STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155191	A. BUILDING 00 B. WING	10/25/2022

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WESTMINSTER VILLAGE KENTUCKIANA	2210 GREENTREE N CLARKSVILLE, IN 47129

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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: 000100 Provider number: 155191 AIM number: 100266130 Census Bed Type: SNF/NF: 60 Residential: 82 Total: 142 Census Payor Type: Medicare: 4 Medicaid: 42 Other: 14 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 31, 2022.	F 0000		
F 0656 SS=E Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stephanie Wise	Administrator	11/29/2022

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

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	psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on record review and interview, the facility failed to develop a care plan with resident centered interventions for urinary tract infections (UTI) and suicidal ideation for 4 of 16 residents whose care plans were reviewed. (Residents 57,	F 0656	**F656** The facility does develop/Implement a Comprehensive Person-centered Care plan for each resident.	11/14/2022

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	12, 44, and 4) Findings include: 1. The clinical record for Resident 57 was reviewed on 10/19/22 at 1:45 p.m. The diagnoses included, but were not limited to, urinary tract infections, hypertension, and reduced mobility. The Quarterly MDS (Minimum Data Set) assessment, dated 10/3/22, indicated the resident was cognitively intact. She required extensive assistance of two staff members for toileting and limited assistance of two staff members for bed mobility. The care plan, dated 6/27/22 and last revised on 10/12/22, indicated the resident was incontinent of bowel and bladder. The interventions, dated 6/28/22, indicated to assist the resident with toileting every 2 hours and as needed, provide peri care and apply a barrier cream after incontinent episodes, complete the bowel and bladder assessment after admission, quarterly and as needed, record bowel movements every shift daily, and record episodes of continent and incontinent voiding and bowel movements. The care plan lacked documentation for current preventative measures to prevent urinary tract infections. The nurse's note, dated 7/1/22 at 12:24 p.m., indicated the resident was continued on Cefdinir twice daily for a UTI. The nurse's note, dated 7/9/22 at 6:46 p.m., indicated the facility received signed laboratory orders from the physician to repeat the CBC (complete blood count) in one week, do a UA		**I. Action taken for those residents identified:** Regarding residents 57, 12, 44 and 4, the care plan was reviewed and updated to include applicable resident-centered intervention(s). **II. How other residents are identified:** An audit was completed of the residents' care plans who have UTIs or behavior/mood symptoms. Any issues identified were addressed with resident-centered specific interventions. **III. System in place:** A contracted Social Service Consultant provided review and training to the SSD regarding behavior and mood symptoms, resident-centered interventions, and follow-up documentation. The SSD will participate in the clinical meetings and 24-hour report review to discuss new or worsening behaviors. Care plans will be updated/revised as needed following the clinical meeting and as needed. An in-service was provided for those staff who develop care plans, including re-education on the following: timing of care plan revisions, development of person centered care plans and resident specific interventions.	

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	(urinalysis) and CXR (chest x-ray) to rule out an underlying infection. The nurse's note, dated 7/15/22 at 6:22 a.m., indicated the UA with culture and sensitivity were collected via clean catch specimen. No foul odor was noted from the urine. The urine was clear golden yellow. The resident tolerated the collection with no difficulties. Denies burning or irritation when urinating. The laboratory company was at the facility to pick up the specimen and draw a CBC with differential. The nurse's note, dated 7/20/22 at 1:25 a.m., indicated the UA with culture and sensitivity were collected via clean catch specimen. The urine was a golden yellow. No foul odor was observed. The urinalysis, completed on 7/26/22, indicated less than 100,000 GNR (gram negative rods). The urine contained one plus blood. The nurse's note, dated 7/26/22 at 3:48 p.m., indicated the UA res with culture and sensitivity results were received by fax from the laboratory and showed two organisms growing less than 10,000 CFU/mL (colony forming units per milliliter), no sensitivity would be done. The results were faxed to the physician. The nurse's note, dated 9/11/22 at 12:24 p.m., indicated the resident voiced to the nurse frequent urination and pain. She also had a burning sensation. The UA was collected and an order was entered. The nurse's note, dated 9/13/22 at 12:38 p.m., indicated the partial UA results were faxed to the MD (Medical Doctor) and he sent over an order to start the resident on Macrobid 100 mg (milligrams)		IV. **How the facility will monitor and quality assurance program**: The facility will monitor during the stand down meeting during which the care plan revisions/updates discussed in the morning clinical meeting will be audited by the DON/Designee for completion. Should concern(s) be identified, immediate corrective action shall be taken. The results of this review and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education and/or revision of the plan made on the basis of findings. ***Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits.*** Date Complete: 11/14/22	

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	po (by mouth) BID (twice daily) for 7 days pending C&S (culture and sensitivity). The nurse notified the resident as well as the POA (power of attorney). The nurse's note, dated 9/13/22 at 10:59 p.m., indicated the resident was started on Macrobid 100 mg two times daily for seven days. The nurse's note, dated 9/14/22 at 12:48 p.m., indicated the UA with culture and sensitivity results were faxed to the physician's office. The organism was sensitive to the current ordered Macrobid. Staff would wait for the physician's response to adjust the medications if indicated. The nurse's note, dated 10/18/22 at 5:43 p.m., indicated a new order from the physician for a UA with culture and sensitivity related to the resident's memory decline and to refer the resident to psychiatric services for evaluation. The urinalysis, completed on 9/4/22, indicated greater than 100,000 CFU/mL klebsiella pneumoniae and less than 10,000 CFU/mL of mixed flora. No sensitivity was completed. The urine was yellow with turbid clarity, one plus blood and two plus protein, two plus leukocytes, and many bacteria. An order for Macrobid 100 mg twice daily for 7 days was received. 2. The clinical record for Resident 12 was reviewed on 10/21/22 at 9:36 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder, anxiety disorder, dementia, depression, psychotic disorder, insomnia, and violent behavior. The Quarterly MDS assessment, dated 7/21/22, indicated the resident was moderately cognitively			

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	impaired. The care plan, dated 6/25/20 and last revised on 8/10/22, indicated the resident had a diagnosis of dementia, Alzheimer's and impaired decision making, short term and long-term memory loss. The interventions indicated to administer medications per physician orders, contact the physician as needed, give support to family if condition worsened, observe for worsening condition as needed, psychiatric to evaluate and treat as needed, and routine medication review. The care plan, dated 7/8/20, revised on 2/28/22, and last revised on 8/10/22, indicated the resident had anxiety and potential for anxious or depressed mood at times. The interventions indicated to administer medications as ordered, assess and record anxious or depressed mood or behavior, determine patterns (time of day, precipitating factors/situations) if possible, assess changes in mental status, encourage her to maintain contact with her family. The care plan lacked documentation of suicidal ideation's, monitoring or interventions to prevent future occurrences. The social services note, dated 11/17/21 at 12:08 p.m., indicated the resident was standing in the door of her room when the SSD (Social Services Designee) entered the room. She stated that she had little interest in doing things, and sometimes had trouble concentrating. The resident had a diagnosis of dementia and was taking Aricept. She also had a diagnosis of mood affective disorder and was taking Quetiapine and Citalopram. She had no behaviors documented during the review period. She showed no signs or symptoms of delirium, delusions, or			

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	hallucinations. The nurse's note, dated 1/18/22 at 12:04 p.m., indicated the resident had recently taken to picking at her face. She currently had approximately 4 places on her face that were bright red. The resident had a habit of picking off scabs on her lower legs. The nursing staff had repeatedly educated the resident not to pick at scabs, and not to pick at her face. This behavior had been reported to social services for possible evaluation by the psychiatric nurse. The DON's (Director of Nursing) note, dated 2/10/22 at 1:01 p.m., indicated she called the physician about the resident's statements, and he wrote for a new order for the resident to be one on one (one staff to one resident) until the psychiatric hospital could evaluate the resident. The social service note, dated 2/10/22 at 1:10 p.m., indicated SSD was notified that the resident had made the comment she wanted to kill herself. The SSD went to the resident's room to find the resident sitting on her bed crying. He sat down beside her, and she indicated she wanted out of the facility. She indicated she had nothing to do here but sit and she had been there too long. When asked if she had thoughts of wanting to hurt herself, resident indicated, "Yes, I think about it from time to time, because I know it's going to be my only way out of here." The resident was immediately put on one on one at 11:30 p.m. The psychiatric hospital was notified, and information was sent to intake. The nurse's note, dated 2/10/22 at 6:11 p.m., indicated the resident had been quietly laying in her bed without signs or symptoms of wanting to cause harm to herself or others. The CNA			

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	(Certified Nurse Aide) was at the resident's bedside for one on one. The nurse's note, dated 2/11/22 at 5:42 a.m., indicated the resident slept most of the night with no sign that she was trying to hurt herself. She was pleasant and cooperative. The resident took her nighttime medications without difficulty. The nurse's note, dated 2/11/22 at 1:06 p.m., indicated two attendants from the psychiatric hospital arrived to transport the resident to the psychiatric hospital for evaluation and treatment. No behaviors were observed before the resident left the facility. The Social Service note, dated 2/11/22 at 5:22 p.m., indicated the resident did well through the night per the nursing staff. She had no signs or symptoms of suicidal ideation. The resident was sent to a psychiatric hospital at 11:50 a.m. to be evaluated and treated. The nurse's note, dated 2/28/22 at 1:29 p.m., the resident arrived back to the facility from the psychiatric hospital. The nurse's note, dated 3/23/22 at 6:07 a.m., indicated the resident was wandering down the hall multiple times. Each time she was asked where she was going and she indicated she was not supposed to be at the facility, her family had dropped her off at the facility, and she was waiting for family to come back. The resident was redirected and assisted back to her room multiple times. She shown that all of her things were at the facility, this was her home, and she was supposed to be here. She seemed to understand and would lay down and try to sleep each time for about 20 minutes before coming into the hallway again. At			

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	approximately 5:30 a.m. the resident was observed sitting in the parlor, with a box and a bag of her things packed. When she was asked what she was doing, she indicated, "I'm waiting for my ... [family] to come get me if ... [family] doesn't get here soon I'm going to get pneumonia, I'm freezing." She was redirected back to her room, assisted her into her bed, and explained again that she now lived at the facility. She verbalized understanding and indicated, "Oh yeah that's right, I don't know why I'm so confused." The nurse's note, dated 7/29/22 at 3:43 p.m., indicated the resident had increased confusion. The resident indicated, "I don't know why I am here. I feel like I have been here forever." The nurse's note, dated 10/18/22 at 6:19 a.m., the nurse was alerted to resident's room by the assigned CNA. When the nurse entered the resident's room, the resident was sitting on her bed, with a skin scratch measuring 1.5 cm (centimeters) and bruises measuring 3 cm long by 3 cm wide and 3 cm long by 2 cm wide on the left lower extremities. The resident indicated she scratched it. The physician was notified for a dressing order. During an interview on 10/24/22 at 11:08 a.m., LPN 21 indicated the resident was seen by psychiatric services, but was unsure if it was every 2 weeks when the psychiatric company came to the facility. One year ago or so, she said something about wanting to kill herself, to the therapist. There were 2 other staff who heard this in the hall. She was monitored in the E-MAR (Electronic Medication Administration Record) for behaviors, when a medication was administered. If a resident mentioned wanting to kill themselves, they would conduct a one on one with staff for the resident to			

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	prevent harm. They would also let the unit manager know. During an interview on 10/24/22 at 11:30 a.m., the DON indicated the note she wrote in February 2022 was about the resident wanting to kill herself. 3. The clinical record for Resident 44 was reviewed on 10/24/22 at 1:21 p.m. The diagnoses included, but were not limited to, major depressive disorder, dementia, Alzheimer's disease, and cognitive communication deficit. The 5-Day MDS assessment, dated 8/30/22, indicated the resident was cognitively intact. The care plan, dated 8/15/22, indicated the resident was at risk for suicidal ideations related to her diagnosis of depression. Interventions included, but were not limited to, 15-minute checks as needed, inpatient hospital stay per physician orders, one on one monitoring as needed, contact MD as needed, observe for worsening signs or symptoms of suicidal ideation each shift, and psychiatric services to evaluate and treat as needed. All of the interventions were implemented on 8/15/22. The Social Services note, dated 8/15/22 at 5:18 p.m., indicated the resident had "surfical" thoughts and was transferred to the behavioral hospital. The Social Services note, dated 8/15/22 at 5:37 p.m., indicated the resident stated she had thoughts of hurting herself. The hospital report, dated 8/15/22, indicated the resident had suicidal ideation with a plan over the past 72 hours. On 8/15/22 the resident verbalized suicidal ideation with a plan of taking pills that			

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	she was saving up. The resident had several medication adjustments and was released to the facility at her baseline level of functioning. The care plan lacked any interventions to address the resident indicating she had been saving pills to take. The nurse's note, dated 9/22/22 at 5:46 p.m., indicated the nurse was notified the resident was pocketing her food. Upon asking the resident why, she initially said she did not know. A few minutes later she stated, "So I can die." This writer was notified that resident was pocketing her food. She told us she didn't know why. A few minutes later the nurse asked her why she was doing that, and resident stated, "so I can die". The resident stated she was pocketing her food "to kill myself". The resident was sent to the hospital for evaluation. The hospital report, dated 9/22/22, indicated the resident was seen due to not eating for 3 days. When social services asked her why she indicated because she wanted to die. At the hospital the resident said she had been feeling more sad lately and the food didn't taste very good. The resident did not appear to be at imminent risk of serious harm to self or others and did not meet criteria for involuntary admission. The resident was discharged to the facility The nurse's note, dated 9/23/22 at 1:43 p.m., indicated the resident returned from the hospital with paperwork from the social worker stating she was not at risk for self-harm or harm to others. The care plan lacked documentation of any interventions to address the resident's behaviors of pocketing food with an intent to kill herself.			

