00 p.m. His diagnoses included, but were not limited to, hemiplegia and hemiparesis, cerebral vascular accident, and hypertension. He was admitted to the facility on 1/25/22. The August 2024 Activity Calendar was posted on the wall in the hallway outside of the dining room. It indicated on 8/28/24 at 11:00 a.m. Daily Chronicle was scheduled and Church with (name of volunteer) was scheduled for 8/28/24 at 11:15 a.m. On observation of residents, including Resident 34, in the main dining room was made on 8/28/24 from 11:11 a.m. to 11:15 a.m. There was no Daily Chronicle or Church with (volunteer name) activity occurring. The television was playing a national news network, but none of the residents, including Resident 34, were watching. There was no substitute activity occurring in place of the Church activity. Resident 34 was sitting at a table. Drinks were being passed by staff, but no activities were occurring.		**weeks times 2 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan will be adjusted accordingly.**	

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	The 8/13/24 Significant Change MDS assessment indicated he was cognitively intact. An interview was conducted with Resident 34 in his room on 8/28/24 at 1:03 p.m. He indicated they didn't really do group activities in the facility, except bingo twice a week. He was unaware of what the "Daily Chronicle" activity, referenced on the August 2024 activity calendar daily, actually was. The Church activity, referenced for 11:15 a.m. today was a volunteer activity, but the volunteer didn't come today. The August 2024 Activity Calendar, posted on the wall in the hallway outside of the dining room, indicated manicures was scheduled for 8/29/24 at 2:30 p.m. An observation of the dining room was made on 8/29/24 at 2:38 p.m. There was one resident receiving a manicure by activity staff. There were ten other residents sitting in the dining room, with no other activity, music, art project, or anything occurring. The television was playing a national news network, but none of the residents were watching, and it was not turned up loud enough to be heard throughout the dining room. An interview and observation was conducted with Resident 34 in his room on 8/29/24 at 2:42 p.m. He was watching television. He indicated he had no interest in doing manicures. As far as activities outside of the facility, there was a fishing activity back in May or June 2024, but that was the last time they left the facility to attend an activity. He would like for the facility to have more activities outside of the facility. Resident 34's activity care plan, revised 8/29/24,			

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	did not reference his preference for activities away from the facility. It referenced inviting him to go outdoors to get fresh air, but not activities away from the facility. The August 2024 Activity Calendar, posted on the wall in the hallway outside of the dining room, did not include any activities away from the facility. The Activities Program policy was provided by the DON (Director of Nursing) on 8/30/24 at 8:40 a.m. It read, "Purpose: To provide an ongoing program of activities designed to appeal to the residents' interests and to enhance his or her highest practicable level of physical, mental, and psychosocial well-being. Guidelines: The Activity Director, trained staff, or volunteer will: 1. Identify and involve each resident in an ongoing program of activities that is designed to appeal to his or her interests and needs....3. A minimum of 4-7 organized activities will be scheduled daily...7. The program of activities will include a system that allows thee activity staff to develop, implement, and evaluate the resident's interests and involvement in the activities provided and adjust the daily programming as needed in order to meet the needs of the residents." 3.1-33(a) 3.1-33(b)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview, observation, and record review, the facility failed to date a dry dressing to a skin impairment (Resident 1) and failed to complete skin assessment as care planned	F 0684	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:**	09/17/2024

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	(Resident 34) for 2 of 2 residents reviewed for skin impairments. Findings include: 1. The clinical record for Resident 1 was revied on 8/30/24 at 1:50 p.m. The medical diagnoses included schizophrenia. A Quarterly Minimum Data Set assessment, dated 8/15/24, indicated that Resident 1 was cognitively impaired. Resident 1 needed minimal to substantial assistance for activities of daily living and was at risk for developing skin alternations. A nursing assessment, dated 8/20/24, indicated that Resident 1 was at high risk of skin alternations. A wound evaluation, dated 8/28/24, indicated Resident 1 had a non-pressure wound to the scalp with undetermined thickness from a fall. Measurements for the wound were 3 centimeters (cm) x 2 cm x "Not Measurable". A skin care plan, revised 8/28/24, indicated Resident 1 had an abrasion to the forehead. An intervention indicated to provide treatment as ordered. A physician order, dated 8/28/24, indicated to cover area to Resident 1's right forehead with a dressing daily. During an observation, on 8/28/24 at 1:55 p.m., Resident 1 had a white dry dressing on the right side of the forehead. The dressing did not indicate a date, time, or initials of the staff member which had applied the dressing.		**Residents 1 and 34 were not affected by this alleged deficient practice. Resident 1 dressing was changed and dated. Skin assessment was completed on resident 34** **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** **All residents have the potential to be affected by this alleged deficient practice** **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** **An audit was completed on residents receiving wound dressing. An audit was completed on weekly skin assessments to ensure dressings were dated.** **Licensed nurses were in-serviced on 9/4/24 over The skin Condition assessments and monitoring policy to include weekly skin assessments and dating dressings.**	

