STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF CARMEL	12315 PENNSYLVANIA STREET CARMEL, IN 46032

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: October 18, 19, 20, 21, 24 and 25, 2022 Facility number: 013444 Provider number: 155833 AIM number: 201294880 Census Bed Type: SNF/NF: 22 SNF: 28 Residential: 24 Total: 74 Census Payor Type: Medicare: 15 Medicaid: 20 Other: 15 Total: 50 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 31, 2022.	F 0000	The submission of this plan of correction does not indicate an admission by Wellbrooke of Carmel the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Wellbrooke of Carmel. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance effective November 18, 2022 with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview and record review, the facility failed to ensure the IDT	F 0554	**F554**	11/18/2022

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

Timothy Yale | Executive Director | 11/18/2022

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	(Interdisciplinary Team) determined which medications may be self-administered and failed to ensure a physician's order to use and keep medications at the bedside was obtained for 1 of 1 resident reviewed for self administration. (Resident 201) Findings include: During an observation and interview, on 10/18/22 at 12:10 p.m., Resident 201 was observed, in her room, lying in bed. Next to her was an over the bed table with a bottle of ibuprofen, vitamin D and a nerve supplement. She indicated her daughter had brought in the medication for her to use. She was not aware of whether she was able to keep medications in her room. During an observation and interview, on 10/20/22 at 10:46 a.m., the Director of Nursing (DON) indicated on the over the bed table Resident 201 had a bottle of Flonase nasal spray, ibuprofen 200 milligrams (mgs), omega 3 and a bottle of nerve supplement. She was unaware if Resident 201 had a self-administration assessment completed or an order was obtained for self-administration of medications. She removed all the medications from Resident 201's room and indicated all medications should be secured in the medication cart. The record for Resident 201 was reviewed. Diagnoses included, but were not limited to, repeated falls, fracture of the fifth lumbar vertebra, atrial fibrillation (irregular heart rhythm), dementia with behavioral disturbances, pneumonia (infection within the lungs), chronic kidney disease (kidneys are damaged and can't filter blood the way they should.), factor VIII deficiency (genetic disorder caused by missing or defective clotting protein) and hyponatremia (low blood		1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice: **Medications were immediately removed from the resident's room after discovery of their delivery by a family member.** 2:¿ How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:¿ **All residents are subject to potentially having nonprescribed medications in their possession. Residents and/or their representatives are/will be informed of the necessity of physician/practitioner orders for retention of medications at the bedside and self-administration. All such requests must be channeled through nursing staff to ensure compliance. This is incorporated into admission**	

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	sodium levels). A care plan, dated 10/14/22, indicated Resident 201's medications were to be administered by facility staff per the physician's order. The physician's orders lacked indication the resident had an order for the self-administration of medications or she had been prescribed Ibuprofen, Flonase, Nerve Supplement or Omega prior to 10/20/22. During an interview, on 10/20/22 at 11:05 a.m., the Corporate Support Nurse (CSN) indicated no medications or supplements should be left at a resident's bedside. All medications and supplements should be locked up in the medication cart. If a resident was going to self-administer medication, a self-administration assessment must be completed and an order obtained by the physician. A current facility policy, titled "Guidelines for Self-Administration of Medications," dated with a revision date of 5/22/18, indicated the purpose was to ensure the safe administration of medication for residents who request to self-medicate or when self-medication is a part of the plan of care. Results of the assessment would be presented to the physician for evaluation and an order for self-medication would be obtained. Medication would be kept in a locked drawer in the resident's room. 3.1-11(a)		**documents.** **¿** /b> **Training will be administered to all nursing personnel with direct-care duties advising them to be aware of medications found in resident rooms. They will immediately confer with nurses/supervisors to determine if residents have appropriate physician orders for same. If not, medications will be removed and directed to managers for dialogue with physician/representatives.** 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? **The Director of Nursing or designee will inspect 5 resident rooms 5 days per week for the next four weeks, then three rooms per week for the next four weeks, then two rooms per**	

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			week for the subsequent four weeks. Any identified findings will generate further education of nursing staff members and/or reprimands for compliance . **Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.** **/b>/b>** **!--[if !supportAnnotations]-->**	
F 0578 SS=E Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed			

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	medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.			
	Based on interview and record review, the facility failed to ensure an advance directive was reviewed, obtained or updated to reflect admitted residents' current wishes for 6 of 55 residents who were reviewed for advance directives. (Resident 26, 42, 46, 100, 200 and 201). Findings include:	F 0578	**F578** 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice: **Cited residents' code status/advance directives were reconciled to reflect desired plans during the**	11/18/2022

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	1. On 10/20/22 at 2:08 p.m., during a random observation, Resident 26 was confused to date, time, and place. She was not able to be interviewed. The record for Resident 26 was reviewed on 10/24/22 at 8:52 a.m. Diagnoses included, but were not limited to, cardiomegaly (an enlarged heart), arthritis, depression and anxiety. Resident 26's record indicated on her banner at the top of her EMR (electronic medical record) screen and face sheet, she wanted all resuscitation procedures if her heart stopped beating and/or she stopped breathing (full code status). A care plan, dated 8/27/21, indicated the resident had a full code status and in an event Resident 26 had a cardiac arrest initiate Cardiopulmonary Resuscitation (CPR) and contact Emergency Medical Services (EMS). A review of the document, titled "Out of Hospital Do Not Resuscitate Declaration and Order," indicated the form was signed and dated, on 8/20/21, by Resident 26. A physician's order, dated 10/21/22 at 3:10 p.m., indicated Resident 26 had a do not resuscitate (DNR) status. A review of a facility document, titled "Code Status Audit," dated 10/19/22, lacked indication the facility found a discrepancy with Resident 26's code status between the banner, face sheet, care plan, the resident's Out of Hospital Do Not Resuscitate Declaration and Order and most current physician's order for DNR status.		**survey.** 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?: **All residents are subject to undesired results when advance directives/code status are not accurately recorded. Training will be completed for all admissions, administrative and nursing managers to appropriately ensure reconciliation of advance directives and related documents. The Executive Director will provide education in conjunction with established Policies and Procedures. He will collaborate with the Social Worker and Admissions Staff to ensure full understanding of processes/significance of accuracy.** ="" b=""> **The Social Worker will audit code status/advance directives of all newly admitted residents. Any discrepancies will be immediately called to the attention of managers for immediate correction. 100% of newly admitted residents will be audited for the next four weeks. Then following four weeks every other admission will be audited. One admission will be audited weekly for the subsequent four weeks.** 4: How the corrective action will be	

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	2. The record for Resident 42 was reviewed on 10/18/22 at 3:00 p.m. Diagnoses included, but were not limited to, rhabdomyolysis (breakdown of muscle tissue which releases a damaging protein into the blood), kidney failure (a condition in which the kidneys lose the ability to remove waste and balance fluids.) Resident 42's record indicated on her banner and face sheet, she had a full code status. A care plan, dated 9/23/22 and updated on 10/24/22, indicated Resident 42 had chosen the advance directive of DNR. Her care plan directed staff to honor her living will. A review of the document, titled "Out of Hospital Do Not Resuscitate Declaration and Order," indicated the form was signed and dated, on 9/22/22, by Resident 42. During an interview, on 10/18/22 at 2:45 p.m., Resident 42 indicated "Let me go, if it is my time." She did not want to be resuscitated if her heart were to stop. During an interview, on 10/19/22 at 10:32 a.m., the Social Service Director (SSD) indicated Resident 42's code status in her records had her as a full code status. The SSD indicated Resident 42 desired a DNR status. During an interview, on 10/19/22 at 10:40 a.m., the Director of Nursing (DON) indicated Resident 42's record and face sheet indicated she had a full code status, while the advance directive form indicated she desired a DNR status. A review of a facility document, titled "Code		monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? **Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes. b="">=="" b="">**	

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	Status Audit," dated 10/19/22, indicated the facility updated the order, face sheet and banner to reflect Resident 42 had chosen a DNR status. 3. The record for Resident 46 was reviewed on 10/19/22 at 9:17 a.m. Diagnoses included, but were not limited to, atrial fibrillation, fracture of the second cervical (neck) vertebrae and atherosclerotic heart disease (a buildup of cholesterol plaque in the walls of arteries causing obstruction of blood flow). Resident 46's record indicated on her banner and face sheet, she had a full code status. A physician's order, dated 9/25/22 at 5:46 p.m., indicated Resident 46 had full code status. A review of the document, titled "Out of Hospital Do Not Resuscitate Declaration and Order," indicated the form was signed and dated, on 10/4/22, by Resident 46's representative. During an interview, on 10/19/22 at 9:55 a.m., Resident 46 indicated "I do not want to be revived if my heart was to stop." During an interview, on 10/19/22 at 10:32 a.m., the SSD indicated Resident 46's code status in her records and order was a full code status. The SSD indicated Resident 46's advance directive indicated she had a DNR status. During an interview, on 10/19/22 at 10:40 a.m., the DON indicated Resident 46's record, face sheet and order indicated she had a full code status, while the advance directive indicated she desired DNR status. A review of a facility document, titled "Code			

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	Status Audit," dated 10/19/22, indicated the facility updated the order, face sheet and banner to reflect Resident 46 had chosen a DNR status. 4. The record for Resident 100 was reviewed on 10/19/22 at 8:15 a.m. Diagnoses included, but were not limited to, hepatitis, hypertensive urgency (elevated blood pressure), atrial fibrillation (irregular heart rhythm), chronic obstructive pulmonary disease (a lung disease which block airflow and make it difficult to breathe), heart failure (a chronic condition in which the heart doesn't pump blood well) and end stage renal disease (permanent kidney failure). Resident 100's record indicated on her banner, physician's order and her face sheet, she had a full code status. A review of the document, titled "Out of Hospital Do Not Resuscitate Declaration and Order," indicated the form was signed and dated, on 10/13/22, by Resident 100. A nurse progress note, dated 10/13/22 at 8:56 p.m., indicated Resident 100 had arrived in a private car and was cooperative with care. The progress note lacked indication Resident 100's code status was reviewed. A nurse progress note, dated 10/13/22, at 9:17 p.m. indicated an admission medication second check was completed. The progress note lacked indication Resident 100's code status was reviewed. A care plan, dated 10/16/22, directed staff to honor Resident 100's living will. Her care plan lacked indication, Resident 100 had requested a DNR status.			

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A care plan meeting progress note, dated 10/18/22 at 5:31 p.m., lacked indication Resident 100's advance directive or code status was reviewed.

A review of the document, titled "An Out of Hospital Do Not Resuscitate Declaration and Order," was signed and dated, on 10/19/22, by Resident 100.

