STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155690	A. BUILDING 00 B. WING	07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF ANDERSON	1821 LINDBERG RD ANDERSON, IN 46012

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00412464. Complaint IN00412464 - Federal/State deficiencies related to the allegations are cited at F568. Survey dates: July 10, 11, 12, 13, and 14, 2023 Facility number: 000027 Provider number: 155690 AIM number: 100266180 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 2 Medicaid: 39 Other: 8 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 21, 2023.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Recertification and State Licensure Survey and complaint survey conducted July 10 - 14, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of August 18, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0565 SS=E Bldg. 00	483.10(f)(5)(i)-(iv)(6)(7) Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval			

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

Eileen Thomas HFA | Executive Director | 08/04/2023

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	of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. Based on interview, record review, and observation, the facility failed to resolve Resident Council concerns related to laundry services and housekeeping services. Findings include:	F 0565	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident Council concerns for Residents 40, 9 and 8 related to	08/18/2023

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	1. During a Resident Council interview, on 7/12/23 at 2:00 p.m., residents in attendance indicated they had voiced multiple concerns related to laundry services and missing clothing items as follows: Resident 40 indicated she had multiple shirts missing, which she labeled herself. Some had been returned damaged. Her items had not been replaced. Resident 9 indicated she had missing socks, even after she labeled them herself. Resident 8 indicated he had missing shirts. Review of the 3/29/23, 4/27/23, and 5/22/23 meeting minutes indicated concerns with laundry not being delivered or returned, and missing clothing items. An official grievance was completed for housekeeping and laundry for the 3/29/23 concerns. During an interview, on 7/13/23 at 3:16 p.m., Laundry Aide 16 indicated there was not a formal document for missing items and the housekeeping supervisor would let staff know if residents were looking for missing items. Residents would tell her if they were missing items as she delivered clean laundry. There was no process for identifying clothing, other than by word of mouth. At the time of the interview, there were two racks and two carts of lost and found items observed. 2. During the Resident Council interview, on 7/12/23 at 2:00 p.m., members indicated the following: a. 6 of 6 residents indicated they had voiced concerns related to facility and room cleanliness. b. 6 of 6 residents indicated the shower rooms on		housekeeping and laundry services have been addressed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents have the potential to be affected by the alleged deficient practice. No other residents have been identified to be affected. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** An audit of environmental concerns has been completed and a cleaning schedule developed and implemented. A Housekeeping/Laundry communication form has been developed and implemented to respond to laundry or housekeeping concerns. All staff have been inserviced regarding the Grievance/Concern Form and the Housekeeping/Laundry Communication form. The Activity Director has been inserviced about providing concerns from Resident Council to the appropriate department with follow up with the Resident Council President/designee.	

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	the 500 and 600 halls were not clean, and smelled badly. c. 6 of 6 residents indicated the dining rooms were not cleaned. d. 3 of 6 residents indicated they had cleaned their own bathrooms, because staff had not done so. e. 2 of 6 residents indicated the hallway carpet was "nasty," "dirty," and "smells". Resident 40 indicated she utilized the shower room on the 600 hall. The shower room was dirty, smelled bad, and had a slow drain. She had cleaned up the shower room before she used it for her showers. Review of the 3/29/23, 5/22/23, and 6/29/23 meeting minutes indicated the resident council members had voiced concerns with resident rooms not being cleaned. Review of the Grievance Log, provided by the Administrator on 7/14/23 at 3:10 p.m., indicated grievances were filed for room cleanliness on the following dates: 2/21/23, twice on 2/22/23, 3/16/23, 6/22/23, and 6/29/23. The log indicated a resolution was reported to the person who had voiced the concern and a resolution had been agreed upon by the reporter and the facility. During an interview on 7/14/23 at 9:47 a.m., the Administrator indicated the current turn over of the management positions in the facility made interviewing previous staff members involved with grievances unattainable. A current facility policy, dated 8/23/22, titled "Resident Concerns and Grievances", provided by the Administrator on 7/14/23 at 3:10 p.m., indicated the following:		**How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ED/Designee will be responsible for the monitoring of resident council concerns for no less than 6 months. The results of these audits will be reviewed by the QA committee. The facility through the QAPI program, will review, update, and/or develop any needed plan of action to sustain substantial compliance ongoing.	

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	" ...Policy... Each resident has the right to: file grievance orally or in writing; file a grievance anonymously, and to obtain a written decisions regarding his or her grievance... Procedure...Definition: a grievance is any written or verbal concern by a resident, relative, or any other representative relating to resident care or the quality of services provided....The Executive Director/Grievance Official will ensure appropriate corrective action is taken in accordance with State law if the alleged violation of the resident's rights confirmed by the facility... P. Resident Council...We will make all reasonable efforts to address any issues voiced by the residents at these meetings...." Cross reference F584 3.1-3(l)			
F 0568 SS=E Bldg. 00	483.10(f)(10)(iii) Accounting and Records of Personal Funds §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. Based on interview and record review, the facility failed to manage Resident Funds in accordance	F 0568	**What corrective action(s) will be accomplished for those**	08/18/2023