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	During an observation, on 8/29/24 at 12: 20 p.m., Resident 1 was in the main dining room. Resident 1 had a white dry dressing on the right side of the forehead. The dressing did not indicate a date, time, or initials of the staff member which had applied the dressing. During an observation, on 8/29/24 at 2:00 p.m., Resident 1 was laying in bed. Resident 1 had a white dry dressing on the right side of the forehead. The dressing did not indicate a date, time, or initials of staff. LPN 13 verified that the dressing did not contain date, time, or initials of the staff member which had applied the dressing. LPN 13 stated that she would "change the dressing" and did not know when it was last changed. 2. The clinical record for Resident 34 was reviewed on 8/24/24 at 1:00 p.m. His diagnoses included, but were not limited to, hemiplegia and hemiparesis, cerebral vascular accident, and hypertension. He was admitted to the facility on 1/25/22. The 8/13/24 Significant Change Minimum Data Set assessment indicated he was cognitively intact. An interview and observation was conducted with Resident 34 in his room on 8/28/24 at 1:14 p.m. He indicated, "I have these dark spots all over my arms," for the past three weeks. "They say it's from blood thinners." Resident 34 had dark reddish, brown spots of various shapes covering both forearms. The physician's orders indicated for one tablet of Clopidogrel Bisulfate (antiplatelet medication used to prevent heart attacks and strokes) 75 milligrams (mg) to be administered one time a day for stroke,		**How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** **ADON/Designee will monitor 5 wound dressings and 5 residents skin assessments weekly x 4 weeks, then every 2 weeks for 2 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan will be adjusted accordingly.**	

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	starting 8/24/24. The 8/7/24 antiplatelet therapy care plan indicated an intervention was, "Daily skin inspection. Report abnormalities to the nurse," initiated 8/7/24. The electronic health record (EHR) indicated one skin assessment was completed thus far in August 2024. It was dated 8/6/24 and referenced bruising to his abdomen. It did not reference his arms. There were no subsequent skin assessments for August 2024 in the EHR. An interview was conducted with the DON (Director of Nursing) on 8/29/24 at 10:27 a.m. She indicated skin assessments were completed weekly and on shower days. The assessments should be documented in the EHR under the assessments tab. The DON reviewed Resident 34's EHR at this time and indicated she only saw the, 8/6/24, skin assessment. She was unaware who was responsible for the daily skin inspections referenced in his, 8/7/24, antiplatelet therapy care plan, but they should also be documented in the EHR. She would look further into this. An interview was conducted with the DON on 8/29/24 at 2:05 p.m. She indicated she did not have verification of any other skin assessments for Resident 34 in August 2024 beyond the, 8/6/24, assessment and no verification of any daily skin assessments, as care planned. The Skin Condition Assessment & Monitoring policy was provided by the DON on 8/30/24 at 8:40 a.m. It read, "Purpose: To establish guidelines for assessing, monitoring and documenting the presence of skin breakdown,			