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	During an interview, on 10/25/22 at 2:06 p.m., the DON (Director of Nursing) indicated on the first incident, they should have checked the resident's room to see if there were pills in the room and they should be making sure no medication was left at her bedside, that no one was bringing in stuff from outside. They should also be monitoring every meal to make sure and assess the resident and ensure she had nothing left in her mouth. 4. The clinical record for Resident 4 was reviewed on 10/19/22 at 1:00 p.m. The diagnoses included, but were not limited to, osteoporosis pathological fracture, Alzheimer's disease, anxiety disorder, Covid-19, dementia, psychotic disorder, difficulty walking, displaced intertrochanteric fracture of left femur, major depressive disorder, pneumonia, and urinary tract infection. The Annual MDS assessment, dated 7/9/22, indicated the resident was cognitively intact. She was frequently incontinent and required extensive assistance with toileting and personal hygiene. She was not on a bowel and bladder program. The clinical record lacked documentation indicating a care plan was initiated with appropriate intervention for the development of urinary tract infections. The nurse's note, dated 2/13/22 at 12:15 a.m., indicated the resident's UA and C&S (culture and sensitivity) result were e-coli,aerococcus urine faxed to the physician. The nurse's note dated 2/15/22, indicated the resident was continued on Macrobid for a UTI. Isolation continued for E-coli. The physician ordered Cipro 250 mg BID x 7 days for a secondary bacteria in her urine.			

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The urinalysis, dated 2/24/22, indicated the resident had escherichia coli (E-coli) in her urine.

The urinalysis, dated 3/11/22, indicated the resident had escherichia coli ESBL (Extended-spectrum beta-lactamase) positive bacteria.

The nurse's note dated 3/13/22, at 4:37 p.m., indicated the UA culture was reported, received and confirmed that the resident had a UTI. The culture indicated her urine was positive for E Coli. A call was placed to the doctor and received a new order for Macrobid 100 mg (Milligram) BID (2 times a day) x 7 days.

The urinalysis, dated 5/17/21, indicated the resident had escherichia coli bacteria growth.

The urinalysis, dated 8/22/22, indicated the resident had escherichia coli bacteria growth.

The nurse's note dated 8/28/22, indicated the resident was on continuous Macrobid related to UTI with e-coli.

During an interview on 10/24/22 at 10:24 a.m., LPN (Licensed Practical Nurse) 4 indicated the care plans would be updated by the unit manager with new interventions. The care plan should be initiated or updated when a problem was identified. They need to be updated as soon as possible.

The Care Plans, Comprehensive Person-Centered policy, last revised December 2016, provided on 10/24/22 at 9:35 a.m., by the Director of Nursing, included, but was not limited to, "...1. The Interdisciplinary Team (IDT), in conjunction with

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	the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment... Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making... When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers..." 3.1-35(b)(1)			
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care			

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	plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to revise and update a care plan related to urinary tract infections (UTI) for 4 of 16 residents review for care plan revision. (Residents 24, 53, 22, and 8) Findings include: 1. The clinical record for Resident 24 was reviewed on 10/20/22 at 10:18 a.m. The diagnoses included, but were not limited to urinary tract infection, chronic kidney disease, Alzheimer's disease, interstitial cystitis, anemia in chronic kidney, benign prostatic hypertension, and retention of urine. The Quarterly MDS (Minimum Data Set) assessment, dated 8/26/22, indicated the resident was cognitively intact. He required limited assistance of one staff for transfers, toileting, locomotion, bed mobility and personal hygiene. The care plan, dated 5/1/19 and last revised on 9/7/22, indicated the resident had chronic UTIs. The interventions included, but were not limited to, administer medications per physician order (dated 1/4/19), contact the physician as needed (dated 1/7/19), and observe for burning during urination (dated 1/7/19). The care plan lacked documentation of updated UTI preventative measures and interventions.	F 0657	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. **F657** The facility does update and revise care plans. **I. Action taken for those residents identified:** Regarding residents 24, 53, 22 and 8, the care plan was reviewed and updated to include applicable resident-centered intervention(s). **II. How other residents are identified:** An audit was completed of the residents' care plans who have a current UTI, history of UTIs, or risk for falls. Any issues identified were addressed with resident-centered specific interventions. **III. System in place:**	11/14/2022

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	The nurse's note, dated 5/9/22 at 11:47 p.m., indicated the resident had returned from the hospital with new orders to increase the Bactrim DS (double strength) to twice daily for the urinary tract infection. Oral fluids of water were encouraged and taken without difficulty. The nurse's note, dated 7/1/22 at 3:12 a.m., indicated the urinalysis was pending. The resident was encouraged to change his pull-up when soiled, to prevent UTI symptoms. The nurse's note, dated 7/5/22 at 9:22 a.m., indicated the facility received a returned fax from the physician on the urinalysis results. The resident was to start Macrobid 100 mg twice daily for 7 days and to hold the Bactrim DS until the Macrobid was completed. The urinalysis results, dated 7/21/22, indicated the urine was cloudy. There was 2 plus leukocytes, 21 to 50 HPF (high power field) white blood cells, few epithelial cells, and calcium oxalate crystals and mucous were present. An order to repeat in one week was obtained. The nurse's note, dated 7/24/22 at 1:18 p.m., indicated the resident was admitted to a local hospital with a UTI and COVID-19. The nurse's note, dated 7/28/22 at 8:54 a.m., indicated the resident returned from hospital with orders for Macrobid 100 mg twice daily for 7 days and the prophylactic Bactrim DS was discontinued. The physician was faxed, and a new order was given to continue the Macrobid 100 mg orally, daily, prophylactically for a UTI. The urinalysis results, dated 9/23/22, indicated the		Resident Care plans will be updated/revised as needed following the clinical meeting/ 24-hour report review for issues to include but not be limited to: changes in condition (e.g., UTI), falls, new or worsening behaviors/mood. An in-service was provided for those staff who develop care plans including re-education on the following: timing of care plan revisions, development of person-centered care plans and resident specific interventions. IV. **How the facility will monitor and quality assurance program**: The facility will monitor during the stand down meeting during which care plan revision/updates discussed in the morning clinical meeting will be audited by the DON/Designee for completion. Should concern(s) be identified, immediate corrective action shall be taken. The results of this review and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of findings. ***Monthly meetings will continue for a minimum of 6 months then will be stopped***	

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	urine was cloudy yellow, with few epithelial cells. Calcium oxalate crystals and mucous were present. During an interview on 10/21/22 at 12:44 p.m., QMA (Qualified Medication Aide) 5 indicated the interventions for UTIs were proper pericare, cranberry capsules, and to encourage fluids. He found the interventions in the care plans. The most important intervention was to conduct good pericare. Residents needed to be checked and changed also. During an interview on 10/24/22 at 10:15 a.m., LPN (Licensed Practical Nurse) 6, indicated care plans were initiated by the unit coordinator. This was done quarterly and as needed. This was done with falls, pain, skin changes, etc. The nurse would enter the updated interventions in the care plan once a fall or other change occurred. 2. The clinical record for Resident 53 was reviewed on 10/19/22 at 2:04 p.m. The diagnoses included, but were not limited to, history of falling, anoxic brain damage, cerebrovascular disease, Alzheimer's disease, anxiety disorder, pain in bilateral feet, dementia, need for assistance with personal care, and muscle weakness. The 5-day MDS (Minimum Data St) assessment, dated 9/25/22, indicated the resident was moderately cognitively impaired, required extensive assistance of one or more staff with bed mobility, and limited assistance of two of more staff with transfers. The care plan, last revised on 10/5/22, indicated the resident was at risk for falls related to her general weakness. Her goal was to be free of falls or any fall related injuries through the next review. Interventions included, but were not limited to;		***after two consecutive months of finding no issues with the stand down meeting audits*** V. Date Complete: 11/14/22	

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	update fall assessment each quarter and as needed, gripper socks when out of bed (dated 8/30/17); keep call light in reach when she is in her room and encourage and remind her to call for assistance as needed (dated 4/4/18); night light in bathroom (dated 5/6/20); remind to ask for assistance with transfers (dated 12/22/20); place call don't fall sign in room (dated 1/21/21); therapy to screen for appropriate assistance device (dated 11/17/21); encourage to keep walker by bedside (dated 2/2/22); grab bar on outside of the bathroom door, therapy to screen, therapy to screen and evaluate walker (dated 1/26/22); on antibiotic related to a urinary tract infection(dated 8/8/22); collect urinalysis (UA), basic metabolic panel (BMP), and complete blood count (CBC) (dated 9/12/22); and hospice to evaluate and treat (dated 10/17/22). The nurse's note, dated 11/15/21 at 4:16 p.m., indicated the resident fell while putting things away in her dresser after getting dizzy. She then scooted on her bottom to her bathroom and pulled the emergency call light. She had no injuries. The IDT (Interdisciplinary Team) note, dated 11/16/21 at 2:19 p.m., indicated the resident fell while putting clothing away and getting dizzy. A new order for therapy to screen was added as an intervention. The care plan did not reflect any revision with new interventions from therapy. The nurse's note, dated 11/17/21 at 6:29 p.m., indicated the resident called out for help and was found sitting on the floor bleeding from her head. The resident was transported to the hospital. The hospital report, dated 11/17/21, indicated the			

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	resident had a scalp laceration to her head from a fall at her nursing home in which she hit her head on her dresser. The wound was closed with 5 staples. The IDT note, dated 11/18/21 at 4:26 p.m., indicated the resident fell while going to the bathroom with a cane and slipped and hit her head. She was sent to the ER and returned with 5 staples to her head. A new order was written to have therapy screen her for an appropriate assistance device. The care plan did not reflect any revision with new interventions from therapy. The nurse's note, dated 1/26/22 at 4:22 p.m., indicated the resident had a fall while she was attempting to go to the restroom and got dizzy and fell on her bottom. There were no apparent injuries. The nurse's note, dated 2/2/22 at 10:02 p.m., indicated the resident had slipped out of her bed and landed on her bottom. The nurse's note, dated 4/5/22 at 10:26 a.m., indicated the resident's emergency alarm was on. The resident was found sitting on the floor facing the bathroom door. She stated "I just went down." There were no apparent injuries. The IDT note, dated 4/7/22 at 12:06 p.m., indicated prior to the fall on 4/4/22 the resident was attempting to walk to the bathroom. The emergency light was sounding and the resident stated she just went down. The new intervention was to place the resident's walker at her bedside and instruct her not to ambulate without her walker and notify staff as needed for assistance.			