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	with acceptable accounting principles regarding reconciliation of withdrawals with corresponding receipts and failure to provide quarterly statements to residents and/or their representative for 4 of 4 residents reviewed for management of Resident Funds (Residents B, C, D, & E) Findings include: 1. A review of resident funds began on 7/11/23 at 9:57 a.m. The Corporate Business Office Manager (C-BOM) provided the following information at this time: a. The facility managed personal Resident Funds for 40 residents and consisted of both current and discharged residents. Residents B, C, D, & E were included on the list of residents for whom the facility managed funds. b. Discharged residents were anticipated to return or had yet to have their accounts closed. 2. Resident B's Resident Funds record indicated the following: a. A withdrawal of $500.00 for "Personal Needs" with a "Date of Service" of 3/31/23, was made to the resident account. The resident funds accounting record lacked a receipt related to this transaction. b. The resident funds record lacked any documentation of a quarterly statement being provided to the resident and/or their representative. During an interview on 7/14/23 at 11:00 a.m., the C-BOM indicated banking records indicated a facility employee had cashed the $500.00 check identified as "Personal Needs" for Resident B. There was no corresponding receipt to reconcile		**residents found to have been affected by the deficient practice?** An accounting of resident funds was completed for Residents B, C, D, & E. Any concerns with accounts for Residents B, C, D & E, have been resolved and statements provided. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents with accounts have the potential to be affected by the alleged deficient practice. All current resident accounts were audited by the Corporate BOM. Statements were issued for all resident trust accounts. Education and Training has been provided on Acceptable Accounting Principles and Resident Accounts Policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** BOM/designee will provide monthly accounting of resident transactions to ED/designee, until substantial compliance of proper accounting as been maintained for at least 6 months. Quarterly statements will be provided to residents or their	

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	with this check having been cashed. During an interview on 7/14/23 at 11:26 a.m., the Activity Director indicated she had cashed a check for $500.00 for Resident B and given the $500.00 cash to the previous BOM. The check had been cashed in March or April. The previous BOM told her the resident needed to do a "spend down" for Medicaid eligibility. She herself had not purchased any items for the resident. 3. Resident C's Resident Funds record indicated the following: a. A withdrawal of $100.00 for "Resident Advance Cash", with a "Date of Service" of 4/27/23, was made to the resident's account. The resident funds accounting record lacked a receipt related to this transaction. b. The resident funds record lacked any documentation of a quarterly statement being provided to the resident and/or their representative. 4. Resident D's Resident Funds record indicated the following: a. A withdrawal of $300.00 for "Personal Needs",with a "Date of Service" of 3/31/23, was made to the resident account. The resident funds accounting record lacked a receipt related to this transaction. b. A withdrawal of $100.00 for "Resident Advance Cash", with a "Date of Service" of 6/6/23 was made to the resident account. The resident funds accounting record lacked a receipt related to this transaction. c. The resident funds record lacked any documentation of a quarterly statement being provided to the resident and/or their		responsible party ongoing, including notification of resource limits. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** BOM/designee will provide monthly accounting of resident transactions to ED/designee, until substantial compliance of proper accounting has been maintained for at least 6 months. ED/designee will be responsible for monitoring compliance of resident accounts monthly ongoing.	

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	representative. 5. Resident E's Resident Funds record indicated the following: a. A withdrawal of $2,000.00 for "Personal Needs", with a "Date of Service" of 3/31/23 was made to the resident account. The resident funds accounting record lacked a receipt related to this transaction. b. A withdrawal of $10.00 for "Resident Advance Cash," with a "Date of Service" of 4/14/23 was made to the resident account. The resident funds accounting record lacked a receipt related to this transaction. c. A withdrawal of $20.00 for "Resident Advance Cash", with a Date of Service" of 4/25/23, was made to the resident account. The resident funds accounting record lacked a receipt related to this transaction. d. The resident funds record lacked any documentation of a quarterly statement being provided to the resident and/or their representative. During an interview on 7/12/23 at 5:25 p.m., the C-BOM, who was covering as temporary Business Office Manager (BOM) for the facility, indicated the facility had terminated the previous BOM on 7/3/23, due to poor job performance. The facility could not provide any documentation of quarterly statements having been provided for the previous two quarters. During an interview on 7/14/23 at 12:45 p.m., the C-BOM indicated she had not been able to directly audit the previous BOM at this facility. The tasks she managed were too large for direct oversight. She had corresponded via email and directed the previous BOM to complete her			

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	required duties. Confidential interviews were conducted during the survey. During a confidential interview with a resident representative, they indicated they had no idea what the resident's current resident funds balance was. They had not been informed the resident was reaching their resource limit at any time during the previous six months. They had not received any money from the facility to "spend down" the resident's resources during the year 2023. During a confidential interview, a resident indicated they had not received quarterly statements in about a year. Review of a current, 12/2022 facility policy, titled "Resident Funds", provided by the C-BOM on 7/13/23 at 2:04 p.m., indicated the following: "...2. Individual accounting ledgers are maintained in accordance with generally accepted accounting principles and include: ...d. The date and amount of each deposited and withdrawal; e. The name of the person who accepted or withdrew funds; f. The balance after each transaction; g. Receipts for charges imposed the facility; and ...5. Individual accounting records are made available to the resident through quarterly statements and upon requests...." This finding relates to complaint IN00412464. 3.1-6(g) 3.1-6 (e)			