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	pressure injuries and other non-pressure skin conditions and assuring interventions are implemented. Guidelines: ...Non-pressure skin conditions (bruises/contusions, abrasions, lacerations, rashes, skin tears, surgical wounds, etc.) will be assessed for healing progress and signs of complications or infection weekly....Residents identified will have a weekly skin assessment by a licensed nurse. A wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA (Certified Nursing Assistant.) Changes shall be promptly reported to the charge nurse who will perform the detailed assessment....Wound Assessment/Measurement: ...3. Dressings which are applied to pressure ulcers, skin tears, wounds, lesions or incisions shall include the date of the licensed nurse who performed the procedure. Dressing will be checked daily for placement, cleanliness, and signs and symptoms of infection." 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision Based on observation, interview, and record review, the facility failed to ensure optometry services were provided timely to a resident who consented to receive optometry services for 1 of 3 residents reviewed for vision or hearing services. (Resident 34) Findings include:	F 0685	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** **Resident 34 will be seen by the optometrist on 9/24/2024** **How Other Residents Having The Potential To Be Affected**	09/17/2024

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	The clinical record for Resident 34 was reviewed on 8/28/24 at 1:00 p.m. His diagnoses included, but were not limited to, hemiplegia and hemiparesis, major depressive disorder, and hypertension. He was admitted to the facility on 1/25/22. The 2/9/22 ancillary services care plan, revised 7/15/24, indicated he consented to receive optometry services through the facility's optometry provider with interventions for him to be seen by the appropriate provider to ensure any issue was resolved. The 10/30/22 physician's order indicated he may be seen by the optometrist, as needed. The 8/12/24 Ancillary Services Assessment form indicated Resident 34 needed assistance with corrective lenses. The 8/13/24 Significant Change Minimum Data Set assessment indicated he was cognitively intact. An observation and interview were conducted with Resident 34 in his room on 8/28/24 at 1:10 p.m. He indicated he currently wore reading glasses, but used to wear regular glasses, and thought he needed to wear regular glasses now. Resident 34 was not wearing any glasses during the interview. There were no optometry consultations in Resident 34's clinical record. An interview was conducted with the SSD (Social Services Director) on 8/29/24 at 10:33 a.m. The SSD indicated they'd worked at the facility since November 2023. The facility used a specific provider for optometry services. The optometry		**By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** **All residents have the potential to be affected by this alleged deficient practice** **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** **An audit of optometrist appointments was conducted to ensure timely service for Optometry for any resident that consented** **The social worker was in-serviced on the provision and coordination of ancillary services including optometry services on 9/12/24** **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** **SSD/Designee will monitor 5 residents in need of optometrist appointments weekly x 4 weeks, then every 2 weeks for 2 months. Any negative findings will be corrected**	

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	provider gathered consent forms and scheduled appointments for residents. The optometry provider remained in touch with the SSD to let them know when they would be coming to the facility. At each MDS assessment, the SSD would reach out to their optometry provider, if the resident needed services. The optometry provider was in the facility on 8/19/24, but Resident 34 was not seen at that visit. The SSD reviewed the upcoming optometry list, but Resident 34 was not on it. The SSD reviewed Resident 34's clinical record at this time and indicated he did not see that Resident 34 had received optometry services in the facility, at least since he'd worked there. The On-Site Health Care Services policy was provided by the SSD on 8/29/24 at 12:23 p.m. It read, "It is the policy of the facility to assist residents in arranging health services on site as needed per resident request. Standards: 1) Facility will make appointments for ancillary services as requested by resident. 2) On-Site services available: ...c) Optometry." 3.1-39(a)(1)		**immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan will be adjusted accordingly.**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview, observation, and record review, the facility failed to complete quarterly smoking assessments for 1 of 1 resident reviewed for smoking safety. (Resident 23) Findings include: The clinical record for Resident 23 was reviewed on 8/29/24 at 2:00 p.m. The diagnoses included chronic obstructive pulmonary disease.	F 0689	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** **Resident 23 was not affected by this alleged deficient practice. Smoking assessment was completed on resident 23 on 9-12-24**	09/17/2024

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	An Annual Minimum Data Set assessment, dated 7/30/24, indicated Resident 23 was cognitively intact and utilized tobacco products. A smoking care plan, revised 12/5/23, indicated Resident 23 was a cigarette smoker with an intervention of smoking assessment upon admission, quarterly and as needed. During an interview on 8/30/24 at 2:15 p.m., the Executive Director indicated the staff could not locate the quarterly smoking assessment for Resident 23 for the last year. Activities and social services were to split the duty of completing smoking assessments. A policy entitled, "Smoking Safety", was provided by the Social Service Director on 8/30/24 at 8:40 a.m. The policy indicated smoking assessment will be completed at the time of admission, quarterly, and as needed. 3.1-45(a)(2)		**How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** **All residents have the potential to be affected by this alleged deficient practice.** **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** **Smoking assessment audit was completed** **Nursing staff, activities director, and SSD were in-serviced on 9/4/24 on the smoking safety policy which is to be completed upon admission, quarterly, and as needed.** **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** **Activities Director will monitor smoking assessments on 5 residents weekly x 4 weeks, then every 2 weeks x 2 months. Any negative findings will be**	