A review of a facility document, titled "Code Status Audit," dated 10/19/22, indicated the facility updated the order, face sheet and banner to reflect Resident 100 had chosen a DNR status.

5. The record for Resident 200 was reviewed on 10/18/22 at 3:00 p.m. Diagnoses included, but were not limited to, diabetes and hypertension (high blood pressure).

The record lacked indication Resident 200 had an advance care directive or staff reviewed his code status upon admission.

A care plan, dated 10/11/22, and revised on 10/24/22, indicated Resident 200 had requested full code status. His care plan directed staff to honor Resident 200's living will.

A review of the document, titled "CPR (Cardiopulmonary) Consent," indicated the form was signed and dated, on 10/19/22, by Resident 200.

A review of a facility document, titled "Code Status Audit," dated 10/19/22, indicated the facility reviewed code status with Resident 200 and uploaded his consent.

6. The record for Resident 201 was reviewed on

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	10/19/22 at 10:12 a.m. Diagnoses included, but were not limited to, atrial fibrillation, Factor VIII inhibitor disorder (autoantibodies which affect clotting factor activity and lead to a bleeding disorder), hypotension (low blood pressure) and atherosclerotic heart disease. The record lacked indication Resident 201 had an advance care directive or staff reviewed his code status upon admission. A care plan, dated 10/6/22, and revised on 10/24/22, indicated Resident 201 had requested full code status. Her care plan directed staff to honor Resident 201's living will. A Social Service care plan meeting progress note, dated 10/10/22 at 4:21 p.m., indicated Resident 201's goal was to return home. The progress note lacked indication Resident 201's had an advance care directive or code status had been reviewed or obtained. A review of the document, titled "CPR (Cardiopulmonary) Consent," indicated the form was signed and dated, on 10/19/22, by Resident 201. A review of a facility document, titled "Code Status Audit," dated 10/19/22, indicated the facility reviewed code status with Resident 201 and uploaded his consent. During an interview, on 10/19/22 at 9:34 a.m., Licensed Practical Nurse (LPN) 3 indicated she could look three places in the Electronic Medical Record (EMR) for the resident's code status. The code status would be on the face sheet, banner or on the Medication Administration record.			

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	During an interview, on 10/19/22 at 9:38 a.m., a Nursing Assistant (NA) indicated she would follow the code status listed on the care profile. If she found a resident unresponsive, she would notify the nurse since she was not certified in CPR. During an interview, on 10/19/22 at 10:40 a.m., the DON indicated on the Code Status Audit Form, dated 10/19/22, four residents were found to be a Full Code, instead of the residents' wishes to be a DNR. Her expectation for staff would be to review the resident's advance directive or code status upon admission to the facility. The Admission Team or Admission Nurse would review the code status with the resident or the resident's representative and obtain the order from the physician. The code status would be reviewed during care meetings or care conferences. If an incident occurred, the staff would access the EMR to verify the code status by looking at the banner, order, care plan or care profile. During an interview, on 10/20/22 at 9:59 a.m., the Clinical Nurse Support (CNS) indicated since admission, Resident 201's record lacked indication the facility staff reviewed or obtained an advance directive or CPR consent form. A CPR Consent form was reviewed and signed by Resident 201, on 10/19/22. During an interview, on 10/21/22 at 2:00 p.m., the CNS indicated a resident's code status should be reviewed upon admission, at care conferences or as needed with any changes. Once the code status was obtained, it would be entered as an order in the EMR. A review of a facility document, titled "Indiana Admission Agreement Checklist," dated 5/1/19,			

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	indicated a CPR Consent or DNR form would be completed. A current facility policy, titled "Guidelines for Advanced Directives," dated as revised on 5/28/18, indicated Advance Directives would be reviewed with the resident and the resident's representative by the Customer Service representative or designee at time of admission. The facility staff obtained and followed the resident's advance directives regarding the end-of-life care. 3.1-4(f)(4)(A)(ii) 3.1-4(f)(4)(B) 3.1-4(f)(5)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to provide assistance with activities of daily living (ADL's), related to shaving, for 2 of 2 residents reviewed for ADL care. (Resident 42 and 46) Findings include: 1. During an observation and interview, on 10/18/22 at 2:45 p.m., Resident 42 had quarter - inch long, white-colored facial hair on her chin. Resident 42 indicated she took pride in her looks and wanted to present herself well. During an observation and interview, on 10/20/22 at 10:30 a.m., Resident 42 was found, in her room,	F 0677	**F677** **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice.** Female residents with facial hair were offered additional grooming at the time of the survey. Not all female residents tolerate facial shaving. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what**	11/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	10/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WELLBROOKE OF CARMEL	12315 PENNSYLVANIA STREET CARMEL, IN 46032

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	seated in her wheelchair. She was dressed and had more than 12 white chin hairs which measured more than a quarter inch long. Resident 42 indicated staff had not offered to shave her chin hairs. The record for Resident 42 was reviewed on 10/19/22 at 3:00 p.m. Diagnoses included, but were not limited to, rhabdomyolysis (a breakdown of muscle tissue which releases a damaging protein into the blood), pneumonia (infection in the lungs), history of falls and a left femur (thigh bone) fracture. Resident 42's Minimum Data Set (MDS) assessment, dated 9/23/22, indicated she required extensive assistance by one staff for personal hygiene, including shaving. A Care Area Assessment (CAA), dated 9/23/22, indicated Resident 42 triggered for activity for daily living (ADL) and required extensive assistance for grooming. A care plan, dated 9/26/22, indicated Resident 42 required staff to assist her to complete ADL tasks completely and safely. The care plan lacked indications to offer or provide assistance to Resident 42 to be shaved. The record lacked an indication Resident 42 refused or was offered to have her chin hairs shaved. During an interview, on 10/21/22 at 12:15 p.m., the Corporate Support Nurse indicated Resident 42 did not refuse or decline assistance with shaving. 2. During an observation, on 10/19/22 at 9:58 a.m., Resident 46 was seated, in her wheelchair, near		**corrective action will be taken: All residents may potentially need assistance with grooming to remove unwanted facial hair. When such is visible, nursing staff will be familiar with asking residents if they desire assistance with shaving. Those who wish to have excessive facial hair removed will be accommodated by caregivers.** **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All nursing staff were educated to observe for excessive facial hair. They will be trained to discretely inquire as to shaving preferences and will assist when indicated. The Director of Nursing or Designee will round to visually evaluate resident grooming on two alternating units **each week for four weeks**, then one unit will be **reviewed every other week for four weeks**, then **1 x per week for four weeks.**The Director of Nursing or Designee will identify any residents who are in need of grooming and advise direct-care team members. She or he will also provide additional training 1:1 education to ensure understanding of grooming standards. **4: How the corrective action will be monitored to ensure the**	

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	the nurse's station and wore a neck brace. On her chin, she had 10 white-colored facial hairs which measured a quarter inch long. During an interview, on 10/19/22 at 2:27 p.m., Resident 46 indicated her preference would be to not have the chin hairs and to look clean and neat. She was not physically able to shave herself. During an observation, on 10/20/22 at 1:30 p.m., Resident 46 was seated, in her wheelchair, in the doorway to her room with her neck brace on. She had 10 quarter inch long white chin hairs. The record for Resident 46 was reviewed on 10/21/22 at 2:45 p.m. Diagnoses included, but were not limited to, fracture of the second cervical (neck) vertebra, dementia, pain and a fall. Resident 46's admission MDS assessment indicated she required extensive assistance by one person for personal hygiene, including shaving. A Care Area Assessment (CAA), dated 10/7/22, indicated Resident 46 triggered for ADL and required extensive assistance for grooming. The record lacked an indication Resident 46 was offered or refused to have her chin hair shaved. During an interview, on 10/20/22 at 11:00 a.m., a Nursing Assistant (NA) indicated she had not asked or offered Resident 42 or Resident 46 if they preferred to be shaved when she assisted with their morning care. During an interview, on 10/21/22 at 10:14 a.m., the Corporate Support Nurse (CSN) indicated residents would be shaved on their shower days		**deficient practice will not recur i.e. what quality assurance program will be put into place?** Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes. **5. Date of completion: November 18, 2022**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	or as needed based on the resident's preferences. Staff should follow the resident's preferences which could be found on the resident's care plan or care guide. During an interview, on 10/21/22 at 10:14 a.m., the CSN indicated they did not have a policy related to shaving. 3.1-38(a)(3)(D)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to implement bowel protocol interventions after a resident did not have a bowel movement (BM) for 1 of 1 resident reviewed for constipation. (Resident 26) Finding includes: During an interview, on 10/18/22 at 2:37 p.m., Resident 26's daughter indicated the resident had not had a bowel movement for 6 days and if she did not question it, the staff would not have known. The record for Resident 26 was reviewed on 10/20/22 at 4:10 p.m. Diagnoses included, but were not limited to, anxiety, depression and	F 0684	**F684** 1: Corrective action(s) will be accomplished for those residents found to have affected by the deficient practice: **The singular cited resident was treated per facility policies and obtained results.** 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:	11/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	10/25/2022

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	constipation. A care plan, dated 08/30/21 and edited on 07/19/22, indicated the resident was at risk for constipation and interventions included, but were not limited to, administer medications, enemas and suppository as ordered. A current physician's order, dated 08/23/21, indicated if the resident went greater than 72 hours without a bowel movement then the bowel protocol should be implemented. The bowel protocol was as follows: a. Start with two tablespoons of natural laxative. b. If no results within 24 hours after natural laxative, administer Milk of Magnesia. c. If no results within 12 hours of Milk of Magnesia then administer a Dulcolax suppository. d. If the results of the suppository within 2 hours or was not sufficient then administer a Fleets enema. A progress note, dated 10/12/22 at 8:50 p.m., indicated the nurse was made aware by the resident's daughter the resident had not had a bowel movement in the last 3 days and was uncomfortable. A Vitals Report document, for Resident 26, indicated the resident did not have a bowel movement form 10/06/22 through 10/11/22. The bowel protocol was not initiated after the resident went greater than 72 hours without a bowel movement. During an interview, on 10/19/22 at 2:30 p.m., the Clinical Support Nurse indicated after the third day of no bowel movement the nursing staff would initiate the bowel regimen protocol on the		**All residents have the potential to be affected by a deficient practice of unmonitored bowel movements.** 3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? **The community utilizes automated medical records to record resident bowel movements. All nursing staff were educated at the time of the survey to properly document bowel movements of residents under their care. The nursing administration team will present a full training for all nursing personnel who perform this task using 'Matrix' the community's electronic medical record. The Director of Nursing or Designee will be responsible to generate reports 5 days per week in Clinical Care meetings to observe for residents who have possibly missed regular bowel movements. Bowel protocols will be followed to induce bowel movements as prescribed by attending physicians.** 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? **The Executive Director**	