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	The resident's fall care plan lacked documentation of the new intervention being added. The nurse's note, dated 4/12/22 at 4:50 p.m., indicated the resident was found sitting in the floor of her room on her bottom. The resident stated she was ambulating from the bathroom back to bed and her walker got away from her. There were no visible injuries. The IDT note, dated 4/13/22 at 10:32 a.m., indicated the resident had a fall on 4/12/22. The note lacked documentation of any new interventions. The care plan lacked documentation of any new interventions. 3. The clinical record for Resident 22 was reviewed on 10/20/22 at 8:48 a.m. The diagnoses included, but were not limited to, wedge compression fracture fourth lumbar vertebra, legal blindness, congestive heart failure, Alzheimer's disease, macular degeneration, epilepsy, and repeated falls. The Significant Change MDS assessment, dated 8/24/22, indicated the resident was cognitively intact and required extensive assistance of one staff member with bed mobility and transfers. The care plan, last revised on 10/9/22, indicated the resident was at risk for falls. Interventions included, but were not limited to; staff to assist the resident with all transfers as needed (dated 6/15/20); encourage rest periods to avoid overtiring (dated 6/5/20); refer to PT/OT (physical therapy/occupational therapy) for evaluation and treatment as indicated (dated 6/15/20); had taken constipation medication (dated 12/23/21); call light			

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	in reach (dated 6/15/21); therapy to screen (dated 5/25/22); check auto locking brakes (dated 9/8/22); and hospice to provide reclining wheelchair (dated 10/11/22). The nurse's note, dated 12/23/21 at 4:01 p.m., indicated the resident self-reported having fallen in the bathroom and hit her head on the arm rest of her wheelchair. The resident stated, "I stood up and missed the side of my chair and hit my head." She then pulled bathroom call light to alert staff while she was still in the bathroom. The IDT note, dated 12/29/21 at 1:32 p.m., indicated the IDT met to review the fall that occurred 12/23/21 at 3:45 p.m. The resident self-reported a fall in her bathroom. The new intervention was specified as, " ... she had taken stuff for constipation and was in a hurry ..." The care plan lacked documentation of any further preventative interventions. The nurse's note, dated 5/25/22 at 12:00 p.m., indicated the resident had fall while in the bathroom. There were no injuries observed. She was found with her feet in front of toilet and head towards door on back. The IDT note, dated 5/26/22 at 1:53 p.m., indicated the IDT met to review fall that occurred 5/25/22 at 12:00 p.m. Prior to the fall the resident was going to the bathroom. The resident was found sitting on the floor back toward the door. The new intervention was for PT/OT to evaluate and treat. The care plan lacked documentation of any further update with preventative interventions. The nurse's note, dated 9/8/22 at 12:01 p.m.,			

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	indicated the nurse was called into resident's room and witnessed resident on the floor kneeling beside bed facing the window with her wheelchair behind her. When the nurse asked what happened, the resident stated she wanted to go to bed. The IDT note, dated 9/9/22 at 12:39 p.m., indicated the IDT met to review the fall on 9/8/22 at 12:01 p.m. The new intervention was to have the resident's auto lock brakes checked to ensure working properly. Maintenance did check and the brakes were working properly. The care plan lacked documentation of any further update with preventative interventions. During an interview on 10/24/22 at 1:42 p.m., the Unit Manager indicated when a resident fell, the IDT came together and came up with new interventions for the fall. Usually, they came up with a new intervention each time, or modified an old one. Usually new interventions would be added to the care plan when they did the IDT note, the care plan would be updated at that time. During an interview on 10/25/22 at 2:06 p.m., the DON (Director of Nursing) indicated when a resident fell the nurse documented it and the next morning, she printed it off and brought it to clinical meeting. Therapy and the clinical team sat down and came up with new interventions. They did a different intervention for each fall. 4. The clinical record for Resident 8 was reviewed on 10/19/22 at 10:55 a.m. The diagnoses included, but were not limited to, chronic kidney disease, fracture of other parts, heart disease, major depressive disorder, urinary tract infections, anxiety disorder, bacterial infections, Alzheimer's, irritable bowel syndrome,repeated falls and a			

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	history of falling. The Quarterly MDS assessment, dated 7/8/22, indicated the resident was severely cognitively impaired. She required limited assistance with toileting and was occasionally incontinent of bladder. The care plan, dated 2/24/22 to 2/28/22, indicated the resident had a diagnosis of a UTI. Interventions included, but were not limited to: observe for signs and symptoms of burning or pain on urination, observe for frequency and urgency, offer and encourage fluids and record intake, contact the physician as needed, and administer medications as ordered. The care plan, dated 4/20/22 and last revised 9/6/22, indicated the resident required isolation due to E-coli (escherichia coli) pathogen in her urine. Interventions included, but were not limited to, medications per the physician orders. The clinical record lacked documentation indicating the interventions were updated and revised for the prevention of UTI's. The nurse's note, dated 3/13/22 at 11:18 a.m., indicated the resident was on antibiotic therapy related to a UTI. She was on contact isolation. The nurse's note, dated 4/18/22 at 12:01 p.m., indicated a call was received from the urology office, after reviewing the C&S (culture and sensitivity) report and new a order was received to change Amoxicillin to Augmentin 500 mg (milligrams) BID (twice daily) for 10 days per the physician. A follow-up appointment was scheduled.			

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	The nurse's note, dated 4/20/22 at 3:16 p.m., indicated due to multiple bacterial organisms observed via urine culture new orders were received by the physician to start Zosyn 4.5 grams IV (intravenous) BID for 7 days. The Augmentin was discontinued. A midline was placed in the right arm. The nurse's note, dated 5/13/22 at 10:35 a.m., indicated the resident continued on antibiotic therapy due to a UTI. No adverse effects noted to therapy. The nurse's note, dated 7/19/22 at 8:43 p.m., indicated doxycycline started for a UTI. No adverse reaction observed or reported. The nurse's note, dated 9/06/22 at 12:15 p.m., indicted the physician ordered Tetracycline 500 mg BID for 7 days due to a UTI. The nurse's note, dated 10/19/22 at 4:06 a.m., indicated the resident was alert with confusion. She had no complaints of pain or discomfort. She voided and cloudy urine was collected and ready for pick up. The nurse's note, dated 4/24/22 at 12:19 p.m., indicated the resident was on continues IV antibiotic Zosyn via midline in her right upper arm for a UTI. No signs and symptoms of infection at midline site. The Care Plans, Comprehensive Person-Centered policy, last revised December 2016, provided on 10/24/22 at 9:35 a.m., by the Director of Nursing, included, but was not limited to, "...13. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change.			

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	14. The interdisciplinary Team must review and update the care plan: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. When the resident has been readmitted to the facility from a hospital stay; and d. At least quarterly, in conjunction with the required quarterly MDS assessment..." 3.1-35 (a)(e)			
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based observation, record review and interview the facility failed to ensure appropriate preventive measures were in place to prevent falls and determine the root cause of resident falls for 5 out of 7 residents reviewed for accidents. (Residents 24, 22, 8, 4, and 53) Findings include: 1. The clinical record for Resident 53 was reviewed on 10/19/22 at 2:04 p.m. The diagnoses included, but were not limited to, history of falling, anoxic brain damage, cerebrovascular disease, Alzheimer's disease, anxiety disorder, pain in bilateral feet, dementia, need for assistance with personal care, and muscle weakness.	F 0689	**F689** The facility does determine the root cause of falls and implement preventative measures **I. Action taken for those residents identified:** Regarding residents 53, 24,22,8 and 4, therapy screens were completed, and care plans were updated as indicated/recommended by therapy. **II. How other residents are identified:** Therapy screens were obtained	11/14/2022

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	The 5-day MDS (Minimum Data Set) assessment, dated 9/25/22, indicated the resident was moderately cognitively impaired, required extensive assistance of one or more staff with bed mobility, and limited assistance of two of more staff with transfers. The care plan, last revised 10/5/22, indicated the resident was at risk for falls related to her general weakness. Her goal was to be free of falls or any fall related injuries through the next review. The interventions included, but were not limited to; update fall assessment each quarter and as needed, gripper socks when out of bed (dated 8/30/17); keep call light in reach when she is in her room and encourage and remind her to call for assistance as needed (dated 4/4/18); night light in bathroom (dated 5/6/20); remind to ask for assistance with transfers (dated 12/22/20); place call don't fall sign in room (dated 1/21/21); therapy to screen for appropriate assistance device (dated 11/17/21); encourage to keep walker by bedside (dated 2/2/22); grab bar on outside of the bathroom door, therapy to screen, therapy to screen and evaluate walker (dated 1/26/22); on antibiotic related to a urinary tract infection (UTI) (dated 8/8/22); collect urinalysis (US), basic metabolic panel (BMP), and complete blood count (CBC) (dated 9/12/22); and hospice to evaluate and treat (dated 10/17/22). The nurse's note, dated 11/15/21 at 4:16 p.m., indicated the resident fell while putting things away in her dresser after getting dizzy. She then scooted on her bottom to her bathroom and pulled the emergency call light. She had no injuries. The IDT (Interdisciplinary Team) note, dated 11/16/21 at 2:19 p.m., indicated the resident fell		from therapy on all residents who experienced a fall in the last 30 days, care plans were updated as indicated with recommendations. All residents with risk for falls care plans were reviewed and updated as needed. **III. System in place:** The IDT will review any resident who experienced a fall to determine the root cause and select an appropriate resident specific intervention. This fall review will be conducted during the clinical meeting review of the 24-hour report. Residents who experience a fall will be screened by therapy for recommendations. Residents will be assessed for fall risk at least quarterly and as needed. An in-service was provided for those staff who develop care plans including re-education on the following: timing of care plan revisions, development of person-centered care plans and resident specific interventions. An in-service was provided for the nursing staff regarding fall prevention, documentation, and assessment post fall. Therapy screen results will be collected at the clinical meeting, any recommendations will be discussed, and care planned as indicated.	

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	while putting clothing away and getting dizzy. A new order for therapy to screen was added as an intervention. The clinical record lacked documentation of any further preventative interventions. The nurse's note, dated 11/17/21 at 6:29 p.m., indicated the resident called out for help and was found sitting on the floor bleeding from her head. The resident was transported to the hospital. The nurse's note, dated 11/17/21 at 11:06 p.m., indicated the resident returned with 5 staples to her head. The hospital report, dated 11/17/21, indicated the resident had a scalp laceration to her head from a fall at her nursing home in which she hit her head on her dresser. The wound was closed with 5 staples. The IDT note, dated 11/18/21 at 4:26 p.m., indicated the resident fell while going to the bathroom with a cane and slipped and hit her head. She was sent to the hospital and returned with 5 staples to her head. A new order was written to have therapy screen her for an appropriate assistance device. The clinical record lacked documentation of any further interventions. The nurse's note, dated 1/26/22 at 4:22 p.m., indicated the resident had a fall while she was attempting to go to the restroom and got dizzy and fell on her bottom. There were no apparent injuries. The nurse's note, dated 2/2/22 at 10:02 p.m.,		Additionally, the facility has initiated a fall committee, who will meet weekly and discuss resident falls and efficacy of revised interventions. IV. **How the facility will monitor and quality assurance program**:The facility will monitor during the stand down meeting where care plan revision/updates discussed in the morning clinical meeting will be audited by the DON/Designee for completion. Should concerns be identified, immediate corrective action shall be taken. The results of this review and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. ***Monthly meetings will continue for a minimum of 6 months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits*** Date Complete: 11/14/22	

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	indicated the resident had slipped out of her bed and landed on her bottom. The IDT note, dated 2/3/22 at 12:00 p.m., indicated for the fall on 1/26/22 the resident stated she was attempting to go to the restroom and got lightheaded and fell on her bottom. A new order for therapy to screen was written. The clinical record lacked documentation of any further interventions. The IDT note, dated 2/3/22 at 4:45 p.m., indicated for the fall on 2/2/22, the resident stated she slipped out of the bed and lowered herself to the floor. New orders for a UA (urinalysis) and x-ray were given. The clinical record lacked documentation of any further interventions. The nurse's note, dated 4/5/22 at 10:26 a.m., indicated the resident's emergency alarm was on. The resident was found sitting on the floor facing the bathroom door. She stated, "I just went down." There were no apparent injuries. The IDT note, dated 4/7/22 at 12:06 p.m., indicated prior to the fall on 4/4/22 the resident was attempting to walk to the bathroom. The emergency light was sounding, and the resident stated she just went down. The new intervention was to place the resident's walker at her bedside and instruct her not to ambulate without her walker and notify staff as needed for assistance. The nurse's note, dated 4/12/22 at 4:50 p.m., indicated the resident was found sitting in the floor of her room on her bottom. The resident stated she was ambulating from the bathroom			

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	back to bed and her walker got away from her. There were no visible injuries. The IDT note, dated 4/13/22 at 10:32 a.m., indicated the resident had a fall on 4/12/22. The note lacked documentation of any new interventions. The nurse's note, dated 8/6/22 at 3:56 p.m., indicated the resident had an assisted fall at 8:50 a.m. The aide was walking the resident to the bathroom and her knees started to give out, so the aide assisted her to the floor. There were no apparent injuries. The IDT note, dated 8/8/22 at 10:51 a.m.., indicated the resident fell when her knees gave out while ambulating to the restroom. The new intervention identified was the resident being on an antibiotic for a urinary tract infection. The nurse's note, dated 9/13/22 at 3:29 a.m., indicated the resident was sitting on the floor in the bathroom. There were no apparent injuries. The IDT note, dated 9/14/22 at 9:10 a.m., indicated the new intervention for the fall on 9/13/22 was to obtain a UA, CBC, and BMP. The nurse's note, dated 10/16/22 at 10:53 a.m., indicated the resident had a fall trying to transfer from her bed to the bathroom and fell in the bathroom. There were no apparent injuries. The IDT review, dated 10/17/22 at 12:20 p.m., indicated the new intervention was for hospice to evaluate and treat the resident. The clinical record lacked documentation of any further preventative interventions.			