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			corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan will be adjusted accordingly.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based in interview, observation, and record review, the facility failed to supervise a dependent resident with administration of an aerosol generating procedure for 1 of 1 reviewed for respiratory care. (Resident 30) Findings include: The clinical record for Resident 30 was reviewed on 8/30/24 at 11:05 a.m. The diagnoses included Alzheimer's disease. An Annual Minimum Data Set assessment, dated 7/26/24, indicated Resident 30 was cognitively impaired. Resident 30 was dependent on staff for all activities of daily living. A respiratory care plan, revised 8/19/24, indicated Resident 30 had altered respiratory status related to a diagnosis of asthma with an intervention of administer medications as ordered. A physician order, dated 6/19/24, indicated to administer an aerosolized medication to Resident 30 every six hours.	F 0695	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** **Resident 30 was not affected by this alleged deficient practice. New tubing was obtained and nurse was present to complete administration of aerosol treatment.** **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** All residents receiving aerosol treatments have the potential to be affected by this alleged deficient practice. **What Measures Will Be Put Into Place and What Systemic**	09/17/2024

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	During an observation on 8/27/24 at 1:46 p.m., Resident 30 was sitting in a wheelchair in the resident's room. A nebulizer was running with the tubing detached from the face mask and the mask was placed under Resident 30's chin. During an observation and interview on 8/27/24 at 1:48 p.m., Licensed Practical Nurse (LPN) 13 was at the nurses' station. LPN 13 entered Resident 30's room to find Resident 30 with the nebulizer detached with the face mask pulled under Resident 30's chin. LPN 13 stated, "[Resident 30] pulls [Resident 30's] treatment off all the time." LPN 13 stated, Resident 30 should "probably" be supervised during administration of aerosolized medication and was not able to self-administer the aerosolized treatment. LPN 13 retrieved new tubing then completed administration of the aerosol treatment. A policy entitled, "Nebulizer- Medication Administration", was provided by the Director of Nursing on 8/30/24 at 8:40 a.m. The policy indicated staff will " ...Remain with the resident for the treatment unless the resident has been assessed and authorized to self- administer ..." 3.1-47(a)(6)		**Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** **Nursing staff were in-serviced on 9/4/24 over the Nebulizer-Medication administration policy to address that a licensed nursing staff must remain with residents while administering aerosol treatments unless a resident has been assessed, authorized to self administer and Plan of Care updated to reflect this assessment.** **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** **DON/Designee will monitor 5 residents on aerosol treatments weekly times 4 weeks, then every 2 weeks x 2 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan will be adjusted accordingly.**	
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals			

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Bldg. 00		F 0761	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** **No residents were affected by this alleged deficient practice. Medication storage rooms have been audited, expired supplies have been disposed of, and new supplies were obtained.** **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** **All residents have the potential to be affected by this alleged deficient practice.** **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** **Licensed nursing staff were in-serviced on 9/4/24 over Medication Storage policy and procedure to include medical supplies that have an**	09/17/2024

Based on observation, interview, and record review, the facility failed to ensure medication storage rooms did not contain expired supplies for 2 of 2 medication rooms observed. (Facility)

Findings include:

An observation conducted of Medication Storage Room 2, on 8/28/24 at 9:40 a.m., indicated a urinary catheter with expiration of 2022 and a box of tuberculin syringes with expiration of 2023.

An observation conducted of Medication Storage Room 1 with Registered Nurse (RN) 12, on 8/28/24 at 9:45 a.m., indicated a box of tuberculin safety syringes expired, on 4/30/23, and six safety syringes with an expiration date of 3/1/24. RN 12 indicated there was a supply room with all needed medical supplies and the medication storage rooms would consist of medical supplies needed for the daily tasks. It was the nurses' responsibility to check the medication storage rooms to ensure the supply items were not expired.