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	155833	A. BUILDING 00 B. WING	10/25/2022

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	fourth day. A current policy, titled "Bowel Protocol Guidelines," dated as reviewed on 03/18/2022 and provided by the Corporate Support Nurse on 10/21/22 at 4:12 p.m., indicated "...The Ineffective Bowel Pattern Event should be initiated for any resident not having a BM within 72 hours a. a progress note associated to the Ineffective Bowel Event, should be completed until the resident has a BM...The progress note should include abdominal distention, pain an bowel sounds...If no bowel movement within 72 hours, 2 tablespoon (30cc) [cubic centimeters] of 'Natural Laxative' b. If no results within 24 hours after 'Natural Laxative' give 30 cc of Milk of Magnesia c. If no results within approximately 12 hours after MOM administer Dulcolax suppository d. If results of suppository are not satisfactory within 2 hours give Fleets enema...." 3.1-37(a)		**or Corporate Health Nurse will track and monitor compliance by nursing staff members charged with daily monitoring. They or their designees will review compiled summaries (BM sheets) twice each week for four weeks, then will review weekly for four weeks, then bi-weekly for four weeks. Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.** ¿5. Date of completion: November 18, 2022 p="" >	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure the hot water temperatures remained between 105 degrees and 120 degrees for 1 of 5 residents reviewed for	F 0689	**F689** 1: What corrective action(s) will	11/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155833	A. BUILDING 00 B. WING	10/25/2022

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	accident hazards. (Resident 38) Finding includes: During an initial environmental observation, on 10/18/22 at 11:10 a.m., Resident 38's hot water was assessed. The hot water, in his bathroom, felt hot to the touch and surveyor's fingers turned bright red after holding them in the water for 10 seconds. The temperature of the water was tested and the thermometer indicated the water was 121 degrees Fahrenheit. During an interview, on 10/18/22 at 11:14 a.m., Resident 38 indicated the water, in the bathroom, felt hot at times and he had to pull his hands out of the water quickly. During an observation and interview, on 10/18/22 at 1:06 p.m., the Director of Plant Operations (DPO) measured the hot water temperature at 121.5 degrees in Resident 38's bathroom. The DPO indicated he had concerns regarding the water temperatures and a sensor on the boiler could be off. The gauges on the boiler displayed 120 degrees but when he tested the water, it was hotter. The hot water temperatures needed to measure below 120 degrees to ensure a resident would not get burnt. He had not been notified of concerns regarding the temperature of the hot water. The record for Resident 38 was reviewed. Diagnoses included, but were not limited to, repeated falls, muscle weakness, malignant neoplasm of the prostate and mild cognitive impairment. A Care Area Assessment (CAA), dated 9/10/22, indicated the Resident 38 had physical limitation		be accomplished for those residents found to have affected by the deficient practice: **No residents suffered adverse outcomes as a result of this finding. Mixing valve adjustments were immediately made by plant operations staff members to reduce water temperature.** 2:¿ How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:¿ **All residents are subject to excessive water temperatures in resident rooms or public areas.** ~~¿~~ /b> **Water temperatures are monitored on ~~at least~~ a weekly basis by the Plant Operations staff members. Adjustments are made when indicated. Life**	

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	related to weakness and had a fall. Resident 38 needed assistance with mobility and transfers. A care plan, dated 9/14/22, indicated the resident had a high risk for falling related to the use of high-risk medications, repeated falls and weakness. The care plan directed staff to encourage Resident 38 to do as much as safely possible for himself. A facility document, titled "Travelers Boiler Fired Pressure Vessel Report of Inspection," indicated an inspection was completed, on 8/31/21, and no concerns were found. A facility document, titled "TELS Work Orders," dated 10/1/22 to 10/18/22, was reviewed and no work orders were found related to concerns regarding hot water in the bathrooms. A facility "TELS Logbook Documentation," dated 10/3/22 to 10/14/22, had no indications of elevated water temperatures above 120 degrees Fahrenheit. During an interview, on 10/24/22 at 2:00 p.m., the Clinical Nurse Support (CNS) indicated the facility did not have documentation of monthly inspections for the boiler. A current policy, titled "Preventative Maintenance Procedures," dated 2/6/18, indicated each piece of equipment or section of the building had its own inspection schedule and procedures to follow to decrease the chances of equipment failure. A current policy, titled "Equipment Care," with a revised date of 2/5/18, indicated the Director of Environmental Services was to inspect environmental equipment monthly and train		**Safety Code walking rounds are completed by the Plant Operations Director on a weekly basis, which will include water temperature monitoring. The Executive Director will evaluate ongoing documentation. Additional training and/or disciplinary action will be taken when/if indicated.** 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? **The Executive Director will audit Plant Operations documentation on a weekly basis for the next twelve (12) weeks. In addition, he will conduct random follow-up water temperature testing to ensure compliance.** **Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or**	

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	employees on equipment care. Staff were to generate work orders through TELS when repairs are needed on equipment. 3.1-45(a)		**extend monitoring times according to outcomes.** **/b>/b>**	
F 0690 SS=G Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that			

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	155833	A. BUILDING 00 B. WING	10/25/2022

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	catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice for 1 of 2 residents reviewed for catheter care. (Resident 44) Resident 44 was not provided care to address concerns which developed after a urinary catheter was placed which led to a hospitalization with intravenous antibiotic intervention for the development of urosepsis. Finding includes: The record for Resident 44 was reviewed on 10/21/22 at 1:39 p.m. Diagnoses included, but were not limited to, sepsis (life-threatening complication of an infection), urinary tract infection (infection in any part of the urinary system), benign prostatic hyperplasia (BPH) (enlargement of the prostate gland) and chronic kidney disease (loss of kidney function). A care area assessment (CAA), dated 9/28/22, indicated the resident had triggered for an indwelling catheter related to BPH, hematuria, urinary retention and CKD. A physician's order, on 9/22/22, indicated staff	F 0690	**F690** **The facility contends the cited resident's hospitalization was solely a result of the noted allegations. Findings did not conclusively 'lead' to hospitalization. This resident has a history of UTIs (Urinary Tract Infections). He was hospitalized for treatment of urinary system disease prior to his original admission to the facility, including leukocytosis.** 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice: **The cited resident's condition was monitored in the**	11/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	were to change the catheter bag as needed, use an indwelling urinary catheter size 16 Fr (French) with a 10 cc (cubic centimeter) balloon for the diagnosis of urinary retention. A Vitals Report, dated 9/24/22 to 10/24/22, indicated Resident 44 had the following recorded: On 9/29/22 at 4:32 p.m., a large amount of urine output was recorded. On 9/30/22 at 12:26 a.m., a large amount of urine output was recorded. On 10/1/22 at 5:50 a.m., 250 ml (milliliters) of urine output was recorded. On 10/1/22 at 1:47 p.m., 400 ml of urine output was recorded. On 10/1/22 at 9:17 p.m., 100 ml of urine output was recorded. On 10/2/22 at 5:05 a.m., 1000 ml of urine output was recorded. On 10/2/22 at 3:27 p.m., 800 ml of urine output was recorded. The documentation indicated the resident had a large output once on each day, of the 9/29 and 9/30, but lacked indication the resident had urine output the rest of the day. A nurse progress note, dated 9/22/22 at 5:34 p.m., indicated Resident 44 was admitted to the facility with a 16 French Foley catheter and had yellow urine. A physician's progress note, dated 9/23/22 at 10:51 p.m., indicated Resident 44 was admitted with a Foley catheter, to attempt a voiding trial and follow up with urology. A review of the nurse progress notes, from 9/29/22 at 8:15 p.m., until 10/1/22 at 4:55 p.m., indicated Resident 44 had no bladder scan		**community prior to hospital transfer. He was treated, stabilized and returned.** 2:¿ How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:¿ **¿** **All residents with indwelling catheters have the potential to be adversely affected by deficient catheter/incontinence care. There were no other similar concerns in the community with no additional finding noted.** /b> **'Matrix' will be utilized to generate orders/schedules for catheter care, incontinence management including trials for discontinuation 'voiding trials.' Education will be provided for all nurses charged with catheter care and associated orders and duties.**	

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	completed, no assessment and no call to the provider to notify of concerns of decreased urine output. The staff did not document the voiding trial or when the catheter was removed or reinserted. A nurse progress note, dated 10/1/22 at 4:55 p.m., indicated Resident 44 had a distended abdomen, fever of 99.6 and was given Tylenol. Resident 44 had an in and out catheterization completed and resulted with 2200 ml of urine. The first 1000 ml of urine had been reported as gross hematuria (blood in the urine) and 1200 cc was reported as dark amber with a foul odor. A urine sample was obtained and on call provider notified. A nurse progress note, dated 10/1/22 at 6:22 p.m., indicated orders were received by the on call provider to re-anchor the Foley catheter. Resident 44 had a Foley 14 Fr 30 cc catheter anchored and had drained dark colored urine. A nurse progress note, dated 10/2/22 at 6:47 p.m., indicated Resident 44's temperature was 102.4 degrees Fahrenheit, was very lethargic, had poor appetite and a blood pressure of 102/58. He had a small amount of urine output in his Foley catheter bag and the family requested the resident be transferred to the hospital for evaluation and treatment. A Lab Report, dated 10/3/22, indicated on 10/1/22, a urine sample was collected. The results indicated his urine was positive for blood, protein, leukocytes and bacteria. His culture was positive for greater than 100,000 enterococcus faecalis bacteria. A hospital discharge summary, dated 10/8/22, indicated Resident 44 was hospitalized for the		**Ongoing audits, monitored by the DON and/or her designee will identify challenges with completion of associated care duties 5 times per week for the next four weeks, then three times per week for the next four weeks, then twice rooms per week for the subsequent four weeks.** 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? **Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.** **/b>/b>**	

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	155833	A. BUILDING 00 B. WING	10/25/2022