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	During an interview on 10/24/22 at 1:40 p.m., LPN (Licensed Practical Nurse) 7 indicated the resident had increased confusion. She had to be checked every 2 hours. The cause of her many falls was her increasing confusion. They kept her door open so they could watch her. When a resident fell, floor staff did not do the care plans, the IDT team did. 2. The clinical record for Resident 22 was reviewed on 10/20/22 at 8:48 a.m. The diagnoses included, but were not limited to, wedge compression fracture fourth lumbar vertebra, legal blindness, congestive heart failure, Alzheimer's disease, macular degeneration, epilepsy, and repeated falls. The Significant Change MDS assessment, dated 8/24/22, indicated the resident was cognitively intact and required extensive assistance of one staff member with bed mobility and transfers. The care plan, last revised on 10/9/22, indicated the resident was at risk for falls. The interventions included, but were not limited to, staff to assist the resident with all transfers as needed (dated 6/15/20), encourage rest periods to avoid overtiring (dated 6/5/20), refer to PT/OT (physical therapy/occupational therapy) for evaluation and treatment as indicated (dated 6/15/20), had taken constipation medication (dated 12/23/21), call light in reach (dated 6/15/21), therapy to screen (dated 5/25/22), check auto locking brakes (dated 9/8/22), and hospice to provide reclining wheelchair (dated 10/11/22). The nurse's note, dated 12/23/21 at 4:01 p.m., indicated the resident self-reported having fallen in the bathroom and hit her head on the arm rest of her wheelchair. The resident stated, "I stood up			

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	and missed the side of my chair and hit my head." She then pulled bathroom call light to alert staff while she was still in the bathroom. The IDT note, dated 12/29/21 at 1:32 p.m., indicated the IDT met to review the fall that occurred 12/23/21 at 3:45 p.m. The resident self-reported a fall in her bathroom. The new intervention was specified as, "... she had taken stuff for constipation and was in a hurry ..." The clinical record lacked documentation of any further preventative interventions. The nurse's note, dated 12/30/21 at 10:49 a.m., indicated the resident was sent to the hospital for an increase in back pain. The nurse's note, dated 12/30/21 at 5:58 p.m., indicated the resident returned to the facility with a compression fracture to her 4th lumbar vertebra. She was to wear a brace when out of bed and follow-up with the physician in 4 to 6 weeks. The nurse's note, dated 5/25/22 at 12:00 p.m., indicated the resident had fall while in the bathroom. There were no injuries observed. She was found with her feet in front of toilet and head towards the door on her back. The IDT note, dated 5/26/22 at 1:53 p.m., indicated the IDT met to review fall that occurred 5/25/22 at 12:00 p.m. Prior to the fall the resident was going to the bathroom. The resident was found sitting on the floor back toward the door. The new intervention was for PT/OT (physical therapy/occupational therapy) to evaluate and treat. The nurse's note, dated 7/19/22 at 5:52 p.m.,			

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	indicated the resident attempted to transfer from her bed to her w/c (wheelchair) and did not lock the w/c brakes. The resident was found sitting on floor with her back up against the nightstand at 11:15 a.m. She had a reddened area on her left mid back and a bruise on her left inner wrist which was purple in color. The resident stated her left hand hurt. A left forearm and left hand x-ray was ordered. The x-ray results were negative for any acute findings. The IDT note, dated 7/20/22 at 10:45 a.m., indicated the IDT met to review the fall on 7/19/20 at 11:15 a.m. The resident attempted to transfer from her bed to her w/c and did not lock her w/c brakes. She was found sitting on the floor with her back up against the nightstand. The new intervention was for auto lock brakes to her wheelchair. The nurse's note, dated 9/8/22 at 12:01 p.m., indicated the nurse was called into resident's room and witnessed resident on the floor kneeling beside bed facing the window with her wheelchair behind her. When the nurse asked what happened, the resident stated she wanted to go to bed. The IDT note, dated 9/9/22 at 12:39 p.m., indicated the IDT met to review the fall on 9/8/22 at 12:01 p.m. The new intervention was to have the resident's auto lock brakes checked to ensure working properly. Maintenance did check and the brakes were working properly. The clinical record lacked documentation of any further root cause analysis or preventative interventions. The nurse's note, dated 10/9/22 at 1:00 p.m.,			

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	indicated the resident's roommate alerted the nurse the resident had fallen out of her chair in their bedroom. The nurse observed the resident on the floor in front of her wheelchair, face down on her knees, underneath bedside table. The resident indicated she hit her head and she had a small bump with bruising that appeared to be new on her right upper forehead. The IDT note, dated 10/11/22 at 12:10 p.m., indicated the IDT team met and reviewed fall the resident's fall on 10/9/22 at 12:30 p.m. The note lacked documentation of any root cause analysis of the fall. The new intervention was for hospice to evaluate and treat. The clinical record lacked documentation of any further preventative interventions During an interview on 10/24/22 at 1:42 p.m., the Unit Manager indicated when a resident fell the IDT came together and came up with new interventions for the fall. They did not have steps they followed. It was individual to the resident's needs. They discussed what interventions would be appropriate, but there was no standard for what happened and what the next step would be. She was familiar with what a root cause analysis was, but they did not do it as part of their IDT meetings. The goal of the fall intervention would be to prevent further falls. Usually, they came up with a new intervention each time, or modified an old one. For instance, if a resident had an auto lock brake on their wheelchair, the new intervention might be to reassess those auto lock brakes. If they were functioning that probably was not the cause of the fall and they needed to reassess the intervention. The resident being on medication for constipation and being in a hurry might have been the cause of the fall, but it wasn't			

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	an appropriate intervention. Usually new interventions would be added to the care plan when they did the IDT note, the care plan would be updated at that time. During an interview on 10/25/22 at 2:06 p.m., the DON (Director of Nursing) indicated when a resident fell the nurse documented it and the next morning, she printed it off and brought it to clinical meeting. Therapy and the clinical team sat down and came up with new interventions. They talked to therapy about the cause of the fall, but they did not document any of that. They did a different intervention for each fall. On the instance where the resident had a fall and the new intervention was, she had taken medication for constipation and was in a hurry, that was the cause of the fall but was not a preventative intervention. If the brakes on a wheelchair were checked and they were fine, they needed to implement another intervention. 3. The clinical record for Resident 24 was reviewed on 10/20/22 at 10:18 a.m. The diagnoses included, but were not limited to metabolic encephalopathy, urinary tract infections, Alzheimer's disease, panlobular emphysema, atherosclerosis of the aorta, abdominal aortic aneurysm, pleural effusion, chronic obstructive pulmonary disease, decreased circulation of the hands and feet, corns and callosities, shortness of breath, history of falling, muscle weakness and difficulty in walking. The Quarterly MDS assessment, dated 8/26/22, indicated the resident was cognitively intact. He required limited assistance of one staff for transfers, toileting, locomotion, bed mobility and personal hygiene. The care plan, dated 12/19/18 and last revised on 9/21/22, indicated the resident was at risk for falls			

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	with the following falls on 10/27/21, 7/18/22, 9/7/22, and 9/21/22. The interventions indicated the following: to encourage the resident to ask for assistance as needed, encourage rest periods to avoid overtiring, provide night light as necessary or requested, refer to physical therapy or occupational therapy, update fall assessment quarterly and as needed, notify the physician as needed (dated 12/7/18); to wear gripper socks at all times (dated 3/4/19); therapy to screen (dated 6/12/19); encourage the resident to lay down when tired (dated 8/8/19); new hand rails to head and foot to help with balance (dated 9/19/19); auto lock brakes (dated 10/22/19); monitor auto lock brakes every shift (dated 11/11/19); replaced auto locking brakes (dated 4/28/20); new pair of gripper socks (dated 6/16/20); continue with current interventions (dated 8/28/20); continue current interventions (dated 11/9/20); labs (dated 1/25/21); continue current interventions (dated 6/23/20); call no fall sign (dated 1/25/21); monitor O2 (oxygen) saturations QID (4 times daily), gripper socks at all times, wheelchair modifications (dated 6/4/21); send to hospital related to third fall in 24 hours (dated 1/25/21); send to a local hospital emergency room to evaluate and treat (dated 7/18/22); sent to emergency room (dated 9/21/22); keep call light and the resident's favorite things near at all times (dated 12/7/18 through 5/15/19). The care plan lacked documentation of updated interventions to prevent falls. The nurse's note, dated 10/27/21 at 6:44 p.m., indicated the resident yelled out for help and was found sitting on the floor, in his room, between the wheelchair and his bed. The resident was attempting to transfer himself to the bed without shoes and socks. The resident voiced no pain, no apparent injuries, and denied hitting his head.			

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	Neurological checks were started due to the fall not being witnessed. The IDT note, dated 10/28/21 at 2:45 p.m., indicated the fall on 10/27/21 at 1:45 p.m., was reviewed. Prior to the fall the resident was sitting up in his wheelchair. The CNA (Certified Nurse Aide) heard the resident yelling for help and the CNA called for the nurse. When the nurse entered the room, the resident was found on the floor, sitting on his buttocks, between the bed and the wheelchair. He indicated he was trying to get back into bed and fell. The new interventions were for therapy to screen the resident. There were no recent medication changes, and the resident was continent of bowel and bladder. Monitor the resident frequently throughout the shift. The nurse's note, dated 12/7/21 at 3:37 p.m., indicated the resident required extensive assistance of one staff with bathing, dressing, and grooming. He transferred to and from his bed or wheelchair with extensive assistance of one staff. He propels himself in his room, on unit and throughout facility with difficulty. The resident ambulated in his room and in the corridor with a walker and extensive assistance of one staff while using a gait belt. The nurse's note, dated 5/9/22 at 3:57 p.m., indicated the grip tape was removed from the bed side floor related to causing wounds to the resident's toes. The nurse's note, dated 7/18/22 at 7:22 a.m., indicated at 2:50 a.m. the CNA heard a noise in the resident's room. The resident was found lying on the floor, next to his bed, with head against the nightstand. He had lacerations on top of his head, left elbow, hand and knee, with a moderate			