A policy titled Medication Storage, revised 7/2/19, was provided by the Executive Director on 8/28/24 at 2:10 p.m. The policy indicated, "...4. Facility should ensure that medications and biologicals that: (1) have an expired date on the label...are stored separate from other medications until destroyed or returned to the supplier...."

3.1-25(j)

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			expiration date. **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** **DON/Designee will monitor medication storage rooms for expired medical supplies weekly times 4 weeks, then every 2 weeks for 2 months. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan will be adjusted accordingly.**	
F 0770 SS=D Bldg. 00	483.50(a)(1)(i) Laboratory Services Based on interview and record review, the facility failed to ensure Resident 19 had a routine lab drawn per physician order for 1 of 1 resident reviewed for laboratory services. Findings include: The clinical record for Resident 19 was reviewed on 8/30/24 at 1:30 p.m. The medical diagnoses included hypothyroidism.	F 0770	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** **Res 5 was not affected by this alleged deficient practice. Res 5 thyroid level will be drawn on 9/17/24.** **How Other Residents Having**	09/17/2024

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	A Quarterly Minimum Data Set assessment, dated 7/26/24, indicated Resident 19 was cognitively impaired. A physician order, dated 5/23/24, indicated routine labs every six months to review Resident 19's thyroid levels. A nursing progress note, dated 5/23/24, indicated lab was unable to obtain blood for the routine tests and "Will try next lab day ..." During an interview, on 8/30/24 at 2:15 p.m., the Executive Director indicated that the facility could not find where the labs were obtained for Resident 11's thyroid levels in May of 2024. The thyroid level lab was "missed" in May 2024. The nursing staff was responsible for obtaining labs per physician order. A policy entitled, "Physician Notification of Laboratory/Radiology/Diagnostic Results," was provided by the Social Services Director on 8/30/24 at 2:10 p.m. The policy indicated the purpose of the policy was to, " ...assure physician ordered diagnostic tests are performed ..." 3.1-49(a)		**The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** **All residents have the potential to be affected by this alleged deficient practice.** **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** **A lab audit was completed to ensure Labs were scheduled as ordered.** **Nursing staff was in-serviced on 9-12-24 on the Physician Notification of Laboratory/Radiology/Diagnosti c Results policy.** **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** **ADON/designee will audit 5 residents lab results weekly on scheduled work days x 4 weeks, then every other week x 8 weeks. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to**	

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			the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan will be adjusted accordingly.	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs Based on observation, interview, and record review, the facility failed to ensure dental services were provided timely to a resident with no bottom dentures for 1 of 2 residents reviewed for dental status and services. (Resident 34) Findings include: The clinical record for Resident 34 was reviewed on 8/28/24 at 1:00 p.m. His diagnoses included, but were not limited to, hemiplegia and hemiparesis, major depressive disorder, and hypertension. He was admitted to the facility on 1/25/22. The 2/25/22 ancillary services consent form indicated Resident 34 consented to receiving dental services in the facility. The 2/9/22 dentures care plan, revised 7/15/24, indicated he wore upper dentures with an intervention to refer to the dentist routinely and as needed. The 10/30/22 physician's order indicated he may be seen by the dentist, as needed. The 8/12/24 Ancillary Services Assessment form indicated Resident 34 needed assistance with	F 0791	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** **Resident 34 was not affected by this alleged deficient practice. Resident 5 has a scheduled dental appointment on 9/17/24** **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** **All residents have the potential to be affected by this alleged deficient practice** **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** **An audit was completed to ensure timely dental services are provided.**	09/17/2024