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	diagnoses of Urosepsis (sepsis caused by infections of the urinary tract), a complicated UTI related to a catheter associated urinary tract infection. A nurse progress note, dated 9/29/22 at 8:15 p.m., entered as a late entry on 10/21/22 at 12:07 p.m., indicated Resident 44 had a Foley catheter removed without difficulty with no signs or symptoms of bleeding, pain or discomfort. During an interview, on 10/20/22 at 9:45 a.m., the Licensed Practical Nurse (LPN) 6 indicated if a resident did not urinate at least once in eight hours after the catheter was removed, the staff should notify the physician. The family had requested Resident 44 be transferred to the hospital for evaluation and treatment. During an interview, on 10/21/22 at 1:20 p.m., the Infection Preventionist (IP) indicated Resident 44 had a catheter in place and re-anchored. He developed Urosepsis and was admitted to the hospital. During an interview, on 10/21/22 at 2:00 p.m., the Clinical Nurse Support (CNS) indicated the staff should obtain specific instructions from the physician when an order to remove a catheter was received. Complications to urinary retention included, sepsis, tearing of the bladder, pain and kidney failure. A current policy, titled "Notification of Change in Condition," indicated the staff must inform the resident, physician, and resident representative when a change in the resident's physical, mental, or psychosocial status. 3.1-41(a)(2)			

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F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on interview and record review, the facility failed to assess and documentation Peripherally Inserted Central Catheter (PICC) care for 2 of 2 residents reviewed for PICC line care. (Resident 41 and 199) Findings include: 1. The record for Resident 41 was reviewed. Diagnoses included, but were not limited to, sepsis (overwhelming and life-threatening response to infection), dementia, hip fracture and history of falls. An Admission Referral note, dated 9/20/22, indicated Resident 41 would need to continue intravenously (IV) Vancomycin (antibiotic) for the diagnosis of Methicillin-Resistant Staphylococcus Aureus (MRSA) (a staph infection which is difficult to treat because of resistance to some antibiotics) for six weeks. An admission nurse progress note, dated 9/21/22 at 6:31 p.m., indicated Resident 41 had a peripherally inserted central catheter line to right upper arm and had received Vancomycin (antibiotic) intravenously. The progress note lacked indication the length of the external catheter of the PICC line. A physician's order, dated 9/26/22, indicated	F 0694	**F694** 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice: **Residents cited have either discharged from the community or had PICC lines removed. There are currently no such residents in the community .** 2:¿ How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:¿ **No other residents were found to be affected.¿** ="" span=""> **The Director of Nursing or her designee will provide training to nurses who manage PICC/Central line care. At such time individuals with PICC/Central lines are admitted, ongoing audits, monitored by the DON and/or her designee will identify challenges with completion of associated care duties.Care orders/procedures will be entered and tracked using 'Matrix.' Audits will be done 5 times per week for such**	11/18/2022

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	Resident 41 was to receive Vancomycin 750 mg (milligram) every 12 hours intravenously for MRSA from 9/21/22 to 9/26/22. A physician's order, dated 9/26/22, indicated Resident 41 was to receive Vancomycin 750 mg every 12 hours intravenously for MRSA from 9/26/22 to 9/28/22. A physician's order, dated 10/20/22, indicated Resident 41 was to receive Vancomycin 750 mg every 12 hours intravenously for MRSA from 10/20/22 to 11/5/22. The nurse progress notes, dated from 9/21/22 to 9/29/22 at 10:42 p.m., indicated Resident 41 had a PICC line in her right upper arm. The progress notes lacked indications measurements of the external catheter was obtained or documented. The nurse progress notes, dated from 9/30/22 to 10/2/22, had no documentation related to Resident 41's PICC line. A nurse progress note, dated 10/3/22 at 11:17 a.m., indicated the PICC line was located in Resident 41's left arm. A nurse progress note, dated 10/3/22 at 8:50 p.m., indicated the PICC line was missing from Resident 41's forearm. A nurse progress note, dated 10/4/22 at 11:09 a.m., indicated a PICC line was placed in Resident 41's right upper extremity and measured 40 centimeters (cm). A nurse progress note, dated 10/4/22 at 12:09 p.m., indicated Resident 41 had missed two doses of her antibiotic, because the PICC line had been		**residents during the term of the PICC/Central line placement – up to four weeks by the Director of Nursing or her designee. This protocol will be used for residents admitted with PICC/Central lines during the next 90 days. Any identified findings/concerns will generate further education of nursing staff members and/or reprimands for compliance.** 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? **Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes. span="">="" span="">** !--[if="" !supportannotations]--="">	

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	pulled out. A nurse progress note, dated 10/6/22 at 11:06 p.m., indicated Resident 41's PICC line was intact, patent, and clean. A nurse progress note, dated 10/8/22 at 7:41 p.m., recorded as a late entry on 10/12/22 at 10:42 a.m., indicated Resident 41 was found on the floor lying next to the bed. The progress note lacked indication the PICC line was assessed after the she was found on the floor. A nurse progress note, dated 10/16/22 at 5:26 a.m., indicated Resident 41's PICC line was found pulled out and under her head. The PICC line was last seen intact and patent at on 10/15/22 at 11 p.m., when the infusion had completed and the PICC line was flushed. A nurse progress note, dated 10/16/22 at 10:36 a.m., indicated a PICC line was replaced in the right Brachial vein, single lumen, 4 French, non-valved line. Internal length was 38 cm, external length 0 cm, and post arm circumference was 32 cm. A nurse progress note, dated 10/17/22 at 9:43 p.m., indicated Resident 41 had pulled out her PICC line and a new PICC line was inserted. The progress note, lacked indication the PICC line was placed, length of catheter, or the catheter was intact. A nurse progress note, dated 10/19/22, indicated the PICC line dressing was changed on Resident 41's right arm, and the external catheter measured 0.4 cm. A nurse progress note, dated 10/21/22 at 7:58 a.m., indicated Resident 41 had pulled the PICC line out			

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	and was found with the PICC line in her hand. The progress note indicated the tip was intact, but lacked documentation of the measurement of the catheter. During the survey, a care plan dated 10/20/22, indicated the resident had required IV medication related to sepsis. The care plan directed staff to administer IV as ordered, assess for complications, provide IV site cares as ordered and notify the physician with complications. During an interview, on 10/20/22 at 3:45 p.m., the Assistant Director of Nursing (ADON) indicated she had not received information regarding the PICC line from the hospital discharge records. 2. The record for Resident 199 was reviewed. Diagnoses included, but were not limited to, osteomyelitis (infection in the bone), hypertension (high blood pressure) and COVID-19. A physician's order, dated 10/8/22 to 10/10/22, indicated Resident 199 received vancomycin one gram in 0.9 percent (%) solution. The order indicated to infuse the antibiotic over 60 minutes two times a day. A physician's order, dated 10/10/22, indicated Resident 199 received cefepime HCL (an antibiotic) two grams in 250 ml (milliliter) of 0.9 % sodium chloride solution. The order indicated to infuse the antibiotic over 30 minutes three times a day. A physician's treatment order, dated 10/10/22, indicated to change Resident 199's PICC line dressing every five days, measure the catheter length and enter the measurements in the			

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	medication notes. The Medication Administration Record (MAR) was reviewed on 10/15/22. The MAR indicated Resident 199's PICC line dressing was change. The MAR lacked documentation of a measurement of the PICC line. A nurse progress note, dated 10/9/22, indicated Resident 199 had a PICC line to her right upper extremity and it was clean, intact and patent. The progress note indicated she received vancomycin through her IV. A nurse progress note was entered after survey started, dated 10/13/22 at 5:45 p.m., and entered as a late entry on 10/18/22 at 4:29 p.m., indicated Resident 199 had fallen when she attempted to return from the bathroom. She sustained a 3 cm (centimeter) by 3.5 cm bruise to her right chest. Her IV site was assessed to have no bleeding or dislodgement and measured 15 cm. A nurse progress note, dated 10/18/22 at 1:15 p.m., indicated the PICC line dressing had been changed to her right upper extremity. During the survey, a care plan dated 10/10/22, was revised on 10/24/22, and indicated to administer IV as ordered, assess for complications, provide IV site care as ordered and to notify physician of any complications. The clinical record lacked assessments or measurements for Resident 199's PICC line from 10/9/22 to 10/11/22. During an interview, on 10/18/22 at 4:15 p.m., Licensed Practical Nurse (LPN) 6 indicated she was not aware of the measurements of Resident			

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	199's PICC line when she was admitted. The facility did not have PICC line records and was unsure of the external length after the PICC line was initially placed. During an interview, on 10/20/22 at 3:45 p.m., the Assistant Director of Nursing (ADON) indicated she had not received information about the PICC line from the hospital for Resident 199. During an interview, on 10/20/22 at 2:00 p.m., the Clinical Support Nurse (CNS) indicated the facility did not receive information on Resident 41's or Resident 199's PICC line from the hospital discharge. The staff would not be aware of the type of PICC line or measurements related to the PICC for ongoing assessments if they did not have the PICC line documentation. Her expectation for staff would be to obtain the records needed to monitor and assess the residents' PICC lines. A current policy, titled "Overview of Infusion Therapy," with a revised date of 12/15, indicated to monitor the external length of the catheter on admission and with each dressing change for outward migration. 3.1-47(a)(2)			
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.			

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	§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. Based on observation, interview and record review, the facility failed to obtain a physician's order, an assessment, to develop a care plan and obtain a consent for the use of side rails for 1 of 5 residents reviewed for accident hazards. (Resident 15) Finding includes: During an observation, on 10/18/22 at 1:17 p.m., the resident was resting, in her bed, with her head elevated and her side rails were elevated on both sides of her bed. During an observation, on 10/19/22 at 12:43 p.m., the resident was sitting up, in her bed, eating her lunch and her side rails were elevated on both sides of her bed. The record for Resident 15 was reviewed on 10/20/22 at 9:32 a.m. Diagnoses included, but were not limited to, fracture of the right lower leg, muscle weakness and CHF (congestive heart failure - a condition where the heart does not pump blood as it should and can result in fluid in	F 0700	**F700** 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice: **The cited resident was properly assessed using facility protocols for use of side rails.** 2:¿ How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:¿	11/18/2022

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	the lungs making it difficult to breath). The record did not contain a physician's order, an assessment, a care plan or a consent for the side rails. During an interview, on 10/20/22 at 11:00 a.m., the Corporate Support Nurse indicated Resident 15 did not have an order, a care plan, consent, or an assessment for the use of side rails and she should have had them documented in her medical record. A current policy, titled "Guidelines for the Use of Bed Rails," dated 12/01/2021 and provided by the Director of Nursing on 10/20/22 at 11:30 a.m., indicated "...The use of bed rails as an assistive device should be addressed in the resident's care plan...Informed consent for the use of bed rails should be obtained from the resident and/or legal representative...." 3.1-45 (a)(2)		**Residents who have side rails have the potential to be affected. A full community audit was conducted during the survey to assess for unauthorized use of side rails on resident beds. Corrections were made immediately.** **¿** /b> **Education will be provided to all nurses regarding bed rail policies and procedures.** **The Plant Operations Director maintains custody of side rails. Facility protocols allow for them to be installed only upon presentation of an order via the therapy department. This practice will continue.** **The Executive Director will conduct weekly audits of resident rooms for the next 90 days with a listing of**	