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F 0569 SS=E Bldg. 00	483.10(f)(10)(iv)(v) Notice and Conveyance of Personal Funds §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law. Based on interview and record review, the facility failed to notify residents and/or their representative when the resident was within two hundred dollars ($200.00) of the state Medicaid resource limit of two thousands dollars ($2,000.00) for 3 of 4 of residents reviewed for management of Resident Funds. (Residents B, D, & E) Findings include: 1. A resident funds review began on 7/11/23 at 9:57 a.m. The Corporate Business Office Manager (C-BOM) provided the following information at that time:	F 0569	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident Trust Accounts for residents B, D, & E were audited, and residents or responsible party were notified of resource limits, and spend downs initiated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective**	08/18/2023

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	a. The facility managed personal Resident Funds for 40 residents and consisted of both current and discharged residents. b. Discharged residents were anticipated to return or had yet to have their accounts closed. c. Six of the accounts had funds in excess of $1,800.00. Residents B, D, & E where included in the list of six with funds in excess of the Medicaid resource limits. 2. Resident B's Resident Funds information indicated a 7/3/23 balance of $2,222.61 (This balance was in excess of the Medicaid resource limit). The funds balance had been in excess of the Medicaid resource limit since the "5/1/23 OPENING BALANCE of $1,851.86". The resident received Medicaid benefits. 3. Resident D's Resident Funds information indicated a 7/3/23 balance of $1,984.39 (This balance was in excess of the Medicaid resource limit). The funds balance had been in excess of the Medicaid resource limit since the "5/1/23 OPENING BALANCE of $1,984.39". The resident received Medicaid benefits. 4. Resident E's Resident Funds information indicated a 7/3/23 balance of $2,143.75. (This balance was in excess of the Medicaid resource limit). The funds balance had been in excess of the Medicaid resource limit since the "5/1/23 OPENING BALANCE of $2,011.77". The resident received Medicaid benefits. During an interview on 7/12/23 at 5:25 p.m., the C-BOM indicated the facility had no evidence of having provided notice of reaching a resource limit for any resident for the last year.		**action will be taken.** All residents with accounts have the potential to be affected by the alleged deficient practice. All current resident accounts were audited by the Corporate BOM. Statements were issued for all resident trust accounts with notifications provided to any resident or their responsible party that was at or exceeded the $1800 threshold. Education and Training has been provided on Acceptable Accounting Principles and Resident Accounts Policy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** BOM/designee will complete monthly monitoring of all resident trust accounts and immediately report to the ED/designee any account at or exceeding the resource limit threshold. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ED/designee will be responsible for the monitoring compliance of resident funds accounts ongoing.	

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	Confidential interviews were conducted during the survey. During a confidential interview, a resident representative indicated they had no idea what the resident's current resident funds balance was, and they had not been informed the resident was reaching their resource limit at any time during the previous six months. A current, 12/22, facility policy, titled "Resident Funds", provided by the C-BOM on 7/13/23 at 2:04 p.m., indicated the following : "...6. A representative of the business office will inform the resident: a. If the balance in his/her personal funds account reaches $200 (two-hundred dollars) less than the resident's SSI limit; and b. That if the amount in the account (plus the resident's other non-exempt resources) reach the SSI recourse limit for one person, the person may lose eligibility for Medicaid or SSI...." 3.1-6(h)			
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident			

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	can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to maintain the resident environment in a clean, comfortable, and homelike manner for 4 of 6 nursing units (200 hall, 400 hall, 500 hall, and 600 hall) and common areas. Findings include: 1. Random facility observations indicated the following concerns:	F 0584	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All identified areas have been cleaned, and repairs have been made where appropriate. **How other residents having the potential to be affected by the**	08/18/2023