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	dental or dentures. The 8/13/24 Significant Change MDS (Minimum Data Set) Assessment indicated he was cognitively intact. An observation and interview were conducted with Resident 34 in his room on 8/28/24 at 1:09 p.m. He indicated he had top dentures but needed bottom dentures. He hadn't seen the dentist at all since he'd been in the facility. Resident 34 was wearing his top dentures but had no bottom dentures. There were no dental consultations in Resident 34's clinical record. An interview was conducted with the SSD (Social Services Director) on 8/29/24 at 10:33 a.m. The SSD indicated they'd worked at the facility since November 2023. The facility used a specific provider for dental services. The dental provider gathered consent forms and scheduled appointments for residents. The dental provider remained in touch with the SSD to let them know when they would be coming to the facility. At each MDS assessment, the SSD would reach out to their dental provider, if the resident needed services. The SSD thought the dental provider was in the facility within the last few months but was not sure of the date. The SSD reviewed Resident 34's clinical record at this time and indicated he did not see that Resident 34 had received dental services in the facility, at least since he'd worked there. The Dental Services and Loss or Damage of Dentures policy was provided by the SSD on 8/29/24 at 12:23 p.m. It read, "The facility will, if necessary or requested by the resident, assist		**SSD was in-serviced on ancillary services on 9-12-24** **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** **SSD/designee will audit 5 residents dental services weekly on scheduled workdays, then every other week x 8 weeks. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan will be adjusted accordingly.**	

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	with scheduling appointments for dental services, arranging for transportation to and from the dental services location and promptly refer residents with lost or damaged dentures for dental services." The On-Site Health Care Services policy was provided by the SSD on 8/29/24 at 12:23 p.m. It read, "It is the policy of the facility to assist residents in arranging health services on site as needed per resident request. Standards: 1) Facility will make appointments for ancillary services as requested by resident. 2) On-Site services available: ...e) Dental." 3.1-24(a)(1) 3.1-24(a)(3)			
F 0814 SS=F Bldg. 00	483.60(i)(4) Dispose Garbage and Refuse Properly Based on observation, interview, and record review, the facility failed to ensure trash was contained within the dumpster and lids were closed on the dumpster for 52 of 52 residents in the facility. Findings include: A tour of the kitchen was conducted with the DM (Dietary Manager) on 8/27/24 at 11:15 a.m. During the tour, an observation was made of the outside dumpster area. There were two dumpsters next to each other located near the outside dry storage food shed. Each dumpster had two lids. The left lid of the left dumpster, when facing the dumpsters, was completely opened. There was a clear bag of trash on the ground to the left of the	F 0814	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** **No residents were affected by this alleged deficient practice.** **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** **All residents have the potential to be affected by this alleged deficient practice.**	09/17/2024

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	left dumpster. There was a blue glove on the ground to the right of the left dumpster. There were several bags of trash inside of the opened dumpster. An interview was conducted with the DM during observation of the outside dumpster area. She indicated she was unable to reach the dumpster door. On 8/28/24 at 10:04 a.m. and 8/29/24 at 11:28 a.m., the same dumpster lid as reference in the 8/27/24, 11:15 a.m. kitchen tour was observed open again. The Garbage and Rubbish Disposal policy was provided by the MDSC (Minimum Data Set Assessment Coordinator) on 8/30/24 at 10:52 a.m. It read, "Procedure: 4. All containers will be provided with tight-fitting lids or covers, and will be leak proof and waterproof....8. Outdoor trash receptacles will be kept covered and the surrounding area kept free of litter." 3.1-21(i)(5)		**What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** **Staff were inserviced on the Garbage and Rubbish Disposal policy.** **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** **Admin/designee will audit the outside trash receptacles weekly on scheduled workdays, then every other week x 8 weeks. Any negative findings will be corrected immediately. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan will be adjusted accordingly.**	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to place soiled linen in bags when transported through the hallway; ensure soiled linen was contained in soiled utility bins located in the hallway of the facility; and ensure PPE (personal protective equipment) was	F 0880	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** **Residents 5,11,29,30,36,45 and 150 were not affected by this**	09/17/2024