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			authorized side rails. Upon permanent discharge of residents with side rails, equipment will be removed from the assigned bed before it is re-occupied by a subsequent resident. This will be reviewed during routine management meetings when admissions/discharges are discussed. The Plant Operations Director and the Executive Director will collaborate on reviews/removals no less than weekly for the next 90 days . 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? **Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.** **/b>/b>**	

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F 0727 SS=F Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was on site for 8 hours a day for 2 of 30 days, from September 18, 2022 to October 18, 2022. This deficient practice had the potential to effect 51 of 51 residents residing in the facility. (October 1, 2022 and October 15, 2022) Finding includes: During review of the schedule for licensed staff, on 10/21/2022 at 1:32 p.m., documentation of the hours worked lacked evidence of a RN for 8 consecutive hours, on October 1, 2022 and October 15, 2022. During an interview, at that time, the Scheduler	F 0727	**F727** 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice: **No residents were adversely affected by the deficient practice.**	11/18/2022

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	reviewed the documents and verified there was no RN coverage, for 8 consecutive hours on those dates. A current facility policy, regarding RN coverage in the facility, was requested on 10/21/2022 at 3:21 p.m. During an interview, on October 21, 2022 at 5:14 p.m., the Corporate Support Nurse indicated the facility did not have a written policy regarding RN coverage. 3.1-17(b)(3)		2:¿ How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:¿ **There were no adverse results stemming from RN staffing not meeting 365-day criteria. The community continuously staffed the nursing units with licensed nurses. There were and are RNs on call at all regardless through both the community and corporate organizations.** **¿** /b> **The community endeavors to employ RNs on each day of the year for at least 8 hours. Staffing personnel offer partial shifts to be worked (under 8 hours) for split shifts to encourage more pickup by RNs of open shifts. Administrative nurses may be engaged to fill open shifts RN staffing will be reviewed daily in the morning**	

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			meeting five days per week. - 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? **The staffing coordinator will report unsuccessful efforts to fill open RN shifts to the Executive Director and DON. They will collaborate on solutions to fill positions until the community has a full compliment of RNs to meet SNF staffing criteria. This will extend into the foreseeable future, but for at least 6 months.** **To review possible solutions, staffing challenges will be reviewed by the QAPI Committee monthly for the next 6 months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.**	

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			/b>/b>	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as			

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	provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to indicate targeted behaviors, specific non-pharmacological interventions, develop a resident centered care plan for insomnia and failed to have an appropriate diagnosis for the use of a psychotropic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 26) Finding includes: The record for Resident 26 was reviewed on 10/20/22 at 4:10 p.m. Diagnoses included, but were not limited to, anxiety, depression, constipation, dementia with behavioral disturbances and insomnia. A physician's order, dated 08/31/2022, indicated the resident received buspirone (a medication used to treat anxiety) 2.5 mg (milligrams) two times a day for anxiety. A physician's order, dated 10/14/2021, indicated the resident received trazadone (a medication used to treat depression and insomnia) 25 mg at bed time for insomnia.	F 0758	**F758** 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice: **The community's medical director was asked for a differential diagnosis for the cited resident and to consider prescription of alternative medication(s). Care plan was revised to address psychotropic medication orders and insomnia.** 2:¿ How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:¿ **Residents with Rx for psychoactive medications have the potential to be affected by incomplete care plans, unsuitable diagnoses and/or alternative interventions for targeted behaviors. Consulting pharmacist evaluates use of psychoactive drugs in conjunction with the Medical**	11/18/2022

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	A physician's order, dated 06/06/22, indicated the resident received Depakote ER (extended release) (a medication used to treat seizures and psychiatric disorders) once a day for behavioral disturbance. A care plan, dated 10/16/2022, indicated the resident had a diagnosis of anxiety. Interventions included, but were not limited to, monitor for increasing signs and symptoms of anxiety. The care plan did not include the targeted specific resident centered signs and symptoms of anxiety as well as any non-pharmacological approaches. The resident's record did not include a resident centered care plan for the use of trazodone and a diagnosis of insomnia. During an interview, on 10/24/22 at 11:28 a.m., the Corporate Support Nurse indicated she could not provide any documentation of specific anxiety symptoms the resident exhibited, as well as any non-pharmacological interventions to implement and they should have been documented in the resident's care plan. She also could not provide a person centered care plan for the resident's use of trazodone for insomnia and she should have had one initiated. During an interview, on 10/24/22 at 3:03 p.m., the facility Pharmacist indicated dementia with behaviors was not an approved FDA (food and drug administration) diagnosis for the use of Depakote ER. During an interview, on 10/25/22 at 4:30 p.m., the Corporate Support Nurse indicated dementia was not an approved or appropriate diagnosis for the use of Depakote ER.		**Director, Director of Nursing and administrative team on a monthly basis. Action and recommendations are discussed/presented at the point of these meetings. A full audit of in-house residents will be repeated to ensure compliance with correction of cited concerns. =""** span=""> **Nursing staff and Social Worker will be educated regarding non-pharmaceutical interventions for those potentially prescribed psychoactive drugs. Targeted behaviors will be identified for training and care planning. Green House Services, the community's psychiatric consulting agency will be educated by the Director of Nursing with respect to the cited medication. The DON/Designee will generate reports on a weekly basis to observe for residents who have behaviors or otherwise may be prescribed psychoactive drugs. Related protocols will be followed to properly plan for care (via the interdisciplinary care team). The team will monitor to ensure appropriate diagnoses are prescribed by attending physicians with medication orders. Residents with new psychoactive drug orders during the next 90 days. Any identified**	

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	A recent publication of "PDR.net" indicated "...Depakote was indicated for the treatment of bipolar disorder including mania...the black box warning indicates antipsychotic's are not approved for the treatment of dementia-related psychosis in geriatric patients and the use of Depakote in this population should be avoided if possible due to an increase in morbidity and mortality...." A current policy, titled "Comprehensive Care Plan Guidelines," dated as reviewed on 05/22/2018 and provided by the Corporate Support Nurse on 10/24/22 at 12:46 p.m., indicated "...interventions should be reflective of thee individual's needs and risks...Comprehensive care plans need to be accurate and current...New interventions will be added and updated...Newly recognized problems will have a care plan developed...." A current policy, titled "Psychotropic Medication Usage and Gradual Dose Reductions," dated as revised on 01/09/2012 and provided by the Corporate Support Nurse on 10/25/22 at 3:39 p.m., indicated "...To ensure every effort is made for residents receiving psychoactive medications to obtain the maximum benefits with minimal unwanted side effects through appropriate use...Procedures 1. Residents shall receive psychotropic medications only...with the appropriate diagnosis...." 3.1-48(a)(3) 3.1-48(a)(4)		**findings/concerns will generate further education of nursing staff members.** 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? **Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes. span="">="" span="">**	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its-			

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	§483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5 percent, based on medication errors observed during 2 of 25 opportunities for errors, during a random medication administration observation, resulting in a medication error rate of 8 percent. (Resident 13 and 101) Findings include: 1. During a random medication administration observation, beginning on 10/21/2022 at 9:33 a.m., QMA (Qualified Medication Aide) 2 was observed to prepare medications. Included in the 7 medications she prepared for Resident 13, she punched out 1 peach colored tablet of Senexon (to treat constipation) 8.6-50 mg (milligrams) into a clear medication cup. The QMA closed the monitoring screen on the computer, locked the medication cart and picked up the medication cup containing Resident 13's medications and a blood pressure cuff and walked away from the medication cart towards Resident 13's room. She told the resident she had his medications and handed him a cup of water. During an interview, at this time, QMA 2 was questioned if she was going to administer the medications in the cup, to which she responded she was. The QMA was requested to check the order for the resident's Senexon 8.6-50 mg. After reviewing the physician's order, she indicated the resident was to receive 2 tablets and she was unaware the resident was to receive 2 tablets of Senexon. The record for Resident 13 was reviewed on	F 0759	**F759** 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice: **Resident 13 had no adverse outcome from taking a 2nd administration of nasal spray. Resident 101 had no adverse outcome based on almost receiving a partial dose of laxative. She was given the correct dosage. QMA 2 was re-educated with medication administration protocols and specifically focused on the cited residents' medication orders.** 2:¿ How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:¿ **All residents may potentially be affected by improperly administered medications. Nursing personnel who are responsible for this duty will be re-educated by administrative nursing staff to emphasize policies and procedures for avoidance of errors.The Director of Nursing/Administrative Nursing Team will conduct audits of medication administration. Observations of 4 resident medication administrations will be done at least 5 days per**	11/18/2022

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	10/21/2022 at 10:21 a.m. A physician's order indicated the resident was to receive Senexon 8.6-50 mg 2 tablets. 2. During a random medication observation, beginning on 10/21/2022 at 9:33 a.m., QMA 2 administered 2 squirts of nasal spray into the right and left nostril of Resident 101. The record for Resident 101 was reviewed on 10/21/2022 at 10:21 a.m. A physician's order indicated the resident was to receive Fluticasone 50 mcg (micrograms) - 1 spray to each nostril. An undated facility policy, titled "Specific Medication Administration Procedures," with the last revision date of 2014 and provided by the Corporate Support Nurse on 10/21/2022 at 4:22 p.m., indicated " ...Review 5 Rights (3 times): 1) Prior to removing the medication package/container from the cart/drawer; a. Check MAR/TAR for order...2)Prior to removing the medication from the container a. Check the label against the order on the MAR...3) After the dose has been prepared and before returning the medication to storage...." 3.1-48(c)(1)		**week for the next four weeks, then four administrations per week for the next four weeks, then two per week for the subsequent four weeks. Any identified findings will generate further education of nursing staff members.** 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? **Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes. span="">="" span="">** !--[if="" !supportannotations]--="">	
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to			

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	applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to serve food in accordance with professional standards for food service safety when one randomly observed cook failed to remove gloves and hand sanitize and another cook failed to wear a hair restraint which completely covered his hair while preparing and serving food for 2 of 2 randomly observed kitchen staff. (Cook 4 and 5) Findings include: 1. During an observation, on 10/18/22 at 11:04 a.m., with the Director of Food Services present, Cook 4 was prepping carrots and lettuce for the salad bar. He had on a baseball cap with an approximate 1 inch pony tail outside his cap in the back. During an interview, at that time, the Director of Food Services indicated he was unsure if Cook 4 needed to wear a hair restraint or cover his pony tail because he had on a ball cap and his hair was not that long. 2. During an observation, on 10/19/22 at 11:56 a.m., with the Director of Food Services present, Cook 5 was observed to have gloves on while at	F 0812	**F812** 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice: **No residents were adversely affected by sanitation concerns. Referenced employee was immediately instructed to don a hairnet. The second one was immediately educated on appropriate hand sanitation.** 2:¿ How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:¿	11/18/2022