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	amount of bleeding from his head. The areas were cleansed with water and bandages were applied. The nurse's note, dated 7/18/22 at 7:27 a.m., indicated at 3:25 a.m. the resident transferred to a local hospital by way of EMS (emergency medical service) for evaluation and treatment. The IDT note, dated 7/18/22 at 12:27 p.m., indicated the fall that occurred on 7/18/22 at 2:50 a.m. was reviewed. The CNA heard a noise from the resident's room, and he was found lying on the floor, next to bed, with his head against the nightstand. Lacerations were on top of his head, left knee, elbow, and hand. A new order was received to transfer the resident to a local hospital ER to evaluate and treat. New interventions to send the resident to a local hospital ER to evaluate and treat were initiated. Monitor resident frequently though out shift. The nurse's note, dated 7/18/22 at 1:45 p.m., indicated the areas on the resident's skin were assessed upon return to the facility from the hospital. The resident sustained several areas of skin impairment status post fall and as follows: left elbow abrasion 2.5 cm long by 2.5 cm wide by 0.1 cm deep; left hand abrasion 1.5 cm long by 0.5 cm wide by 0.1 cm deep; left knee abrasion 3 cm long by 1.6 cm wide by 0.1 cm deep; front head abrasion 1 cm long by 3.5 cm wide by 0.1 cm deep; head crown abrasion 1.8 cm long by 5 cm wide by 0.1 cm deep. An order to cleanse all areas with normal saline, pat dry, apply bacitracin, then a dry dressing, twice daily and PRN (as needed) per MD. The nurse's note, dated 9/21/22 at 8:47 a.m., indicated at 6:35 a.m. the resident was transferred to a local hospital by way of EMS with a stretcher			

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	for evaluation after being found sitting on the floor, with a laceration to the right side of his head, and right knee. The IDT note, dated 9/21/22 at 1:19 p.m., indicated the fall that occurred 9/2/22 at 6:35 a.m., was reviewed. The resident was found lying on the floor, between the wall and the bed. He had a laceration to the right side of his head and right knee. EMS was called and he was transferred to a local hospital hospital. An order to transfer the resident to a local hospital to evaluate and treat was received. A new intervention to send to the local hospital to evaluate and treat was initiated. The nurse's note, dated 9/21/22 at 7:25 p.m., indicated the resident returned to the facility from the hospital related to the fall. During an interview on 10/21/22 at 12:44 p.m., QMA (Qualified Medication Aide) 5 indicated interventions for falls would be to use non-skid socks, keep the room free of clutter, have good lighting, keep call lights within reach and a toileting schedule. He would find the interventions in the care plan, and he knew to complete the interventions. The nurse and unit manager initiated the care plans. As a QMA, he would go to the nurse to initiate the care plan. During an interview on 10/24/22 at 11:00 a.m., LPN (Licensed Practical Nurse) 6 indicated the resident's interventions were to encourage the resident to ask for assistance. He was not cognitively intact because he had a decline after having COVID. He had UTIs at times but was getting prophylactics for it. He also had a sign on his wall indicating to call for assistance. His wheelchair was changed to have anti-tips, he was given gripper socks, lied down when tired,			

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	handrails for balance, keep his room free of clutter. The resident moved a lot in his wheelchair. The cause was he wanted to get up to his wheelchair from his bed, or he wanted to stand to use the bathroom. The staff tried to keep an eye on him. 4. The clinical record for Resident 4 was reviewed on 10/19/22 at 1:00 p.m. The diagnoses included, but were not limited to, osteoporosis pathological fracture, Alzheimer's disease, anxiety disorder, Covid-19, dementia, psychotic disorder, difficulty walking, displaced intertrochanteric fracture of left femur, major depressive disorder, pneumonia, and urinary tract infection. The Annual MDS (Minimal Data Set) assessment, dated 7/9/22, indicated the resident was cognitively intact. The resident required extensive assistance with transfers. Her balance and walking was not steady. The physician's order, dated 3/25/22, indicated mobility by wheelchair. The care plan, dated 7/16/18 and last revised on 7/20/22, indicated the resident was at risk for falls. The interventions included, but were not limited to; assist the resident with all transfers as needed, encourage rest periods to avoid overtiring, keep the call light and her favorite things (telephone, TV remote, etc.) near at all times, make sure pathways in her room are free from clutter and ensure adequate lighting (dated 6/10/19); provide night light as necessary or requested, observe for changes in gait when walking, notify the physician as needed, update the Fall Assessment each quarter and as needed (dated 6/11/19); encourage the resident to call for assistance before getting out of bed (dated 6/25/19); occupational and physical to evaluate as needed (dated 10/9/20, 12/21/21 and 1/21/21); auto lock			

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	brakes (dated 12/5/19); remind the resident to always lock the wheelchair brakes (dated 11/30/20 and 1/13/20); continue the current interventions (dated 1/9/20); gripper socks (dated 6/9/20); no fall sign (dated 8/3/20); dycem to recliner (dated 11/20/20 and 6/1/21); educate the resident on asking for assistance with transfers (dated 6/10/19); dycem under the quilt pad in her recliner (dated 4/14/21); fix auto locking breaks (dated 4/26/21); x-rays (dated 5/15/15); urinary analysis with culture and sensitivity (dated 5/17/21); dycem to her wheelchair, and gripper tape on both sides of the bed (dated 12/24/21); maintenance to assess the wheelchair for repair to auto locking breaks (dated 12/5/10 and 8/28/22); wheelchair modification (dated 1/15/21 and 1/20/21); fix auto locking brakes (dated 4/26/21); continue with therapy (dated 1/3/20); send to the emergency room for evaluation and treatment, encourage to call for assistance before getting out of bed (dated 6/25/19); continue with current interventions (dated 6/2/22 and 10/9/20); complete Blood count (CBC), basic metabolic panel (BMP) and urinalysis (UA) with culture and sensitivity (C&S) (dated 1/17/20, 5/17/21, and 8/19/22); gripper socks (dated 6/9/20); and no call no fall sign (dated 8/3/20). The IDT note, dated 12/21/21 at 1:21 p.m., indicated the IDT met to review a fall that occurred 12/21/21 at 6:45 a.m. Prior to the fall, the resident was sitting in her wheelchair. She was found on the floor. The clinical record lacked documentation indicating the root cause of the residents fall and appropriate interventions were implemented. A nurse's note, dated 12/24/21, indicated the nurse was called to resident's room by the CNA.			

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	The CNA heard the resident calling for help and went into her room to find her lying on the floor between her bed and the window. When the nurse entered the room the resident was sitting on her bottom with her legs out in front of her. The nurse assessed the resident no injuries were observed. The resident stated that she was trying on her new socks and thought they were the kind that didn't slip but they weren't. Her feet started to slide so she slid herself off the side of the bed onto the floor on to her bottom. Her bottom was the only thing she hit and that nothing hurt. She had no complaints of pain or discomfort. She was able to move all extremities without difficulty. The resident's shoes were put on and she was assisted off the floor and sat on the side of the bed by staff. The IDT note dated 8/29/22, indicated IDT met to review a resident fall that occurred 8/28/22 at 3:45 p.m. The CNA informed the nurse that Resident 4 had an unwitnessed fall. The nurse went immediately to her room and found Resident 4 sitting on the floor with her wheel chair by her side. A neurological check was immediately given along with skin and pain assessment. An abrasion along the spine was observed measuring 1 cm (centimeters) wide and 4.5 cm long. No other signs of injury were noted and the resident did not have any complaints of pain. Staff assisted the resident into her wheel chair. When asked what happened she stated she was trying to transfer out of her chair and move to her wheel chair, the wheel chair slid away from her and she scraped her back on the way down to the floor. Resident 4 stated that she did not hit her head on the way down. The new intervention was to have maintenance assess the resident's wheelchair for proper functioning of auto locking breaks.			

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	The nurse's note, dated 9/19/22 at 1:23 p.m., indicated the Interdisciplinary Team met regarding a fall without injury on 9/17/22 at 6:50 am. The charge nurse at time of fall indicated the CNA alerted the nurse that the resident was sitting on the floor. Upon arrival the nurse observed the resident sitting on the floor, on the right side of her bed, back leaning against bedside drawer, and her bilateral lower extremities were straight forward. When she asked what happened. the resident stated " I'm trying to get up ". The new intervention was to obtain a CBC (Complete Blood Count), BMP (Basic Metabolic Panel); urinalysis with culture and sensitivity (if indicated). During an interview on 10/24/22 at 9:30 a.m., QMA (Qualified Medication Aide) 8 indicated fall interventions included, bright colored tape, for the residents at high risk for fall would be monitored more closely, strips on the floor, nonskid footwear, handicap bars, and fall education. During an interview on 10/24/22 at 10:24 a.m., LPN (Licensed Practical Nurse) 9 indicated the care plans would be updated by the unit manager with new interventions. The care plan should be initiated or updated when a problem was identified. They needed to be updated as soon as possible. 5. During an observation on 10/19/22 at 10:55 a.m., Resident 8 was observed coming out of the bathroom without her walker or staff assistance. She had one sock and one shoe on. Her left foot was bare. The clinical record for Resident 8 was reviewed on 10/19/22 at 10:55 a.m. The diagnoses included, but were not limited to, chronic kidney disease, fracture of other parts, heart disease, major			

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	depressive disorder, urinary tract infections, anxiety disorder, bacterial infections, Alzheimer's, irritable bowel syndrome, repeated falls and a history of falling. The Quarterly MDS (Minimal Data Set) assessment, dated 7/8/22, indicated the resident was severely cognitively impaired. She required supervision with transfers and walking. The care plan, dated 7/16/18 and last revised 10/14/22, indicated the resident was at risk for falls. The interventions included, but were not limited to; assist the resident with all transfers using her walker and a gait belt for safety, de-clutter the room and move the beds, keep the call light within reach and remind and encourage her to use it to call for assistance as needed (dated 2/24/22), physical therapy and occupational therapy to evaluate and treat as indicated (dated 2/24/22 and 8/30/22); reassess quarterly and as needed, follow-up (dated 2/24/22); urinalysis with a culture and sensitivity (C&S) if indicated 3 days post antibiotics (dated 4/18/22); schedule follow-up appointment with neurology (dated 2/28/22); emergency room visit for evaluation and treatment if indicated, antibiotic order changed per urologist based on the C&S results (dated 4/18/22); continue current interventions (dated 7/2/22); send to the emergency room for treatment and evaluation (dated 8/9/22); family to take slide on shoes home (dated 9/19/22); maintenance to replace grip strip tape in the shower room (dated 10/14/22); and send to the emergency room for evaluation and treatment as indicated (dated 3/11/22 and 10/14/22). The clinical record lacked documentation indicating appropriate interventions and the root			

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	cause of the resident's falls. The IDT met to review the fall that occurred on 2/27/22 at 6:30 p.m.. The resident was in the room across the hall and came out into the hallway yelling that the resident was in the floor. Upon entering the room she was found sitting on her buttocks next to her spouse's bed. He was sitting on the side of his bed holding the resident's hand. She denied pain or discomfort. She was assessed with no injuries noted. She was assisted off the floor and into the wheelchair. She moved all extremities well. She and her family member were brought out to sit by the nurses station. She was asked what she was doing and she replied just sitting on the floor. When asked if she was hurt anywhere she said no but that's going to get bigger referring to the bruising from a previous fall. The new interventions are to repeat UA with/ C&S (if indicated) 3 days post antibiotic therapy and to schedule a follow-up appointment with the neurologist. The IDT note, dated 3/15/22 at 12:00 p.m., indicated the resident had a fall that occurred on 3/11/22 at 12:45 p.m. She was in the room across the hall and staff was notified that the resident had fallen. The resident was found on the floor received an abrasion to her right forehead and complained of her right leg hurting. The new interventions was send to hospital for evaluation and treatment as indicated. The IDT note, dated 4/18/22 at 9:00 a.m., indicated the resident was very emotional that morning thinking that her father had passed away. She had gotten herself and her family member dressed. Both were walking up the hall from their room with her stating "We have to go! We have to get there he has done passed." The CNA assisted the			

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	family member back to the room without issues. The nurse attempted to reassure and redirect the resident. All attempts were unsuccessful. Resident 8 was sitting in a chair, visible to the nurse from nurse's station, looking out the window stating "I am waiting for them to get here." She stood up and lost her balance. She fell back onto the chair then slid down to the floor with the nurse witnessing the incident. The resident was able to move all of her extremities without increased pain or discomfort. The new intervention was antibiotics order changed per urologist based on the C&S results. Will repeat UA with/ C&S (if indicated) 3 days post antibiotics. The IDT note, dated 7/11/22 at 12:42 p.m., indicated the resident was observed laying on her right side asleep with her head on a pillow next to the toilet with her walker by her feet as if she had walked into the bathroom to lay down in the floor and go to sleep. When asked what happened the resident stated she must have rolled out of bed. Informed her that she was in the bathroom floor and she then stated that she rolled out of the bed and scooted into the bathroom. When asked how she got her walker in there with her she was unable to answer. Staff assisted the resident from laying to a sitting to a standing position with complaints of pain in both hips and her lower back. Assisted the resident into the bed and head to toe assessment revealed a reddened			