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	a. On 7/10/23 at 9:42 a.m., there was a strong urine smell at the 500 and 600 hall nurses station. b. On 7/10/23 at 9:42 a.m., the floors of rooms 501, 502, 503, and 504 were soiled and did not appear to have been mopped recently. Each had multiple dark black scuff marks approximately 6 to 10 inches in length and approximately ½ inch thick. c. On 7/10/23 at 10:03 a.m., the white tile in the main hallway, stretching from the lobby, public restrooms, through the dining room, and to the surrounding 500/600 Unit nurses station, was scattered with debris. The debris was heavier approximately 2 inches from the walls. Multiple areas of scattered brown/black dried spots were in the main hallway, both sides of the dining areas surrounding tables, and surrounding the 500/600 unit nurses station. The dried spots on the white tile were approximately the size of a nickel and highly visible on the white tile. d. During an observation on 7/10/23 at 10:19 a.m., Room 615's floor tile was heavily soiled with brown and black spots throughout. A medical glove and two pieces of cookie wafer were on the floor. A large, brown, dried spill surrounded the resident's trash can. The floor was sticky. The toilet in the adjoined restroom contained a prominent brown ring in the toilet bowl. During an observation on 7/10/23 at 1:04 p.m., Room 615's floor remained heavily soiled and unchanged from the previous observation. During an observation on 7/11/23 at 12:10 p.m., Room 615's floor remained with dirt and debris. The cookie wafer was not on the floor, but the brown residue from the cookie wafer remained on the floor. When walked on, the floor was sticky.		**same deficient practice will be identified and what corrective action will be taken.** All residents had the potential to be affected by the alleged deficient practice. A facility-wide audit was conducted, and a cleaning schedule has been developed and implemented by the new Housekeeping Supervisor. An all staff inservice was conducted which included implementation of a Housekeeping Communication form to identify specific areas of concern for additional housekeeping concerns beyond the newly developed cleaning schedule. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** An all staff inservice was conducted to provided education about acceptable clean, comfortable, homelike environment. A cleaning schedule has been developed and implemented by the new Housekeeping Supervisor. The IDT will be conducting ongoing audits to ensure that a clean, comfortable, homelike environment is maintained. **How the corrective action will be monitored to ensure the**	

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	The toilet in the resident's room remained with a brown ring. During an observation on 7/12/23 at 10:27 a.m., Room 615's floor was clean. Her toilet remained unchanged from the previous observation. During an observation and interview on 7/13/23 at 11:30 a.m., Housekeeper 15 indicated room 615's toilet contained an obvious brown ring in the toilet bowl. Housekeeper 15 assisted from another facility in the corporation on 7/11/23 and 7/13/23. When she arrived on 7/11/23, the toilets were not cleaned to the standard she was accustomed too. Additionally, resident room floors were sticky. She had not found any cleaning supplies out of stock. Floors throughout the building should have been swept and mopped every day. Public restrooms should have been cleaned 2-3 times each day. Resident restrooms should have been cleaned daily to include toilets, sinks, and floors. Carpet in the hallways should be cleaned weekly. During an observation and interview on 7/13/23 at 11:50 a.m., Housekeeper 15 indicated she had finished cleaning room 615's toilet and the brown ring was removed. The toilet was crisp white. Housekeeper 15 indicated all toilets, whether in use or not, were required to be cleaned each day. She had not been made aware of any problematic rooms that required any additional cleaning. e. On 7/10/23 at 12:50 p.m., the main hallway had black and brown stains on white tile approximately 1 cm to 1.6 cm in size between the dining rooms. f. During an observation on 7/10/23 at 1:25 p.m., Resident 6's white floor tile in his room was visibly soiled with dull brown/black appearance. The floor was sticky when walked upon. During an		**deficient practice will not recur i.e., what quality assurance program will be put into place?** ED/Designee will complete monitoring to ensure that the facility maintains a clean, comfortable, homelike environment. The monitoring will be documented and presented to the IDT weekly and reviewed in the monthly QAPI meeting ongoing.	

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	interview, Resident 6 indicated the facility did not keep his restroom and floors clean and this made his shoe stick to floor from the dirt. The toilet in his room had dark brown residue around the back of the toilet seat. Observation indicated the rim of the toilet contained hair, dust, and splattered brown residue. Brown splatters were on the sticky floor in the resident's restroom, surrounding the toilet. He indicated they only cleaned his room and restroom one to two times each week. During an observation on 7/11/23 at 11:41 a.m., Resident 6's soiled floors and restroom remained unchanged from the observation on 7/10/23. Resident 6 indicated he was showered in the 600 Unit shower room across from his room. g. On 7/10/23 at 1:26 p.m., resident room 203 had dark black scuff marks all over the floor by the resident's bed and recliner. Each scuff was approximately 6 to 12 inches in length. The scuffs were dark black and approximately ½ inch thick. The bottom of the overbed table had a sticky yellow residue. h. During an observation on 7/10/23 at 2:50 p.m., resident room 609 had a dead black bug the size of a raisin on the floor in front of the bookshelf. The floor near the head of the bed had a large brown soiled area the size of a soccer ball, against the wall. A black residue was along the bottom of the widow frame, at the windowsill, and beside the resident's bed. During an observation on 7/12/23 at 12:37 p.m., room 609 remained with a large brown soiled area on the floor near the head of the bed against the wall. Black residue remained along the bottom frame of the window.			