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	the steam table preparing and serving foods for lunch. He plated food items from a steam table, turned and touched a card board box. He reached inside a bread bag and removed two slices of bread and set them down on a plate. He then wiped his hands on his apron, picked up menu slips and plated more food items. He stopped and went to the refrigerator. He took a handful of onion rings and placed them into the fryer basket, took two frozen raw hamburger patties and placed them on the oven top and placed fresh onions on top of the burgers. He was not observed to remove his gloves, until 12:01 p.m. He removed his gloves, threw them in the trash and put on another pair of gloves. He was not observed to perform any hand hygiene when removing the gloves. During an interview, at that time, the Director of Food Services indicated staff should wash their hands and change gloves between touching surfaces and touching food. During an interview, on 10/21/22 at 1:47 p.m., the Corporate Support Nurse indicated Cook 5 should have changed his gloves and washed his hands in-between touching food and other surfaces. A current policy, titled "Hair Restraint," undated and provided by the Cooperate Support Nurse on 10/18/22 at 4:00 p.m., indicated "...Those employees that have hair the extrudes out of the cap will be required to have hair...tucked under hat. Food service employees will wear hair restraints while in all food preparation areas...." A current policy, titled "Yellow Lines/Hair Restraint Policy," dated as reviewed on 08/23/19 and provided by the Corporate Support Nurse on 10/21/22 at 4:15 p.m., indicated "...Entering food		**All residents can potentially be affected by failure of dietary team members to follow infection control practices appropriately.** **¿** /b> **Sanitation practice education for all dietary team members will be completed by the Food Service Manager. He will perform handwashing/glove use audits and hair containment compliance during both shifts 10 times per week for the next four weeks, then 5 times per week for the next four weeks, then twice weekly for the subsequent four weeks. Team members who are found to be out of compliance will be re-educated and/or reprimanded.** **The Executive Director will audit documentation and will directly observe audits randomly to ensure compliance by the Food**	

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	production areas...requires the proper use of hair restraints to help prevent the chance of hair contaminating food for consumption...." A current policy, titled "Guideline for Handwashing/Hand Hygiene," dated as reviewed on 12/01/2021 and provided by the Corporate Support Nurse on 10/24/22 at 10:39 a.m., indicated "...Handwashing is the single most important factor in preventing transmission of infections...Health Care Workers shall use hand hygiene at times such as...before /after preparing/serving meals...." 3.1-21(i)(3)		**Service Manager.** 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? **Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.** **/b>/b>**	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a			

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	communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to follow the Centers for Disease Control (CDC) guidelines to prevent and/or minimize the risk of transmission of Methicillin-resistant Staphylococcus aureus (MRSA) (a cause of staph infection which is difficult to treat because of resistance to some antibiotics) for 1 of 2 residents reviewed for transmission-based precautions. (Resident 41) Finding includes: During an observation, from 10/18/22 to 10/20/22, no sign was found to alert for the need of contact precautions or personal protective equipment to be used while providing specific cares. In Resident 41's room, there was an IV pole with a pump, used IV tubing, an empty vial of antibiotic	F 0880	**F 880 DPOC** 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice: Resident 41 was immediately placed in contact precautions per policy. All other current resident records were audited to ensure no other residents were to be placed in transmission based precautions. Staff were educated on Donning and Doffing of PPE per facility policy.	11/18/2022

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	and an IV fluid bag. The record for Resident 41 was reviewed. Diagnoses included, but were not limited to, sepsis (overwhelming and life-threatening response to infection), Methicillin-resistant Staphylococcus aureus (staph infection which is difficult to treat because of resistance to some antibiotics), dementia, hip fracture and history of falls. A hospital summary, on 9/14/22, indicated Resident 41's blood culture grew positive for MRSA. Her computerized tomography (CT) scan (series of Xray's) of the femur indicated her thigh had a deep soft tissue abscess (confined pocket of pus which collects in tissues) with cellulitis (a skin infection). Resident 41's wound cultures from her irrigation and debridement were positive for staphylococcus aureus bacteria on 9/15/22. She was to continue intravenous (IV) vancomycin (an antibiotic) until her blood cultures were clear from MRSA. Her record lacked indication she was placed on contact precautions after admission to the facility. A Care Area Assessment (CAA), dated 9/6/22, indicated the Resident 41 had impaired cognition and required supervision. A physician's order, dated 9/26/22, indicated Resident 41 was to receive Vancomycin 750 mg (milligram) every 12 hours intravenously for MRSA from 9/21/22 to 9/26/22. A physician's order, dated 9/26/22, indicated Resident 41 was to receive Vancomycin 750 mg every 12 hours intravenously for MRSA from 9/26/22 to 9/28/22.		**A. Systemic** 1. Root Cause Analysis a) System Failure: The RCA with the IP, DHS, ED and Medical Director determined the admitting nurse failed to place resident 41 in transmission-based precautions secondary to active MRSA infection. IP failed to audit the re-admission chart of resident 41 with new diagnosis of MRSA after resident 41 returned to facility. b) Systemic Change/Solution: A replacement in-house IP was trained and assigned. The IP will review all new and re-admission charts to determine whether transmission-based precautions are warranted within 48 hours of admission to facility. 2. LTC Infection Control Assessment: Control self-assessment was reviewed, and applicable changes were made. **B. Training** 1. Training will be provided on transmission-based precautions to all pertinent staff members. **C. Monitoring** 1. The IP Nurse/DON/Designee will monitor each solution and	

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	155833	A. BUILDING 00 B. WING	10/25/2022

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	A physician's order, dated 10/20/22, indicated Resident 41 was to receive Vancomycin 750 mg every 12 hours intravenously for MRSA from 10/20/22 to 11/5/22. A care plan, updated on 10/21/22, indicated the resident had the need for modified contact isolation during dressing changes due to MRSA of her left hip. During an interview, on 10/19/22 at 11:02 p.m., Licensed Practical Nurse (LPN) indicated Resident 41 had not been placed on precautions when she admitted from the hospital with a surgical wound on her hip. During an interview, on 10/21/22, at 9:20 a.m., the Clinical Nurse Support (CNS) indicated Resident 41 was not placed on modified contact precautions for MRSA, once she admitted to the facility. Staff should put on gloves and wear a gown over their clothing when providing care to Resident 41 and could come in contact with her wound. During an interview, on 10/21/22 at 2:24 p.m., the Assistant Director of Nursing (ADON) indicated she did not put Resident 41 on contact precautions because she was not aware Resident 41 had a diagnoses of MRSA at the time of admission to the facility. The resident's admission note, orders or care plan did not indicate she required special precautions when providing care. A review of the facility's Infection Log and Antibiotic Stewardship report indicated Resident 41 was on cephalexin and vancomycin for MRSA. A current policy, titled "Guidelines for Contact		systemic change identified in RCA, daily or more often as needed for 6 weeks and until compliance is maintained. 2. The IP Nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified in B-1 above (training). This will occur for 6 weeks and until compliance is maintained. **D. QAPI** 1. An ad hoc QAPI meeting was held on 11/10/22 and was attended by ED, DHS, IP, and Interdisciplinary team. Root Cause determined that the IP failed to audit **The facility will review, update and make changes to the DPOC as needed for sustaining substantial compliance monthly x6 months.**	

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	Precautions," dated 5/22/18, indicated guidelines to prevent the spread of infectious disease organisms. Contact precautions were indicated to prevent and control healthcare associated infections transmission of infection which included MRSA. The Center for Disease Control and Prevention article, titled "Healthcare Settings - Preventing the Spread of MRSA," dated 2/28/19, indicated MRSA was usually spread by direct contact with an infected wound or from contaminated hands, usually those of healthcare providers. MRSA was usually spread by direct contact with an infected wound or from contaminated hands, usually those of healthcare providers. 3.1-18(b)			
F 0909 SS=D Bldg. 00	483.90(d)(3) Resident Bed §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. Based on observation, interview and record review, the facility failed to implement routine inspections of a resident's bed to ensure a resident's bed was in proper working order for 1 of 16 residents reviewed for bed safety. (Resident 38) Finding includes: During an observation, on 10/18/22 at 11:14 a.m., Resident 38's footboard on his bed was loose and	F 0909	**F909** 1: What corrective action(s) will be accomplished for those residents found to have affected by	11/18/2022

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	hanging down lower on the left side. The left side of the footboard bracket was not securely attached to the bed frame. During an observation and interview, on 10/18/22 at 12:36 p.m., the Director of Plant Operations (DPO) indicated Resident 38's footboard was loose and not attached to the bed frame. The bracket on the back of the footboard was not secured to the bed and a bolt needed to be tightened. The DPO indicated "Resident 38 could have fell if he would have grabbed onto the footboard." The record for Resident 38 was reviewed. Diagnoses included, but were not limited to, repeated falls, muscle weakness, malignant neoplasm of the prostate and mild cognitive impairment. A Care Area Assessment (CAA), dated 9/10/22, indicated Resident 38 had physical limitation related to weakness and had a fall. Resident 38 needed assistance with mobility and transfers. A care plan, dated 9/14/22, indicated the resident had a high risk for falling related to the use of high-risk medications, repeated falls and weakness. The care plan directed staff to encourage Resident 38 to do as much as safely possible for himself. A fall event note, dated 9/26/22 at 6:30 p.m., indicated Resident 38 was found on the floor in front of his wheelchair. During an interview, on 10/19/22 at 12:02 p.m., Resident 38 indicated he had a fall in September but was unsure of what happened.		the deficient practice: **Resident 38 was not affected by his loose footboard. It was repaired immediately by plant operations and a complete audit was performed throughout the community to identify other related concerns.** 2:¿ How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:¿ **¿** **There were no residents adversely affected by the citation. All residents may potentially be affected equipment in need of repairs or adjustments.** /b> **The Plant Operations Director will receive detailed education via the Executive Director for successful inspection of beds,**	