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	blanchable area on her right shoulder from pressure of the hard bathroom floor and old scattered bruises. When asked if her shoulder hurt she stated that it did hurt. Her hips appeared to be in alignment. She was able to move all of her extremities, but stated that it hurt when she goes from sitting to standing or standing to sitting. She denied hitting her head. She was confused and at baseline. Staff would continue current interventions at that time.The IDT note, dated 8/9/22 at 12:24 p.m., indicated the nurse heard some noise while passing the resident's room. When staff entered the room the resident was lying on the floor on her right side between the bed and the window the resident was asked what had happened she stated she was trying to hold her family member. An assessment was done while the resident was on the floor. The resident received a skin laceration on her left arm measuring 7.5 cm, as well as a skin tear to the right arm measuring a 6 cm. The resident complained of severe pain in her right upper leg and neck. The new intervention was to send the resident to the emergency room for evaluation. The IDT note, dated 8/30/22 at 2:21 p.m., indicated the CNA found the resident sitting on the floor. with her bilateral lower extremities straight forward and her back was leaning against the right side of the bed. When			

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	asked what happened, the resident stated that she slid down onto the floor. The new intervention was to have PT to evaluate and treat as indicated. The IDT note, dated 9/19/22 at 10:45 a.m., indicated the CNA found the resident laying on the floor, on her right side outside of the bathroom . The resident obtained 2 skin tears to her right elbow and a skin tear to her left lower leg. The new intervention was to have the family to take the resident's slide on shoes home. The IDT note, dated 10/17/22 at 9:34 a.m., indicated the CNA came out of the shower room indicating Resident 8 had fallen in the shower while preparing for her shower. While holding on to the shower chair she turned her head to check the water temperature with her other hand and felt the shower chair move. When she turned around Resident 8 had tried to stand up and slid out of the shower chair onto the floor. She hit the back of her head on the wall on the way down to the floor. Upon entering the shower room the resident was observed sitting on her buttocks with her legs out in front of her. She was holding her head saying that it hurt. Staff put a hospital gown on her and laid her flat on her back with her head on a blanket. She was assessed and complained of head pain and a finger on her left was hurting. She had a small, raised area on the back right side of her head. She			

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	started to complain of knee pain and a new bruise was observed on her left knee. The new intervention was to send the resident to the hospital for evaluation and treatment and replace grip strips in shower room. During an interview on 10/24/22 at 10:30 a.m., QMA 8 indicated fall interventions included, bright colored tape, for the residents at high risk for fall would be monitored more closely, strips on the floor, nonskid footwear, handicap bars, and fall education. During an interview on 10/24/22 at 10:24 a.m., LPN 9 indicated the care plans would be updated by the unit manager with new interventions. The care plan should be initiated or updated when a problem was identified. They need to be updated as soon as possible. The Fall Protocol policy, last revised March 2018, provided on 10//24/22 at 9:35 a.m. by the Director of Nursing, included, but was not limited to, "... 2. In addition, the nurse shall assess and document/report the following... Precipitating factors, details on how fall occurred... For an individual who has fallen, the staff and practitioner will begin to try to identify possible causes within 24 hours of the fall... Often, multiple factors contribute to a falling problem... If the cause of a fall is unclear, or if a fall may have significant medical causes such as a stroke or an adverse drug reaction (ADR), or if the			

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	individual continues to fall despite attempted interventions, a physician will review the situation and help identify causes and contributing factors... After a fall, the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling... The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified, or it is determined that the cause cannot be found or is not correctable... The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling... If the individual continues to fall, staff and physician will re-evaluate the situation and reconsider possible reasons for the resident's falling (instead of, or in addition to those that have already been identified) and also reconsider the current interventions... As needed, and after an appropriately thorough review, the physician will document any uncorrectable risk factors and underlying causes..."3.1-45(a)(1)			
F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on record review and interview, the facility	F 0745	**The filing of this plan of**	11/14/2022

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	failed to ensure appropriate social services follow-up and monitoring residents with hallucinations and suicidal ideation for 3 of 4 residents reviewed for social services. (Residents 44, 12, and 35) Findings include: 1. The clinical record for Resident 44 was reviewed on 10/24/22 at 1:21 p.m. The diagnoses included, but were not limited to, major depressive disorder, dementia, Alzheimer's disease, and cognitive communication deficit. The 5-Day MDS (Minimum Data Set) assessment, dated 8/30/22, indicated the resident was cognitively intact. The care plan, dated 8/15/22, indicated the resident was at risk for suicidal ideations related to her diagnosis of depression. Interventions included, but were not limited to, 15-minute checks as needed, inpatient hospital stay per physician orders, one on one monitoring as needed, contact MD (Medical Doctor) as needed, observe for worsening signs or symptoms of suicidal ideation each shift, and psychiatric services to evaluate and treat as needed. All of the interventions were implemented on 8/15/22. The Social Services note, dated 8/15/22 at 5:18 p.m., indicated the resident had "surfical" thoughts and was transferred to the behavioral hospital. The Social Services note, dated 8/15/22 at 5:37 p.m., indicated the resident stated she had thoughts of hurting herself. The clinical record lacked any further assessment		**correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**. **F745** The facility does provide medically related social services **I. Action taken for those residents identified:** Regarding residents 12 and 44, the care plan was reviewed and updated. Resident 35 expired. **II. How other residents are identified:** An audit was completed of the residents' care plans who have behavior/mood symptoms. Any issues identified were addressed with resident specific interventions. **III. System in place:** A contracted Social Service (LSW) Consultant provided review and training to the SSD regarding behavior and mood symptoms, assessment for cause, immediate interventions/monitoring, follow-up documentation and further assessment, if warranted. The SSD will participate in the clinical meetings and 24-hour	

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	by the SSD (Social Services Designee) of the resident's reports of suicidal thoughts. There was no assessment of any plan or method the resident considered for hurting herself. The hospital report, dated 8/15/22, indicated the resident had suicidal ideation with a plan over the past 72 hours. On 8/15/22 the resident verbalized suicidal ideation with a plan of taking pills that she was saving up. The resident had several medication adjustments and was released to the facility at her baseline level of functioning. The nurse's note, dated 8/16/22 at 3:44 p.m., indicated the resident returned to the facility and was happy to return. She had no distress observed. The clinical record lacked documentation of any follow-up or monitoring related to the resident's suicidal ideations until 8/31/22. The social services note, dated 8/31/22, indicated the resident denied any depression or suicidal ideations. The nurse's note, dated 9/4/22 at 2:53 p.m., indicated the resident's family member requested she have her psychiatric medications re-evaluated due to her mood. She was not talking to her family member and very little to staff. She was not talking to her other family members and her main family member was very concerned. The nurse's note, dated 9/7/2 at 3:54 p.m., indicated the resident's family member requested for psychiatric services to re-evaluate the resident's psychiatric medications that were changed while the resident was in the hospital. The psychiatric provider would see the resident		report review to discuss new or worsening behaviors, new/readmissions. Care plans will be updated/revised if indicated following the clinical meeting and as needed. An in-service was provided for those staff who develop care plans including re-education on the following: timing of care plan revisions, development of person-centered care plans and resident specific interventions IV. **How the facility will monitor and quality assurance program**: ***The DON/Designee will monitor the SSD by discussing the resident's medically related social service needs during morning meeting. The facility will monitor during the stand down meeting where care plan revision/updates discussed in the morning clinical meeting will be audited by the DON/Designee for completion. Should concerns be identified regarding medical related social service resident needs, immediate corrective action shall be taken.*** The results of this review and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of findings.	

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	on their next visit. The nurse's note, dated 9/7/22 at 5:27 p.m., indicated the resident's order for Depakote 125 mg (milligrams) twice daily was changed to Depakote 125 mg at bedtime. The nurse's note, dated 9/22/22 at 4:06 p.m., indicated the nurse was informed by another staff member the resident had pocketed her food that same day and the day prior. Speech therapy would evaluate the resident. The nurse's note, dated 9/22/22 at 5:46 p.m., indicated the nurse was notified the resident was pocketing her food. Upon asking the resident why, she initially said she did not know. A few minutes later she stated, "So I can die." This writer was notified that resident was pocketing her food. She told us she didn't know why. A few minutes later the nurse asked her why she was doing that, and resident stated, "so I can die". The resident stated she was pocketing her food "to kill myself". The resident was sent to the hospital for evaluation. The hospital report, dated 9/22/22, indicated the resident was seen due to not eating for three days. When social services asked her why she indicated because she wanted to die. At the hospital the resident said she had been feeling more sad lately and the food didn't taste very good. The resident did not appear to be at imminent risk of serious harm to self or others and did not meet criteria for involuntary admission. The resident was discharged to the facility The nurse's note, dated 9/23/22 at 1:43 p.m., indicated the resident returned from the hospital with paperwork from the social worker stating she		Monthly meetings will continue for a minimum of 6 months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits. V. Date Complete: 11/14/22	

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	was not at risk for self-harm or harm to others. The clinical record lacked documentation of any psychosocial follow-up by the SSD after the resident's return to the facility, or any monitoring for further suicidal ideation or pocketing of food. During an interview on 10/21/22 at 10:11 a.m., the SSD indicated he would normally go and check on the residents when they came back and make sure they were doing alright and make sure they weren't having any ideations. During an interview on 10/21/22 at 10:40 a.m., the SSD indicated he saw the resident daily up at the nurse's station, but this was his first time dealing with a resident with suicidal ideations. He had not been in social services very long. He would usually follow up with them once or twice after the incident, but he probably should be doing more. During an interview on 10/25/22 at 2:06 p.m., the DON (Director of Nursing) indicated on the first incident, they should have checked the resident's room to see if there were pills in the room and they should be making sure no medication was left at her bedside, that no one was bringing in stuff from outside. They should also be monitoring every meal to make sure and assess the resident and ensure she had nothing left in her mouth. The Suicide Precautions Policy and Procedure, dated 5/10/10, provided on 10/21/22 at 12:31 p.m. by the SSD, included, but was not limited to, "... If a resident states that he or she no longer wishes to live and intends to harm him-or-herself the facility will initiate suicide precautions... 2. Maintain a one-on-one relationship with the resident. Do not leave the resident alone when actively suicidal... 4. Search the residents room			

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	thoroughly each shift for any and all potentially dangerous objects... 6. Check on resident every 15 minutes to ensure the resident's safety. Document the checks on the daily flow sheet. Staff will report no less than hourly and report any observed behavior to the charge nurse. Increase the frequency of monitoring at the nurse's discretion. Document the results... 7. The nurse will chart behaviors in the nursing notes each shift and reassess as needed... 8. Nursing and social services will document observations, efforts, interventions, and resident response in progress notes..." 2. The clinical record for Resident 12 was reviewed on 10/21/22 at 9:36 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, major depressive disorder, anxiety disorder, dementia, depression, psychotic disorder, insomnia, and violent behavior. The care plan, dated 6/25/20 and last revised on 8/10/22, indicated the resident had a diagnosis of dementia, Alzheimer's and impaired decision making, short term and long-term memory loss. The interventions indicated to administer medications per physician orders, contact the physician as needed, give support to family if condition worsens, observe for worsening condition as needed, psychiatric to evaluate and treat as needed, and routine medication review. The care plan, dated 7/8/20 and last revised on 8/10/22, indicated the resident had anxiety and potential for anxious or depressed mood at times. The interventions indicated to administer medications as ordered, assess, and record anxious or depressed mood or behavior, determine patterns (time of day, precipitating factors/situations) if possible, assess changes in mental status, encourage her to maintain contact			