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	i. During an observation on 7/10/23 at 4:07 p.m., the 600 Unit shower room had three coves (one toilet cove and two shower coves) Upon entering the room, a musty odor was observed. The toilet was not functioning and displaced from the wax ring. The floor in the shower room contained a large clump of hair and dirt, scattered debris, plastic wrap, various trash, a medication cup, a broken lid off of a soap bottle, and wet paper underneath the shower chair in the first shower cove. Black and pink residue was along the floor where it met the wall on all sides. Black residue, the width of eight floor tiles, was along the floor in the main part of the shower room. The entry to the first shower cove had three tiles missing from the floor up the wall. Black residue was noted where the tiles were missing. The second shower cove was not functional, as it did not have a shower head or faucet. Small gnat-sized dead bugs were all over the floor under the shower chairs. The drain grate was partially off of the drain with 1/4 of the drain cover plugged with hair and dirt. The shower bed contained a rolls of bags, three loose gloves, a washcloth, and a shave cream lid. j. During an observation on 7/10/23 at 4:30 p.m., the nickel sized brown dried spills on the white tile around the 500/600 Unit Nurse's station, in the hallway through the dining room to the front lobby, and in the dining room remained. In the dining room, residents were being served their supper. k. On 07/11/23 at 09:00 a.m., there were cracked tiles in the hallway between the dining areas. Large brown and black stains, approximately 1 cm to 1.6 cm in size, were present on the white square tiles in front of nurse station between 500 and 600			

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	halls. l. On 7/11/23 at 9:04 a.m., in room 501, the floor was sticky, had food crumbs, and black scruff marks throughout. Each scuff was approximately 6 to 10 inches in length. The scuffs were dark black and approximately ½ inch thick. The closet door was broken and hanging incorrectly off the track. m. On 7/12/23 at 9:13 a.m., in room 501, the floor was sticky and black scruff marks throughout. Each scuff was approximately 6 to 10 inches in length. The scuffs were dark black and approximately ½ inch thick. The closet door was broken and remained hanging incorrectly off the track. n. On 7/11/23 at 9:10 a.m., in room 502, the floor had approximately 12 brown stains, approximately 1 cm to 1.6 cm in size and black scuff marks. Each scuff was approximately 6 to 10 inches in length. The scuffs were dark black and approximately ½ inch thick. o. On 07/12/23 at 9:14 a.m., in room 502, the floor had black scuff marks, each scuff was approximately 6 to 10 inches in length and were dark black and approximately ½ inch thick, and brown sticky areas measuring approximately 1 cm to 1.6 cm in size. p. On 7/11/23 at 9:13 a.m., in room 504, the floor was sticky and had black scuff marks all over the floor. Each scuff was approximately 6 to 10 inches in length. The scuffs were dark black and approximately ½ inch thick. q. On 7/11/23 at 9:18 a.m., in room 511, the floor had approximately 10 red-brown stains, measuring approximately 1 cm to 1.6 cm in size at the bedside.			

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	r. On 7/11/23 at 9:41 a.m., in room 506, the floor was sticky and had five large gouges to wall at head of bed. Each gouge was approximately 4 to 6 inches in length and approximately ½ inch thick. s. On 7/11/23 at 10:46 a.m., the 500 hall shower room was very warm and smelled of strong chemicals. The sink hung crooked on wall, and there was dirty grout in both shower areas. The ceiling light was missing, and electrical wires and plugs were exposed. t. On 7/11/23 at 12:35 p.m., Certified Nurse's Aide (CNA) 9 delivered a meal tray to room 613. The floor had dark brown spots throughout the room. When she stepped onto the resident's floor, each step of her shoes made a loud popping noise as they stuck to the floor. u. On 7/12/23 at 9:37 a.m., the main lobby focal piece, with a platform painted pink, was covered with dirty footprints. v. On 7/12/23 at 11:14 a.m., room 516 had a sticky floor with black scuffs and stained tiles. Each scuff was approximately 6 to 10 inches in length. The scuffs were dark black and approximately ½ inch thick. w. On 7/13/23 at 9:19 a.m., there was a strong urine smell in 500 hallway. Approximately 12 dead brown bugs the size of large almonds were located on the floor at emergency exit on the end of 500 hallway. The carpet throughout the area was stained. The common area between the 500 and 600 halls had approximately 10 dead black bugs, measuring the size of almonds. The bugs were located behind the brown fabric couch.			

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	x. During an observation on 7/14/23 at 10:34 a.m. the hallway through the main dining room contained multiple black and brown spots, ranging from 1 cm to 1.6 cm in size. The dining area to left side of the hallway had several similar sized spots of black, brown, and red on white tile. There was a strong urine smell at nurse station for the 500 and 600 halls. The dead bugs remained at end of the 500 hall. 2. Resident interviews indicated the following concerns: a. During an interview on 7/10/23 at 2:36 p.m., Resident 5 indicated the floors in her room were rarely or never cleaned. She had contacted her family member who brought her cleaning supplies for her to clean the floors herself and motioned to a broom and "Swifer" style wet dust mop resting against her closet. The bathrooms needed to be cleaned better and more frequently than they were done. b. During an interview on 7/10/23 at 2:45 p.m., Resident 17 indicated his room had gnats and bugs. The 600 Unit shower room had mold and gnats, and the shower was "gross" and he would not shower in there. c. During an interview on 7/12/23 at 4:09 p.m., Resident 17 indicated he had reported his concerns about bugs and concerns about black mold and gnats in the 600 Unit shower room to the Housekeeping Supervisor and the DON. This was reported when he changed rooms in April of 2023. The shower room had black mold and a piece of feces in the floor of the shower. d. During an interview on 7/11/23 at 9:33 a.m., Resident 25 indicated there was a hole in the			