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	During an interview, on 10/21/22 at 9:20 a.m., the Clinical Nurse Support (CNS) indicated staff should notify the maintenance department when any concerns regarding patient equipment come up. Staff should be monitoring the equipment for safety concerns each time they work with a resident. The facility's work order report, dated 10/1/22 to 10/18/22, was reviewed and no work orders were found related to Resident 38's footboard. A current policy, titled "Equipment Care," with a revised date of 2/5/18, directed the Director of Environmental Services to inspect environmental equipment monthly and train employees on equipment care. The policy directed staff to generate work orders through TELS when repairs are needed on equipment. 3.1-19(f)(5)		**equipment in conjunction with TELS details to ensure he is conversant with requirements.** **Inspections of 4-5 beds/rails, and patient equipment for proper placement/functionality will be conducted 2 times per week for the next eight weeks, then once weekly for the next four weeks. Repairs will be made immediately, or beds/equipment will be replaced.** 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? **Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.**	

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			/b>/b>	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to provide a safe, clean, and comfortable interior environment for 1 of 2 residents reviewed who received medications intravenously. (Resident 41) Finding includes: During an observation, on 10/18/22 at 11:26 a.m., in Resident 41's room an intravenous (IV) pole with a pump was in her room covered with a white pillowcase, with used IV tubing, an empty vial of antibiotic and IV fluid bags next to Resident 41's door. The base of the IV pole had white and gray colored spots of dirt and multiple areas of rust on each leg. In the bathroom, on the right side of the sink, was a visibly soiled white washcloth with dry, black colored stain. During an observation, on 10/18/22 at 2:45 p.m., in Resident 41's room, there was an IV pole with a pump covered with a white pillowcase, with used IV tubing, an empty vial of antibiotic and an IV fluid bag next to Resident 41's door.	F 0921	**F921** **The community provides a safe, clean and comfortable environment.** 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice: **Cited resident's IV pole was replaced with a model in full compliance. In addition, a 2nd resident with IV therapy's pole was also replaced.** 2:¿ How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:¿ **All residents with IV therapy could potentially be affected by equipment with visible signs of use, obsolescence.** **Used/discontinued supplies (tubing, bags, labels) were**	11/18/2022

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	During an observation, on 10/19/22, at 2:30 p.m., in Resident 41's room there were two IV poles. An IV pole with a pump was next to her exit side of the bed, and a second pole with used IV tubing, an empty vial of antibiotic, and an IV fluid bag was next to Resident 41's door. During an observation, on 10/20/22 9:20 a.m., in Resident 41's room, an IV pole with a pump was plugged into a lamp on the bedside table in Resident 41's room. The used IV fluid bag, IV tubing and an empty vial of antibiotic was still hung on the IV pole. The record for Resident 41 was reviewed. Diagnoses included, but were not limited to, sepsis (overwhelming and life-threatening response to infection), Methicillin-resistant Staphylococcus aureus (staph infection which is difficult to treat because of resistance to some antibiotics), dementia, hip fracture and history of falls. Resident 41's Minimum Data Set (MDS) assessment, dated 9/23/22, indicated she had a history of falls prior to admission and wandering behavior symptoms at the facility. A Care Area Assessment (CAA), dated 9/6/22, indicated the Resident 41 had impaired cognition and required supervision. A care plan, dated 10/21/22, indicated the resident had a risk for safety related to impaired cognition and reduced safety awareness related to her dementia. The care plan directed staff to observe Resident 41 for wandering into unsafe areas. A nurse progress note, dated 10/8/22 at 7:41 p.m.,		**discarded. A complete audit of IV equipment was done to identify any with need for maintenance.** **¿ ="" span=""> All residents using IV therapy equipment will have same monitored for repair/maintenance needs and used supplies discarded timely. The IP nurse will evaluate equipment when placed in service. She will visually inspect equipment weekly for the next eight weeks, then bi-weekly for the next four weeks. Findings will generate immediate work orders for compliance. Ongoing concerns will generate education and/or disciplinary action.** 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? **Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes. span="">="" span="">**	

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	recorded as a late entry on 10/12/22 at 10:42 a.m., indicated Resident 41 was found on the floor lying next to the bed. During an interview, on 10/20/22 at 9:24 a.m., the Corporate Facility Maintenance (CFM) representative indicated the IV pump should be plugged directly into a wall outlet and not a bedside table lamp. During an interview, on 10/20/22 at 1:30 p.m., the Corporate Support Nurse (CSN) indicated staff should remove all used IV tubing and bags from the IV pole once the infusion was completed. The dirt and rust on the IV poles could put a resident at risk for infection. The Zyno Medical manufacture's document, titled "Z800F Infusion Pump, Instructions for Use," undated, indicated the power cord was to be plugged into an AC (alternating current) power outlet. The facility's work order report, dated 10/1/22 to 10/18/22, was reviewed and no work orders were found related to rusty and dirty IV poles. A current policy, titled "Equipment Care," with a revised date of 2/5/18, directed the Director of Environmental Services to inspect environmental equipment monthly and train employees on equipment care. The policy directed staff to clean all equipment after each use. 3.1-19(f)(5)			
F 9999 Bldg. 00	p) Initial orientation of all staff must be conducted	F 9999	**F999**	11/18/2022

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	and documented and shall include the following: (1) Instructions on the needs of the specialized population or populations served in the facility, for example: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) children; or (E) care of cognitively impaired; residents. (2) A review of residents' rights and other pertinent portions of the facility's policy manual. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures and universal precautions. (4) A detailed review of the appropriate job description, including a demonstration of equipment and procedures required of the specific position to which the employee will be assigned. (5) Review of ethical considerations and confidentiality in resident care and records. (6) For direct care staff, instruction in the particular needs of each resident to whom the employee will be providing care. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1)		1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice: **All active personnel files for the community were reviewed.** 2:¿ How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:¿ **¿ Missing elements from personnel files were secured or communication was implemented to related staff members to have elements provided to the community or be removed from the work schedule. In lieu of immediate PPD testing for all team members, TB assessment questionnaires have been completed for those scheduled to have placement of serum.** =”” span=””> **All Department heads have been educated on personnel file check list for new hires. Business office Manager or designee will audit all newly hired staff personnel files monthly to ensure all required documents are included.** 4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? **Audit findings will be submitted to the QAPI**	

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	month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure new employees received a 1st and/or 2nd PPD (Purified Protein Derivative) (a skin test to determine if a person had been exposed to TB) for 5 of 5 new employee files reviewed for TB skin test; to ensure new employees received a physical upon hire for 2 of 5 new employee files reviewed for health screens; failed to have job descriptions for 4 of 5 new		**Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes. span="">="" span="">**	

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	155833	A. BUILDING 00 B. WING	10/25/2022

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	employee files reviewed for job descriptions; failed to have general orientation and/or specific job orientation information for 3 of 5 new employee files reviewed for general and specific job orientation; failed to provide documentation of dementia and/or abuse training for 5 of 10 employee records reviewed for dementia and abuse training; and failed to provide documentation of resident rights training for 2 of 10 employee records reviewed for resident rights training. (RN 6, Cook 7, QMA 8 (Qualified Medication Aide), Director of Nursing, CNA 9, Dining Assistant 10, CNA 11, Environmental Assistant 12 and Cook 13) Findings include: 1. Employee personnel files for RN 6 (date of hire 7/13/2022) did not contain the following: a 1st or 2nd step TB test and job description. 2. Employee personnel files for Cook 7 (date of hire 08/03/2022) did not contain the following: Step 2 TB test, job description and general and job specification orientation. 3. Employee personnel files for QMA 8 (date of hire 11/13/2018) did not contain the following: dementia training. 4. Employee personnel files for the Director of Nursing (date of hire 02/09/2022) did not contain the following: a physical examination, 1st and 2nd step TB test, job description, job specific orientation and resident rights. 5. Employee personnel files for Certified Nursing Assistant 9 (date of hire 06/01/2022) did not contain the following: a physical examination, 2nd step TB test, job description, general and specific			

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	orientation, and dementia training. 6. Employee personnel files for Dining Assistant 10 (date of hire 03/19/2019) did not contain the following: 2nd step TB test and dementia training. 7. Employee personnel files for Certified Nursing Assistant 11 (date of hire 08/01/2017) did not contain the following: job specific orientation. 8. Employee personnel files for Environmental Assistant 12 (date of hire 07/12/2022) did not contain the following: a physical examination, 1st and 2nd step TB test and dementia training. 9. Employee personnel files for Cook 13 (date of hire 04/29/2017) did not contain the following: resident rights, abuse and dementia training. A policy related to employee files was not provided during the survey.			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey Survey dates: October 18, 19, 20, 21, 24 and 25, 2022 Facility number: 013444 Residential Census: 24 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on October 31,	R 0000	The submission of this plan of correction does not indicate an admission by Wellbrooke of Carmel the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Wellbrooke of Carmel. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is	

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	2022.		in substantial compliance with the requirements of participation for skilled health care facilities. To this end, the plan of correction shall serve as the credible allegation of compliance effective November 18, 2022 with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the			

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	155833	A. BUILDING 00 B. WING	10/25/2022

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	provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the facility failed to provide signed service plans for 5 of 5 residents reviewed for service plans. (Resident 1, 2, 3, 4 and 5) Findings include: 1. The record for Resident 1 was reviewed on 10/25/2022 at 2:14 p.m. Diagnoses included, but were not limited to, anxiety and heart failure. The record for Resident 1 did not contain a signed service plan. 2. The record for Resident 2 was reviewed on 10/25/2022 at 10:41 a.m. Diagnoses included, but were not limited to, chronic cough, abnormal weight loss and nasal congestion. The record for Resident 2 did not contain a signed service plan. 3. The record for Resident 3 was reviewed on 10/25/2022 at 11:26 a.m. Diagnoses included, but were not limited to, depression. The record for Resident 3 did not contain a signed service plan. 4. The record for Resident 4 was reviewed on 10/25/22 at 1:23 p.m. Diagnoses included, but were not limited to, dementia, insomnia and muscle weakness. The record for Resident 4 did not contain a signed service plan.	R 0217	R217 1. Residents 1-5 were affected. No adverse occurrences noted. The resident was immediately assessed with no concerns noted. The residents and responsible parties were notified and service plans were reviewed and signed. 2. All residents have the potential to be affected. All residents service plans were reviewed for appropriate dates of completion with signatures. Education was provided to the DHS on the policy for service plans 3. As a measure of ongoing compliance, the Director of Health Services or designee will complete a service plan audit on 5 residents weekly for 4 weeks, then every other week for 2 months, and then monthly for 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	11/18/2022