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	with her family. The nurse's note, dated 1/18/22 at 12:04 p.m., indicated the resident had recently taken to picking at her face. She currently had approximately 4 places on her face that were bright red. The resident had a habit of picking off scabs on her lower legs. The nursing staff had repeatedly educated the resident not to pick at scabs, and currently not to pick at her face. This behavior had been reported to social services for possible evaluation by the psychiatric nurse. The DON's note, dated 2/10/22 at 1:01 p.m., indicated she called the physician about the resident's statements and he wrote for a new order to be one on one until the psychiatric hospital could evaluate the resident. The social service note, dated 2/10/22 at 1:10 p.m., indicated the SSD was notified that the resident had made the comment she wanted to kill herself. The SSD went to the resident's room to find the resident sitting on her bed crying. He sat down beside her, and she indicated she wanted out of the facility. She indicated she had nothing to do at the facility but sit and she had been there too long. When asked if she had thoughts of wanting to hurt herself, resident indicated, "Yes, I think about it from time to time, because I know it's going to be my only way out of here." The resident was immediately put on one on one at 11:30 p.m. The psychiatric hospital was notified and information was sent to intake. The nurse's note, dated 2/11/22 at 1:06 p.m., indicated two attendants from the psychiatric hospital arrived to transport the resident to the psychiatric hospital for evaluation and treatment. No behaviors were observed before the resident			

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	left the facility. The Social Service note, dated 2/11/22 at 5:22 p.m., indicated the resident did well through the night per the nursing staff. She had no signs or symptoms of suicidal ideation. The resident was sent to a psychiatric hospital at 11:50 a.m. to be evaluated and treated. The nurse's note, dated 2/28/22 at 1:29 p.m., the resident arrived back to the facility from the psychiatric hospital. The Psychiatry Initial Consult assessment, dated 3/25/22, indicated the resident was first evaluated. She denied past suicidal attempts. The clinical record lacked documentation of a Social Service follow up after the arrival back to the facility and monitoring and follow up of suicidal ideations. During an interview on 10/21/22 at 10:42 a.m., the SSD indicated he may have checked on the resident for a follow up but was not sure. During an interview on 10/21/22 at 12:31 p.m., the SSD indicated he could only find the one follow-up note and he should have assessed the resident more often after the suicidal ideation and return from the hospital. He indicated he knew to do that now. 3. The clinical record for Resident 35 was reviewed on 10/23/22 at 1:00 p.m., Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, benign neoplasm of meninges, chronic respiratory failure with hypercapnia, acute and chronic respiratory failure with hypoxia, generalized anxiety disorder, attention-deficit hyperactivity disorder, major depressive disorder,			

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	recurrent, benign neoplasm of the brain and psychotic disorder with hallucinations due to known physiological condition. The Day Minimum Data Set (MDS) assessment, dated 10/12/22, and the Quarterly assessment , dated 9/8/22, indicated the resident was cognitively intact with occasional forgetfulness and had no hallucinations during the assessment periods. A Social Services note, dated 6/27/2022 at 5:35 p.m., indicated the resident was having self reported hallucinations per nursing note on 6/26/22. No further documentation by the Social Worker was made to indicate he had followed up with the resident or staff on her hallucinations. He only made a referral for the psychiatric nurse to see the resident on next visit to the facility. A nursing note, dated 7/16/22 at 12:39 a.m., indicated the resident was heard yelling down the hall and upon entrance to her room to check on the resident, the resident immediately started yelling and cussing at the nurse and speaking nonsense. When the nurse tried to get the resident to explain what was wrong, the resident yelled and cussed that it was none of her business and to get out of her room. Upon re-approach a short time later, the resident continued to yell and cuss and began swinging her arms in an attempt to hit the staff. She again told the staff to "get the hell out of my room." The resident continued to yell and cuss and spoke nonsense at the nursing staff when checked again later and refused care. A nursing note, dated 7/16/2022 at 2:13 a.m., indicated the resident had called the local ambulance company to come and get her. When			

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	the company verified with the nurse if the resident was okay, the nurse explained she was being combative and refusing care. The ambulance then indicated they were en route to take the resident to the local hospital. A nursing note, dated 7/16/22 at 2:19 a.m., indicated the resident's family member was contacted to speak with the resident in an attempt to calm her down. After the resident was off the phone, the nurse went into the resident's room to offer help and the resident again yelled "get the hell out." All attempts at re-approaching, changing care giver, and redirecting failed. EMS (Emergency Medical Service) then arrived to take the resident to the hospital. The resident was returned to the facility a few hours later. A nursing note, dated 7/17/22 at 3:00 p.m., indicated the resident was heard yelling and screaming from her room. When the Certified Nursing Aide (CNA) 11 went to see what the resident needed, she became very loud, agitated and aggressive toward him. Yelling, screaming and cursing at him. When the nurse entered the resident's room, she was lying in bed yelling, screaming and cursing that she had been in the same spot in the same room all day. Staff tried to tell her because she had COVID, she was unable to leave her room. Despite this explanation, the resident continued to argue with staff that she was able to leave the room because she had gone to the hospital the day before. After staff left the room, the resident started yelling, screaming and cursing again. When the nurse came back into the room with some medication, she was standing with her walker yelling, screaming and cursing making statements that made absolutely no sense and were completely untrue. Saying no one had checked on her all day; she was going to call the			

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	police because staff were holding her hostage. She asked the CNA to call her family member, but she did not like her family member's answers to her demands of wanting to go home and hung up on him. When the staff tried to get her to sit down as they were afraid she was going to fall and break a hip, the resident responded that it was good as maybe it would kill her as she was ready to go. The family member was notified again of the resident's behaviors and he indicated he would come in. It was also explained to the family member that if this behavior continued, the facility might have to send the resident to a psychiatric hospital for evaluation and treatment. The resident's clinical record lacked documentation pertaining to the SSD having spoken to or assessed the resident for causes after she was sent to and from the hospital for the behaviors on 7/16 and 7/17/22. The Social Services note, dated 7/25/22 at 4:30 p.m., only indicated the resident had behaviors of cussing at staff. No discussion was held between the Social Worker and the staff as to reasons for the behaviors. A nursing note, dated 7/30/22 at 11:00 a.m., indicated the resident had been inappropriate with staff as well as therapy staff. Resident was yelling at the Physical Therapy assistant for various issues. A nursing note, dated 8/18/22 at 5:51 a.m., indicated when the nurse came back into the resident's room to provide care, the resident was very aggressive, yelling, trying to throw out cups and clothing at staff. Documentation was lacking of the Social Worker			

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	having assessed the resident for causes of her behaviors on 8/18/22 or having had a discussion with the staff on the behaviors. A nursing note, dated 8/24/22 at 1:29 a.m., indicated the resident refused her night medications three times; was very aggressive, cursing, being rude to staff, started to throw out cups at staff. The resident also told a CNA she wished to fall down to the floor so she will die of bleeding due to being on blood thinners. New orders were received to send the resident to the hospital for evaluation. The resident returned a few hours later. The Social Worker did speak with the resident on 8/25/22 at 8:33 a.m., although she continued to have delusions and hallucinations during their conversation. A nursing note, dated 8/25/22 at 2:49 p.m., indicated the resident was currently sitting at the nurses station and stated that "there are wholes [sic] in the walls of this building and the entire building is shaking." Attempts to reassure the resident were not effective as she did not believe what the nurse was telling her. Also while sitting at the nurses station, the resident kept talking to the CNA and told her there was dust hanging down and was getting all over the CNA. Attempts at redirection were again unsuccessful as the resident argued with the nurse that she knew exactly what she was seeing. The Activities staff also reported the resident didn't want to go into her room as it wasn't her room since she indicated she just had new furniture delivered. This was not a true statement. Family member and Physician notified of the current hallucinations. Documentation was lacking of the Social Worker having spoken to the resident or staff about her hallucinations on 8/25/22.			

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A Social Services note, dated 9/8/22 at 4:12 p.m., indicated the resident showed no signs of hallucinations, delusions or behaviors during the assessment period.

A nursing note, dated 10/3/22 at 3:42 p.m., indicated the resident was hallucinating this day and indicated she had a man come in and try to take her car away for $14.99. Resident was trying to get out of bed thinking she was in the wrong room. The resident also indicated she saw dogs that weren't there and saw ink on table that wasn't there.

A nursing note, dated 10/4/22 at 2:48 a.m., indicated the resident was alert with increased hallucinations.

A nursing note, dated 10/5/22 at 2:47 a.m., indicated the resident was alert with increased confusion and increased hallucinations.

Documentation was lacking of the Social Worker having addressed the resident's hallucinations on 10/3,10/4 and 10/5/22 with the resident or staff.

A Social Services note, dated 10/12/22 at 4:43 p.m., only indicated the resident has had hallucinations per nursing notes and no behaviors were noted during review period.

A care plan, dated 6/21/22, indicated the resident had hallucinations. No interventions for Social Work involvement were listed except to have psych services evaluate and treat the resident.

A care plan, dated 6/12/22 and revised on 9/14/22, indicated the resident made false accusations and falsely accused others of wrong doing. The SSD

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	intervention was to have psych services evaluate and treat the resident and for all staff to encourage the resident to talk about feelings as needed. During an interview with the Social Worker on 10/24/22 at 1:30 p.m., he indicated nursing would report to him whenever behaviors, hallucinations, etc occurred with the resident, although they did not always tell him in a timely manner. He would then go and talk with the resident and assessed them and made sure psych services saw them as well. He further indicated the resident had acted out a lot since admission because she didn't want to be in the facility and she had those brain tumors. Her hallucinations were not as bad now as they were since she had been put on medication and it had eased up. Her vision was also impaired due to the tumors so she said she "sees" things that really were not there. If a resident was sent to the emergency room or hospital due to behaviors or hallucinations, within 24 to 48 hours he would go and see them to assess them. On 10/21/22 at 2:30 p.m., the Director of Nursing (DON) presented a signed copy of the Social Worker's Job Description dated 9/10/20. Review of this Job Description included, but was not limited to, "...Duties and Responsibilities: Administrative Functions...Interview residents as necessary...Record and maintain regular Social Service progress notes indicating response to treatment plan and/or adjustment to institutional life... Maintain routine visits to residents and perform services as necessary... Work with emotional problems including assisting resident/family with anxieties and stress caused by illness and admission to the facility, difficulties in coping with residual physical disabilities, fears related to helplessness and death, and the need			

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	for institutional and specialized care... Assist in interpreting social, psychological, and emotional needs of the resident/family to the medical staff, attending physician, and other resident care team members..." 3.1-34(a)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent 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 and interview, the facility failed to ensure the kitchen, dry storage room and equipment were clean and in good repair during 3 of 3 kitchen observations. . Findings include:	F 0812	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory**	11/14/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. During the initial kitchen tour on 10/18/22 between 9:25 a.m. and 10:00 a.m., while accompanied by the acting Dietary Manager (DM) the following observations were made: - Inside the milk/soda walk in refrigerator - the 2 condenser fans and an area of approximately 1 inch around the fans unit and the ceiling 2 feet out from the condenser fans had a black greasy dust on them. The fans were running at this time. - Inside the walk in fruit/vegetable refrigerator the floor had onion skins on it, cardboard pieces were under the shelves and in the walk way. There was a build-up of black dirt and food particles in the corners, the floor around the carts' wheels and 6 inches around the entire floor from the baseboards out. The ceiling 1 foot away from the condenser fans had black grease on it. - The walk-in freezer was observed to have a 1 foot long by 4 inch wide frost build up on both the door and the door frame. There was a frozen ice puddle on the floor which was several inches thick by 4 feet in length and 8 feet width with ice frost on the wall behind this ice puddle which measured 3 feet by 4 feet. The floor was littered with cardboard pieces and food debris. The DM indicated at this time that maintenance was getting bids on fixing the freezer as a pipe had broken, but it had been at least 2 months since he started that the ice puddle on the floor had been like that. The Salad prep aide indicated it was more like 4 to 5 months since it was last fixed. - 2 of 2 ceiling vents above the food prep area and 2 feet surrounding the vents had black grease dust on them - food was being prepped on the counter at this time.		**requirements and continue to provide quality care**. **F812** The facility does store, prepare and distribute and serve food in accordance with food service safety. **I. Action taken for those residents identified:** No residents were identified. The kitchen was thoroughly cleaned and repairs made to include but not be limited to: Walk In floor in the corners were cleaned. The fans in the walk-in refrigerator, fans and floors were cleaned. The pipe in the walk-in freezer was repaired. Ceiling cleaned 2 Ceiling vents in prep area were cleaned. 9 ceiling vents were cleaned. 14 ceiling sprinkler heads were cleaned. The knife holder was cleaned. Dry storage room air duct cleaned. The Fryer and skillet were cleaned. The dietary Manager was replaced, the contracted dietary service contract was terminated. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:**	