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	shower room on the 600 hall, where the floor met the wall. She was concerned about mold starting there ,and this is where she went to shower. e. During an interview on 7/11/23 at 9:34 a.m., Resident 29 looked at the floor in their room and indicated "what are these marks all over my floor? My floor needs cleaned." During the interview, the flooring was observed to be covered in long black streaks. 3. Facility staff were interviewed during the survey process and provided the following information and concerns regarding the environment and cleanliness: a. During an interview on 7/12/23 at 10:35 a.m., CNA 10 indicated she had just assisted a resident in the 600 Unit shower room. The shower room normally had the black and pink residue which remained in the shower during the observation. The shower had not been clean. She had not been instructed to stop using the 600 Unit shower room. She thought the drain screen was off to help the water drain better, but she could see hair and dirt in the drain screen. The toilet had been off to the side for approximately 1 month and was gone now. CNA 10 noticed the resident rooms had not been getting cleaned properly for the last month. She reported dirty floors that were sticky and toilets were not getting cleaned to the Housekeeping Supervisor. b. During an interview on 7/12/23 at 4:53 p.m., CNA 19 indicated she worked all of the units. She indicated for the past 3 and a half months, the facility had ongoing problems with a lack of floor cleanliness and toilet cleanliness throughout the whole building. The cleanliness of the 600 Unit shower was an ongoing problem and the shower			

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	room was in poor repair, with an inoperable toilet and broken tiles. Three residents had reported concerns to her regarding the cleanliness of their floors and restrooms. When she reported it to the the Housekeeping Supervisor, he told her he was aware of the concerns because he was short on staff. c. During an interview on 7/12/23 at 4:32 p.m., QMA 20 indicated residents had reported concerns to her regarding the lack of sweeping and mopping the floors and the lack of toilet cleaning. She indicated these concerns were reported to an unidentified interim Administrator who planned to discuss it with housekeeping. d. During an interview on 7/13/23 at 10:02 a.m., CNA 18 indicated the building cleanliness was repulsive, and the building needed to be taken better care of, as it was dirty and not cleaned enough. There were bugs that looked like cockroaches. e. During an interview on 7/14/23 at 1:30 p.m., the Administrator indicated the facility environment cleanliness was not acceptable. f. During an interview on 7/14/23 at 3:28 p.m., LPN 6 indicated he found the lack of cleanliness in the 200 Unit medication storage room to be embarrassing. Review of a a current facility policy, dated 8/2022, titled "Homelike Environment," and provided by the Administrator on 7/14/23 at 9:30 a.m., indicated the following: "...Policy Statement... Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation... 2. The			

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	facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized homelike setting. These characteristics include: a. Clean, sanitary and orderly environment... f. Pleasant, neutral scents...." Cross reference F565. 3.1-19(f) 3.1-19(f)(4)			
F 0637 SS=D Bldg. 00	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) Based on record review and interview, the facility failed to complete a significant change assessment after a significant weight loss for 1 of 4 residents reviewed for nutrition (Resident 20). Findings include: The clinical record for Resident 20 was reviewed on 7/13/23 at 9:31 a.m. Diagnosis included end stage renal disease on hemodialysis, vitamin D deficiency, zinc deficiency, anemia, and diabetes	F 0637	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 20 was assessed for significant weight change and significant change assessment was completed. **How other residents having the**	08/18/2023

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	mellitus type 2. The resident had a quarterly MDS (minimum data set), dated 3/3/23, which indicated a 5 percent weight loss. A skin assessment weekly and PRN (as needed) document, dated 7/3/23, indicated she experienced weight decline of 4.4 percent loss at 30 days, 11.3 percent loss at 90 days, and 12.7 percent loss at 180 days. She had a decrease in albumin and phosphates, likely related to poor appetite and poor intakes. A current nutrition care plan, dated 7/3/23, indicated significant weight loss on 4/23, 5/23, 6/23, and 7/23. The quarterly MDS assessment, dated 7/6/23, indicated a 5 percent weight loss. A nutrition note, dated 7/7/23 at 7:20 p.m., indicated the resident experienced a significant weight loss at 30 days, 90 days, and 180 days. During an interview on 7/13/23 at 3:05 p.m., the DON indicated the dietitian consultant came in once a week and she did not recall being directed to complete a significant change assessment for Resident 20's weight loss. She utilized the electronic medical record lookback report and the RAI (Resident Assessment Instrument) manual as the policy and procedures for completing MDS assessments. She had access to the online manual. The weight loss listed above would require the completion of a significant change assessment. Review of the current online RAI manual (April 25, 2023), retrieved from www.cms.gov on 7/16/23,		**potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents with significant weight change have the potential to be affected by alleged deficient practice. An audit was conducted, and no other residents were identified. Education has been provided regarding Change of Condition assessments and comprehensive care planning. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** MDS and DNS were inserviced on the RAI manual in regard to Significant Change Assessments. MDS/designee will review residents with weight loss during clinical meeting to ensure that the residents with significant weight change will have significant change assessment completed. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** DNS/designee will be responsible for monitoring compliance of significant change assessments for 6 months. The results of these audits will be reviewed by the QA	