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	5. The record for Resident 5 was reviewed on 10/25/22 at 1:45 p.m. Diagnoses included, but were not limited to, urinary tract infection and anxiety. The record for Resident 5 did not contain a signed service plan. During an interview, on 10/25/2022 at 2:45 p.m., the Corporate Support Nurse indicated all 5 residents should have had a current signed service plan in their record and she could not provide any. A current policy, titled "Assisted Living Evaluation and Service Plan Guidelines," dated as reviewed on 03/24/2022 and provided by the Corporate Support Nurse on 10/25/2022 at 12:34 p.m., indicated "...Upon admission, semi-annually, and with significant change in health status or functioning, the licensed nurse shall evaluate the resident's physical, mental, psychosocial functioning and care needs...A service plan shall be identified and implemented in response to the resident's evaluation...."			
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation, interview and record review, the facility failed to ensure medications were administered as ordered by the physician during 2 of 8 opportunities for errors during random medication administration observations. (Residents 6 and 5)	R 0247	R247 1. Residents 5 and 6 were affected without adverse occurrences noted. The physicians orders were immediately clarified. The	11/18/2022

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	Findings include: 1. During a random medication administration observation, on 10/25/2022 at 11:34 a.m., Qualified Medication Aide (QMA) 3 attempted to administered Ventolin aerosol inhaler (a medication to make breathing easier) to Resident 6. The resident had not requested the inhaler and did not indicate she had a difficult time breathing. The record for Resident 6 was reviewed on 10/25/2022 at 11:35 a.m. Diagnoses included, but were not limited to, respiratory disease and heart failure. A current physician's order, dated 09/09/22 and discontinued on 10/25/22, indicated the resident was to receive Ventolin inhaler every four hours with special instructions to use as needed for shortness of breath and wheezing. During an interview, on 10/25/22 at 11:40 a.m., QMA 3 indicated he thought the order was to be administered every four hours and as needed. The MAR (Medication Administration Record) for Resident 6, dated 10/01/22 to 10/25/22, indicated the resident received the medication every 4 hours for a total of 16 times out of a possible of 99 attempts to administer. During an interview, on 10/25/22 at 12:16 p.m., the Corporate Support Nurse indicated the medication was not documented correctly in the resident's MAR and should have been given only as requested and needed by the resident. 2. During a random medication administration observation, on 10/25/2022 at 4:18 p.m., QMA 1		residents and responsible parties were notified and orders changed. 2. All residents have the potential to be affected. All orders for residents were reviewed with no additional errors noted. QMAs 1 and 3 educated on reading/interpreting physican's orders. 3. As a measure of ongoing compliance, the Director of Health Services or designee will audit newly written physican's orders to ensure accuracy. Audit will be conducted weekly x4 weeks, then bi-weekly x8 weeks then monthly x3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	administered Artificial Tears to Resident 5's right eye. The record for Resident 5 was reviewed on 10/25/22 at 4:30 p.m. Diagnoses included, but were not limited to, anxiety. A physician's order, dated 04/16/21 and discontinued 10/25/22, indicated the resident was to receive Artificial Tears and to administer "two drops, right eye, four times a day, administer two drops to right eye every two hours WHILE AWAKE..." The MAR for Resident 5, dated 09/26/22 to 10/25/22, indicated the resident received the medication every 4 hours for a total of 115 times out of 120 possible times of administration. During an interview, on 10/25/22 at 5:04 p.m., the Corporate Support Nurse indicated the order should have been clarified with the physician prior to administrating. A current policy, titled "Physician's Orders Guidelines," dated as reviewed 03/24/22 and provided by the Corporate Support Nurse on 10/25/22 at 12:40 p.m., indicated "...Orders shall be properly written...medication orders shall include the name of medication, dosage, route of administration, diagnosis for use...All orders and treatment plans shall be reviewed and signed by the physician...."			
R 0274 Bldg. 00	410 IAC 16.2-5-5.1(g)(1-3) Food and Nutritional Services - Noncompliance (g) There shall be an organized food service department directed by a supervisor competent in food service management and			

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	knowledgeable in sanitation standards, food handling, food preparation, and meal service. (1) The supervisor must be one (1) of the following: (A) A dietitian. (B) A graduate or student enrolled in and within one (1) year from completing a division approved, minimum ninety (90) hour classroom instruction course that provides classroom instruction in food service supervision who has a minimum of one (1) year of experience in some aspect of institutional food service management. (C) A graduate of a dietetic technician program approved by the American Dietetic Association. (D) A graduate of an accredited college or university or within one (1) year of graduating from an accredited college or university with a degree in foods and nutrition or food administration with a minimum of one (1) year of experience in some aspect of food service management. (E) An individual with training and experience in food service supervision and management. (2) If the supervisor is not a dietitian, a dietitian shall provide consultant services on the premises at peak periods of operation on a regularly scheduled basis. (3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation.			
	Based on observation, interview and record review, the facility failed to serve food in accordance with professional standards for food service safety when one randomly observed cook failed to remove gloves and hand sanitize and another cook failed to wear a hair restraint which completely covered his hair while preparing and serving food for 2 of 2 randomly observed kitchen	R 0274	R274 1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice: **No residents were adversely**	11/18/2022

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	staff. (Cook 4 and 5) Findings include: 1. During an observation, on 10/18/22 at 11:04 a.m., with the Director of Food Services present, Cook 4 was prepping carrots and lettuce for the salad bar. He had on a baseball cap with an approximate 1 inch pony tail outside his cap in the back. During an interview, at that time, the Director of Food Services indicated he was unsure if Cook 4 needed to wear a hair restraint or cover his pony tail because he had on a ball cap and his hair was not that long. 2. During an observation, on 10/19/22 at 11:56 a.m., with the Director of Food Services present, Cook 5 was observed to have gloves on while at the steam table preparing and serving foods for lunch. He plated food items from a steam table, turned and touched a card board box. He reached inside a bread bag and removed two slices of bread and set them down on a plate. He then wiped his hands on his apron, picked up menu slips and plated more food items. He stopped and went to the refrigerator. He took a handful of onion rings and placed them into the fryer basket, took two frozen raw hamburger patties and placed them on the oven top and placed fresh onions on top of the burgers. He was not observed to remove his gloves, until 12:01 p.m. He removed his gloves, threw them in the trash and put on another pair of gloves. He was not observed to perform any hand hygiene when removing the gloves. During an interview, at that time, the Director of Food Services indicated staff should wash their hands and change gloves between touching surfaces and touching food.		**affected by sanitation concerns. Referenced employee was immediately instructed to don a hairnet. The second one was immediately educated on appropriate hand sanitation.** 2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:¿ **All residents can potentially be affected by failure of dietary team members to follow infection control practices appropriately.** **¿** ="" b="">
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="" b="">**Sanitation practice education for all dietary team members will be completed by the Food Service Manager. He will perform handwashing/glove use audits and hair containment compliance during both shifts 10 times per week for the next four weeks, then 5 times per week for the next four weeks, then twice weekly for the subsequent four weeks. Team members who are found to be out of compliance will be re-educated and/or reprimanded.**
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	During an interview, on 10/21/22 at 1:47 p.m., the Corporate Support Nurse indicated Cook 5 should have changed his gloves and washed his hands in-between touching food and other surfaces. A current policy, titled "Hair Restraint," undated and provided by the Cooperate Support Nurse on 10/18/22 at 4:00 p.m., indicated "...Those employees that have hair the extrudes out of the cap will be required to have hair...tucked under hat. Food service employees will wear hair restraints while in all food preparation areas...." A current policy, titled "Yellow Lines/Hair Restraint Policy," dated as reviewed on 08/23/19 and provided by the Corporate Support Nurse on 10/21/22 at 4:15 p.m., indicated "...Entering food production areas...requires the proper use of hair restraints to help prevent the chance of hair contaminating food for consumption...." A current policy, titled "Guideline for Handwashing/Hand Hygiene," dated as reviewed on 12/01/2021 and provided by the Corporate Support Nurse on 10/24/22 at 10:39 a.m., indicated "...Handwashing is the single most important factor in preventing transmission of infections...Health Care Workers shall use hand hygiene at times such as...before /after preparing/serving meals...."		=" b="">**The Executive Director will audit documentation and will directly observe audits randomly to ensure compliance by the Food Service Manager.** =" b="">=" b="">4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place? =" b="">=" b="">**Audit findings will be submitted to the QAPI Committee monthly for two months, then quarterly for two quarters to ensure compliance goals. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes.** =" b="">=" b="">**b="">=" b="">** =" b="">**b="">=" b="">**	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and			

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	by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to administer admission 2-step Tuberculin (TB) skin tests (a test used to determine if a person had been exposed to Tuberculosis) and failed to administer an annual Tuberculin (TB) skin test for 2 of 5 residents reviewed for TB skin testing. (Resident 1 and 2) Findings include: 1. The record for Resident 1 was reviewed on 10/25/2022 at 2:14 p.m. Diagnoses included, but were not limited to, anxiety and heart failure. An Assisted Living Continuity of Care Document indicated Resident 1 was admitted to the facility on 08/22/2022. During an interview, on 10/25/2022 at 12:20 p.m., the Corporate Support Nurse indicated she could not provide a two step admission TB test and the resident should have had one completed when she was admitted.	R 0410	R410 1. Residents 1 and 2 were affected without adverse occurrences noted. Residents were administered TB skin tests per policy. 2. All residents have the potential to be affected. An audit was conducted to ensure all residents were current with TB skin tests (or risk assessments) per policy. 3. As a measure of ongoing compliance, the DHS or designee will audit TB skin tests on 5 residents weekly x4 weeks, then 5 residents bi-weekly x 8 weeks, then 5 residents monthly x3 months. 4. As a quality measure, the DHS or designee will review any	11/18/2022

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	2. The record for Resident 2 was reviewed on 10/25/2022 at 10:41 a.m. Diagnoses included, but were not limited to, chronic cough, abnormal weight loss and nasal congestion. An Assisted Living Continuity of Care Document indicated Resident 2 was admitted to the facility on 02/10/2018. A Preventive Health Care Report indicated Resident 2's last TB test was administered on 07/16/2019. During an interview, on 10/25/2022 at 12:20 p.m., the Corporate Support Nurse indicated she could not provide an annual TB test after 2019 and the resident should have one completed each year. A current policy, titled "Assisted Living Tuberculin Testing Guidelines," dated as reviewed on 03/24/22 and provided by the Corporate Support Nurse on 10/25/22 at 2:30 p.m., indicated "...Residents should have a Mantoux PPD test [TB test]...Indiana - within 3 months of admission...Mantoux testing should be a two-step process...First step shall read between 48-72 hours after administration. b. Second step shall be administered between 1-3 weeks after the first test and read within 48-72 hrs after administration...." A current policy, titled "Assisted Living Tuberculin Testing Guidelines," dated as reviewed on 03/24/22 and provided by the Corporate Support Nurse on 10/25/22 at 2:30 p.m., indicated "...Mantoux testing [TB test] should be...annual...."		findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	