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	properly discarded after resident care, prior to leaving the room for 2 of 2 soiled utility bins randomly observed; 1 of 1 random observation of soiled linen transportation by staff; and 7 of 7 residents who were or resided in rooms with a roommate who were in EBP (enhanced barrier precautions). (Residents 5, 11, 29, 30, 36, 45, and 150) Findings include: On 8/27/24 at 1:10 p.m., an observation of a soiled linen bin in the hallway was made. There was unbagged, soiled linen hanging out of the bin. The unbagged, soiled linen was piled so high within the bin, that the lid was unable to be closed and was resting on top of the soiled linen. On 8/29/24 at 10:16 a.m., an observation of a soiled linen bin in the hallway near the social services office was made. There was white linen hanging out of the bin, draped over the side. The linen hanging out of the bin was not contained within the bin or within a bag. An interview was conducted with CNA (Certified Nursing Assistant) 10, who happened to be in the area of the above referenced soiled linen bin, on 8/29/24 at 10:16 a.m. She indicated they brought the soiled linen from the residents' rooms and placed them into the bins in the hallway, as they did not bring the bin itself into residents' rooms. At the end of their shift, they brought the soiled linen bins into the soiled linen room. On 8/29/24 at 3:45 p.m., an observation of CNA 11 was made. She walked down the hallway from the employee breakroom area towards the dining room with a trash bag and a cloth bed pad partially rolled up in her gloved hand. There was a brown		**alleged deficient practice. How were they proven not to be affected? Psychosocial assessments completed 9-17-24 showing no psychosocial distress.** **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will Be Taken:** **All residents residing in the facility have the potential to be affected.** **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** **Staff were in-serviced on 9-12-24 on the Linen Handling Principles policy and Donning/doffing PPE policy** **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** **DON/Designee will complete daily IP rounds on scheduled workdays x 4 weeks, then weekly x 8 weeks that include**	

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	substance on the floor in three spots in the area located between the employee break room and the nurses' station. LPN 6 was observed to bend over and pick up the brown substances from the floor. An interview was conducted with LPN 6 on 8/29/24 at 3:45 p.m. She indicated she didn't know what the brown substance was and just "picked it up." On 8/30/24 at 10:19 a.m., an observation of a soiled linen bin in the hallway near the beauty shop was made. There was unbagged, soiled linen hanging out of the bin. The unbagged, soiled linen was piled so high within the bin, that the lid was unable to be closed and was resting on top of the soiled linen. An interview was conducted with CNA 4 on 8/30/24 at 10:19 a.m. during the above observation. He indicated the soiled linen was supposed to be in a bag. They bagged the soiled linen in the residents' room, then put it into the soiled linen bin in the hallway. He stated, "I'm not sure why this isn't in a bag." On 8/27/24 at 11:12 a.m., an observation of an uncovered trash receptacle in the hallway outside of Resident 5's room was made. The receptacle had no lid and there was trash visible inside of the receptacle. There was a sign on the doorway indicating this room was being utilized by a resident who was in EBP (enhanced barrier precautions-infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.) On 8/27/24 at 1:05 p.m., an observation of an		**monitoring of soiled linen, ensuring trash bins lids are closed, and proper disposal of PPE. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan will be adjusted accordingly.**	

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	uncovered trash receptacle in the hallway outside of Resident 5's room was made. The receptacle had no lid and there was used PPE (personal protective equipment,) including gowns and gloves visible inside of the receptacle. On 8/27/24 at 1:05 p.m., an observation of an uncovered trash receptacle in the hallway outside of Resident 11's and Resident 30's room was made. The receptacle had no lid and there was trash visible inside of the receptacle, including used PPE. There was a sign on the doorway indicating this room was being utilized by a resident who was in EBP. On 8/27/24 at 1:09 p.m., an observation of an uncovered trash receptacle in the hallway outside of Resident 36's and Resident 150's room was made. The receptacle had no lid and there was trash visible inside of the receptacle, including used PPE. There was a sign on the doorway indicating this room was being utilized by a resident who was in EBP. On 8/27/24 at 1:11 p.m., an observation of an uncovered trash receptacle in the hallway outside of Resident 29's and Resident 45's room was made. The receptacle had no lid and there was trash visible inside of the receptacle, including used PPE. There was a sign on the doorway indicating this room was being utilized by a resident who was in EBP. An interview was conducted with the ADON (Assistant Director of Nursing) on 8/27/24 at 1:07 p.m. He indicated staff were doffing their PPE in the hallway and throwing it away in the uncovered trash receptacles. He did not know where the lids to the trash receptacles were, but the receptacles should probably be covered.			