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	indicated the following: "... emergence of unplanned weight loss problem (5 % change in 30 days or 10 % change in 180 days)..." 3.1-31(d)(1)		committee. The facility, through the QAPI program, will review, update, and/or develop any needed plan of action to sustain substantial compliance for no less than 6 months.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to obtain a physicians order related to oxygen administration for 1 of 2 resident reviewed for respiratory care (Resident 27). Findings include: During an observation on 7/10/23 at 9:45 a.m., Resident 27 was sitting upright in bed with her nasal cannula in place. The oxygen concentrator was set at 4 liters per minute. On 7/11/23 at 9:20 a.m., she was observed sitting up in bed with her nasal cannula in place. The oxygen concentrator was set at 4 liters per minute. On 7/12/23 at 9:24 a.m., she was observed sleeping while sitting upright in her bed with her nasal cannula in place. The oxygen concentrator was	F 0695	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 27 was immediately assessed for the need for oxygen therapy and an order was received by the physician and entered into resident medical record. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents receiving oxygen therapy have the potential to be affected by alleged deficient practice.	08/18/2023

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	set at 4 liters per minute. On 7/13/23 at 9:54 a.m., she was observed sitting up in bed, eating breakfast with her nasal cannula in place. The oxygen concentrator was set at 4 liters per minute. Resident 27's clinical record was reviewed on 7/12/23 at 11:40 a.m. Her diagnoses included chronic obstructive pulmonary disease, congestive heart failure, chronic respiratory failure with hypoxia or hypercapnia, morbid obesity, and emphysema. The MDS (Minimum Data Set) assessment, dated 5/9/23, indicated she required the use of oxygen. Resident 27's current physician orders lacked an order for oxygen. During an interview, on 7/11/23 at 9:20 a.m., the resident indicated her oxygen concentrator should be set on 3 liters per minute. During an interview, on 7/12/23 at 11:22 a.m., RN 7 indicated she was not able to locate a physician order for oxygen and was not sure why, since the resident required oxygen while up. Review of a current, 12/2022 policy, titled " Physician Orders", provided by the AVP of Clinical services on 7/13/23 at 3:48 p.m., indicated the following: "...Policy Interpretation and Implementation. 1. The Charge Nurse will maintain medication order and receipt records. 2. The medication order/receipt record shall contain: ...c. Name, quantity ordered, and strength of the drug; d. Name and title of person placing the order...." 3.1-47(a)(6)		All residents receiving oxygen therapy were audited for appropriate physician orders, no other residents were identified to be affected by the deficient practice. Education was provided the following policies: Physicians Orders Policy **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Education was provided to all licensed nursing staff regarding: Physicians Orders Policy DNS/designee will complete review during clinical meeting to ensure that the residents receiving oxygen therapy will have an appropriate physician order. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** DNS/designee will be responsible for monitoring compliance of oxygen therapy physician orders for 6 months. The results of these audits will be reviewed by the QA committee. The facility, through the QAPI program, will review, update, and/or develop any needed plan of action to sustain substantial compliance.	

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F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to ensure narcotic reconciliation counts were completed and acknowledged for 2 of 3 medication carts reviewed. (500 Unit and 600 Unit	F 0755	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	08/18/2023

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	medication carts) This deficiency had the potential to affect 31 residents who received medications from the 500 Unit and 600 Unit medication carts of 49 residents in the facility. Findings include: During an interview on 7/13/23 at 9:37 a.m., the Qualified Medication Aide (QMA) 8 indicated she had not completed the Shift to Shift Narcotic Verification Log when she began her shift for the day at 6:00 a.m. Narcotic count and log completion were required by the Nurses and QMAs at the beginning and end of each shift. During a review of the Shift to Shift Narcotic Log for the 600 Unit cart, along with QMA 8, she indicated the log lacked completion of the form with signatures on several different dates from 7/7/23 to 7/13/23. Review of the 600 Unit Shift to Shift Narcotic Count Verification Log from 7/7/23 to 7/13/23 indicated a lack of the following information: a. 7/10/23 Day shift- count completion b. 7/10/23 Night shift - Oncoming Shift Signature c. 7/11/23 Day shift- Oncoming and Offgoing Shift Signatures and count completion d. 7/11/23 Evening shift - Offgoing Shift Signature e. 7/12/23 Evening shift - count completion f. 7/13/23 Day shift - Oncoming Shift Signature During an interview on 7/13/23 at 10:08 a.m., Registered Nurse (RN) 7 indicated she had not completed the Shift to Shift Narcotic Verification Log when she began her shift for the day on 7/13/23. Narcotic count and log completion were required by the Nurses and QMAs at the beginning and end of each shift. During a review of the Shift to Shift Narcotic Log for the 500 Unit cart along with RN 7, she indicated the log lacked		**practice?** Narcotic reconciliation counts for 500- and 600-unit medication carts were assessed and reconciled to ensure accurate and proper accounting of narcotics. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** The alleged deficient practice had the potential to affect all residents who receive narcotic medications from the 500 Unit and 600 Unit medication carts. All narcotic reconciliation counts were audited by the DNS for accounting of narcotics with no additional concerns identified. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Education was provided to Nurses and QMAs regarding Narcotic Reconciliation Count Procedure. DNS/designee will complete daily monitoring to ensure that narcotic reconciliation counts will have appropriate documentation, daily 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly for 3 months or until substantial compliance has been met.	