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	- 9 of 9 ceiling vents had black dust on vents as well as the surrounding ceiling. - 14 of 14 ceiling sprinkler heads were rusty with black dust on the sprinkler and 1 foot of the ceiling surrounding them. - the top of the knife holder had light dust and white specks on it. - dry storage room's air duct vent extending from the ceiling above the cereal rack was covered with a white mesh net. This mesh was now black and the cereal rack had gray dust on the top shelf. The DM indicated that he was told anything above 6 feet in the kitchen was maintenance's responsibility to clean. 2. During the tray line observation, on 10/18/22 between 10:48 a.m. and 11:15 a.m., the same issues remained as previously identified at 9:45 a.m. In addition there were two deep fryers which had brown food particles in the oil and on top of the frame surrounding the oil. Three sides of each fryer, the right side of the stove, the left side of the tilt skillet, and the floor in front of and underneath the fryers had a heavy build-up of brown oil. 3. During a kitchen observation, on 10/20/22 between 10:30 a.m. and 11:00 a.m., the same areas of concerns identified on 10/18/22 at 9:45 a.m. and at 10:48 a.m. remained. During an interview with the Executive Director on 10/24/22 at 8:35 a.m., she indicated the dietary department had a cleaning schedule, but they just weren't using it. All areas of the kitchen needing		The facility hired a Dietary Manager and dietary staff. The dietary staff were provided with a cleaning schedule and training regarding kitchen sanitation. The Dietary Manager will be responsible for the coordination of cleaning schedules and completion of tasks. IV. **How the facility will monitor and quality assurance program**: ***V.*** The Administrator/Designee will be responsible for monitoring by completing a kitchen sanitation tour/audit twice weekly. Should concerns be identified, immediate corrective action shall be taken. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. ***Monthly meetings will continue for a minimum of 6 months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits*** VI. Date Complete: 11/14/22	

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

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	(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 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, record review, and interview, the facility failed to ensure infection	F 0880	**F880** The facility does store, prepare	11/14/2022

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	control practices were followed related to proper use of personal protective equipment (PPE) for 6 of 9 staff observed for Infection Prevention. (Dietary Aide 14, Dietary Cook 15, Housekeeping Supervisor, Social Services Designee, Hospice Volunteer, and Maintenance Man) Findings include: 1. During the initial tour of the kitchen with the Acting Dietary Manager (DM), on 10/18/22 between 9:25 a.m. and 10:00 a.m., the following concerns were observed: a. The Dishwashing Aide walked through the kitchen talking to another worker without her mask on. When questioned if masks were required to be worn at all times, Dietary Aide 14 indicated that yes they were. Throughout the rest of the observation of the kitchen, Dietary Aide 14 was observed with her mask half pulled up covering her mouth only but not her nose. b. Dietary Cook 15 was observed with no mask covering her nose or mouth. 2. During the lunch tray line observation on 10/18/22 between 10:48 a.m. and 11:15 a.m., Dietary Aide 14 was observed with her with mask down off her face and then it was pulled up to only below her nose while she completed setting up the resident food trays. 3. During a random observation on 10/24/22 at 1:05 p.m., the Housekeeping Supervisor entered the front of the building. There was a sign on the door which indicated a mask was to be worn at all times. The Housekeeping Supervisor stopped at the snack machines next to the resident dining room, and then walked down to Assisted Living		and distribute and serve food in accordance with food service safety. **I. Action taken for those residents identified:** No residents were identified. Dietary Aide 14, Dietary Cook 15, Housekeeping Supervisor, Social Service Designee, and Maintenance Man were educated on how to don and doff PPE with return demonstration. It is important to note that the SSD was not meeting with a resident in the office. This observation made was actually a member of the Psychiatric Service provider reviewing and discussing a resident's documented symptoms. The Hospice Volunteer was educated on Mask wearing in the facility and to follow the facility signage in addition to masking when visiting Hospice residents. If questions exist to inquire with the nurse for direction. **II. How other residents are identified:** No residents were identified. An Inservice was provided to the facility staff regarding Mask usage and facility signage. Staff are encouraged to take "mask breaks" outside of the facility and during breaks in non-resident	

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	with no mask on. At 1:12 p.m., he was observed at the snack machines without a mask on and Resident 57 was observed to have been wheeled past him while he was at the snack machines. 4. During a random observation on 10/24/22 at 3:30 p.m., the Social Services Designee was observed to be sitting in his office speaking with Resident 14 who was leaning across the Social Worker's desk. The Social Services Designee had no mask on. On 10/24/22 at 3:20 p.m., the Infection Preventionist presented a memo, dated 9/30/22, which she indicated she had passed out to all staff. This memo indicated that all staff were still required to wear face masks. She also included pictures of how the mask was to be worn properly which covered their mouth and nose. 4. During an observation on 10/18/22 at 11:34 a.m., the Hospice Volunteer was observed enter the building without a face mask on. Eight staff members were observed at the nurses station and in the hallways and seen the visitor without the mask and and no one approached the visitor with a mask and educating the visitor on mask usage. The visitor entered a resident's unit then turned around and went to the nurse's station and asked a staff member for the room number for a resident he was going to visit. The staff member did not make any attempt to encourage the visitor to wear a mask. 5. During an observation on 10/20/22 at 3:00 p.m., the Maintenance Man was observed walking down the hallway and into the dining room with his mask down. Four residents were observed in the dining room watching a movie on the television.		areas such as break rooms, employee bathrooms, appropriate offices where residents are not present. Lotion is available for staff to use for dryness of the face that can be caused by mask wearing. . **III. System in place:** A Root Cause Analysis (RCA) was completed in collaboration with the Infection Preventionist (IP) Medical Director and DON. The facility identified the root cause as “mask fatigue”. Training by the facility IP was provided for the facility staff regarding mask usage, donning and doffing mask. Per the RCA Employees are encouraged to take “Mask Breaks” in non-resident/non- food preparation areas of the facility (e.g., outside, in the employee restrooms, offices) where residents are not present. Lotions are made available for staff to use if mask is causing dry skin. Staff are encouraged to notify the facility if a different mask is needed. Signage was changed and relocated throughout the facility in an effort to again draw staff	

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	The review of the Community Transmission Positive Rate Log, on 10/24/22 at 3:00 p.m., indicated the county positivity transmission rate was high. During an interview on 10/24/22 at 3:00 p.m., the Infection Preventionist indicated the staff would be monitored for compliance by observations of handwashing, proper PPE usage, and daily check offs. Visitors would be educated not to visit if they had symptoms. Education on signs and symptoms are posted on the doors and the proper PPE's to wear. All staff and visitors must wear a mask at all times while in the facility. The staff and visitors had been educated on proper use of the PPE's. The facility offer visitors and staff mask. The surgical mask are required to enter the facility. The county positivity was high at this time. 3.1-18(a)		attention. The LTC infection control self-assessment was completed without needed changes. **IV. How the facility will monitor and quality assurance program**: The IP nurse/DON/Designee will complete daily visual rounds throughout the facility of random staff at random times to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions. Should non-compliance be observed, re-education will immediately be provided and follow up monitoring for compliance conducted. Daily rounds will occur for 6 weeks and until compliance is maintained. Thereafter, visual rounds will be conducted on a monthly basis. The results of these rounds and any corrective actions taken shall be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of findings. ***Monthly meetings will continue for a minimum of six months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits.***	

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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: 000100 Residential Census: 82 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 31, 2022.	R 0000		
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure the kitchen, dry storage room and equipment were clean and in good repair during 3 of 3 kitchen observations. . Findings include: 1. During the initial kitchen tour on 10/18/22 between 9:25 a.m. and 10:00 a.m., while accompanied by the acting Dietary Manager (DM)	R 0273	**The filing of this plan of correction does not constitute that the alleged deficiency did in fact exist. This Plan of correction is filed as evidence of the facility's desire to comply with the regulatory requirements and continue to provide quality care**.	11/14/2022

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	the following observations were made: - Inside the milk/soda walk in refrigerator - the 2 condenser fans and an area of approximately 1 inch around the fans unit and the ceiling 2 feet out from the condenser fans had a black greasy dust on them. The fans were running at this time. - Inside the walk in fruit/vegetable refrigerator the floor had onion skins on it, cardboard pieces were under the shelves and in the walk way. There was a build-up of black dirt and food particles in the corners, the floor around the carts' wheels and 6 inches around the entire floor from the baseboards out. The ceiling 1 foot away from the condenser fans had black grease on it. - The walk-in freezer was observed to have a 1 foot long by 4 inch wide frost build up on both the door and the door frame. There was a frozen ice puddle on the floor which was several inches thick by 4 feet in length and 8 feet width with ice frost on the wall behind this ice puddle which measured 3 feet by 4 feet. The floor was littered with cardboard pieces and food debris. The DM indicated at this time that maintenance was getting bids on fixing the freezer as a pipe had broken, but it had been at least 2 months since he started that the ice puddle on the floor had been like that. The Salad prep aide indicated it was more like 4 to 5 months since it was last fixed. - 2 of 2 ceiling vents above the food prep area and 2 feet surrounding the vents had black grease dust on them - food was being prepped on the counter at this time. - 9 of 9 ceiling vents had black dust on vents as well as the surrounding ceiling.		**F273** The facility does store, prepare and distribute and serve food in accordance with food service safety. **I. Action taken for those residents identified:** No residents were identified. The kitchen was thoroughly cleaned and repairs made to include but not be limited to: Walk In floor in the corners were cleaned. The fans in the walk-in refrigerator, fans and floors were cleaned. The pipe in the walk-in freezer was repaired. Ceiling cleaned 2 Ceiling vents in prep area were cleaned. 9 ceiling vents were cleaned. 14 ceiling sprinkler heads were cleaned. The knife holder was cleaned. Dry storage room air duct cleaned. The Fryer and skillet were cleaned. The dietary Manager was replaced, the contracted dietary service contract was terminated. **II. How other residents are identified:** All residents have the potential to be affected. **III. System in place:** The facility hired a Dietary Manager and dietary staff. The dietary staff were provided	

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	- 14 of 14 ceiling sprinkler heads were rusty with black dust on the sprinkler and 1 foot of the ceiling surrounding them. - the top of the knife holder had light dust and white specks on it. - dry storage room's air duct vent extending from the ceiling above the cereal rack was covered with a white mesh net. This mesh was now black and the cereal rack had gray dust on the top shelf. The DM indicated that he was told anything above 6 feet in the kitchen was maintenance's responsibility to clean. 2. During the tray line observation, on 10/18/22 between 10:48 a.m. and 11:15 a.m., the same issues remained as previously identified at 9:45 a.m. In addition there were two deep fryers which had brown food particles in the oil and on top of the frame surrounding the oil. Three sides of each fryer, the right side of the stove, the left side of the tilt skillet, and the floor in front of and underneath the fryers had a heavy build-up of brown oil. 3. During a kitchen observation, on 10/20/22 between 10:30 a.m. and 11:00 a.m., the same areas of concerns identified on 10/18/22 at 9:45 a.m. and at 10:48 a.m. remained. During an interview with the Executive Director on 10/24/22 at 8:35 a.m., she indicated the dietary department had a cleaning schedule, but they just weren't using it. All areas of the kitchen needing cleaning, including the ceiling tiles and vents, fell under the dietary's responsibility to clean, not maintenance.		with a cleaning schedule and training regarding kitchen sanitation. The Dietary Manager will be responsible for the coordination of cleaning schedules and completion of tasks. IV. **How the facility will monitor and quality assurance program**: ***V.*** The Administrator/Designee will be responsible for monitoring by completing a kitchen sanitation tour/audit twice weekly. Should concerns be identified, immediate corrective action shall be taken. The results of these audits and any necessary corrective actions will be discussed during the monthly QAPI meetings with additional education or revision of the plan made on the basis of the findings. ***Monthly meetings will continue for a minimum of 6 months then will be stopped after two consecutive months of finding no issues with the stand down meeting audits*** VI. Date Complete: 11/14/22	

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