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	The Linen Handling Principles policy was provided by the Social Services Director on 8/30/24 at 2:10 p.m. It read, "Purpose: To ensure proper handling of soiled and clean linen and personal laundry to prevent the spread of microorganisms. Guidelines: ...8. Soiled linen hampers shall be transported to the Laundry Department on a regular schedule to prevent overflowing by assigned personnel....10. Soiled linens shall be carefully removed from beds, rolled inward, and placed directly into plastic bag or soiled linen containers, at the location of use and not transported openly through corridors (unless in plastic bag.)" 3.1-18(b)(1)(A) 3.1-18(b)(2) 3.1-18(j)			
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program Based on interview and record review, the facility failed to ensure an antibiotic was appropriate for the treatment of a urinary tract infection (UTI) for 1 of 2 residents reviewed for antibiotic therapy. (Resident 45) Findings include: The clinical record for Resident 45 was reviewed on 8/30/24 at 11:30 a.m. The diagnoses included, but were not limited to, dementia, psychotic disorder, and recurrent UTIs. A progress note, dated 7/9/24 at 4:31 a.m., indicated a urine specimen was obtained for a urinalysis with culture and sensitivity (a	F 0881	**What Corrective Action(s) Will Be Accomplished For Those Residents Found To Have Been Affected By The Deficient Practice:** **Resident 45 was not affected by this alleged deficient practice.** **MD was notified, resident asymptomatic, no new orders received.** **How Other Residents Having The Potential To Be Affected By The Same Deficient Practice Will Be Identified And What Corrective Action(s) Will**	09/17/2024

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	diagnostic test to identify and quantify the microorganisms present in a urine sample and determine their sensitivity to various antibiotics). A physician note, dated 7/10/24, indicated a possible concern for a UTI. The urine culture was pending, and if the results were not available (on 7/10/24), the plan was to start Macrobid 100 milligrams twice daily for 7 days. A care plan, initiated 7/11/24, indicated Resident 45 had a UTI. The interventions included, but were not limited to, administer antibiotic therapy as prescribed and monitor laboratory results. A progress note, dated 7/12/24 at 10:31 p.m., indicated Resident 45 was being treated for a UTI with Macrobid 100 milligrams twice daily until 7/17/24. The urinalysis and culture with sensitivity resulted. The Nurse Practitioner was notified and indicated to continue Macrobid treatment, as previously ordered, for a UTI. A lab result, reported 7/12/24, indicated a urinalysis along with culture and sensitivity was completed. The culture indicated the organism as "PROETUS MIRABILIS". The culture and sensitivity did not have Macrobid as an antibiotic listed to determine if it was "sensitive", "resistant", or "intermediate". An article published by the National Institutes of Health under National Library of Medicine, dated December of 2011, was reviewed on 8/30/24 at 3:20 p.m. The article indicated the following, "...Nitrofurantoin [generic drug name and Macrobid and Macrodantin both contain the drug nitrofurantoin, but in different forms] is active against most common uropathogens, but most Proteus species...are naturally resistant...If urine		**Be Taken:** **All residents have the potential to be affected by this alleged deficient practice** **What Measures Will Be Put Into Place and What Systemic Changes Will Be Made To Ensure That The Deficient Practice Does Not Recur:** **MD and NP in-serviced on antibiotic stewardship and McGreer criteria on 9-11-24** **Nursing staff was in-serviced on the Antibiotic Stewardship program on 9-12-24.** **How The Corrective Action(s) Will Be Monitored To Ensure The Deficient Practice Will Not Recur:** **ADON/designee will audit antibiotic usage daily on scheduled workdays x 4 weeks, then weekly x 8 weeks. Any negative findings will be corrected immediately and forwarded to the Administrator. A report of progress will be forwarded to the QA Committee monthly for a minimum 6 months and/or 100% compliance and plan will be adjusted accordingly.**	

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	cultures are positive for Proteus species...an alternate agent should be selected...." A policy titled Antimicrobial Stewardship Program, undated, was provided by the Minimum Data Set (MDS) Nurse on 8/30/24 at 12:00 p.m. The policy indicated the following, "...Antibiotic Stewardship Program (ASP). This program will promote appropriate use of antibiotics in our facility...This multidisciplinary team will regularly review appropriateness of antibiotic courses and make recommendations for adjustment in practice where necessary...monitor and report patterns of antibiotic use and resistance...."			