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	completion of the form with signatures on several different dates from 7/7/23 to 7/13/23. Review of the 500 Unit Shift to Shift Narcotic Count Verification Log from 7/7/23 to 7/13/23 indicated a lack of the following information: a. 7/8/23 Night shift- Oncoming Shift Signature and count completion b. 7/9/23 Day shift - Offgoing Shift Signature c. 7/10/23 Day shift- Offgoing Shift Signature and count completion d. 7/10/23 Evening shift - count completion e. 7/11/23 Night shift - Offgoing Shift Signature f. 7/12/23 Evening shift - count completion g. 7/13/23 Day shift - Oncoming Shift Signature and count completion During an interview on 7/14/23 at 3:33 p.m., the DON indicated Shift to Shift Narcotic Count Verification Logs should have been completed by the oncoming and offgoing staff member at the beginning and end of each shift. Signatures were required on the logs during the reconciliation process. A current, undated facility policy titled "Controlled Medications - Administration," provided by the Administrator on 7/13/23 at 11:30 a.m., indicated the following: "...Medications included in the Drug Enforcement Administration [DEA] classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations... Procedure... 8. At each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and/or one nurse and a CMA, QMAP, Med Tech or equivalent and is documented on an audit record... 9. Current controlled medication		**How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ED/designee will be responsible for the monitoring compliance of narcotic reconciliation counts for 6 months. The results of these audits will be reviewed by the QA committee. The facility, through the QAPI program, will review, update, and/or develop any needed plan of action to sustain substantial compliance.	

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	accountability records and audits records are kept on the medication cart...." 3.1-25(e)(2) 3.1-25(e)(3)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to securely and hygienically store drugs, biologicals, and nursing supplies on the 400, 500, and 600 nursing units.	F 0761	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	08/18/2023

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	Findings include: During a random observation on 7/13/23 at 9:04 a.m., the 500/600 Unit treatment cart was unlocked and unattended at the 500/600 Unit Nurse's Station. Three unidentified residents were near the treatment cart, in a common area adjacent to the Nurse's Station. The Nursing Supply Closet door at the 500/600 Unit Nurse's Station was ajar and unattended by staff. It had a sign on the door that indicated the door was to remain locked at all times. During a random observation on 7/13/23 at 9:20 a.m., the 500/600 Unit treatment cart and the 500/600 Unit Nursing Supply Closet door remained unlocked and unattended. During an interview on 7/13/23 at 9:22 a.m., Qualified Medication Aide (QMA) 8 indicated the treatment cart and nursing supply closet should not have been left unlocked and unattended by staff. The Nursing Supply Closet contained briefs, medicine cups, razors, shave cream, mouthwash, toothpaste, creams, and other activity of daily living supplies. During a random observation on 7/13/23 at 9:30 a.m., the 500/600 Unit treatment cart contained various insulins, lancets, glucometers, prescription creams for treatments, wound care supplies, and wraps. During a medication storage observation on 7/13/23 at 9:37 a.m., the 600 Unit medication cart contained 29 loose pills in the bottom of the second drawer on the right side. The bottom of the 3rd drawer on the right side contained 2 loose pills. During an interview, at the time of the observation, QMA 8 indicated medications		The 500/600 treatment cart, Nurse Supply Closet were properly locked. The 500 & 600 Hall Medication Cart was cleaned of all loose pills and pills were disposed of properly. The Medication Storage Room for halls 200, 300 and 400 was cleaned and organized. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** All residents had the potential to be affected by the alleged deficient practice. An audit of all medication rooms, medication carts and treatment carts were conducted no other concerns were identified. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All Nurses and QMAs were provided inservicing regarding medication storage. DNS/designee will complete random daily monitoring to ensure proper medication storage in both medication rooms, medication carts and treatment carts. A cleaning schedule has been developed to be implemented for all medication rooms, medication	

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	should not be loose in the medication cart. She should have checked the cart for loose medications at shift change when she took over the 600 Unit medication cart at 6:00 a.m., but it was not done. During a medication storage observation on 7/13/23 at 10:08 a.m., the 500 Unit medication cart contained 5 loose pills in the bottom of the second drawer on the left side of the cart. During an interview, at the time of observation, RN 7 indicated medications should not be loose in the medication carts and should be destroyed. She had not checked for loose pills in the 500 Unit medication cart on this date. During an observation on 7/14/23 at 2:48 p.m., the 200/300/400 Unit Medication Storage Room was in an unsanitary condition, with a spilled chocolate nutritional shake on the floor. The liquid was also spilled on boxes piled in the corner to the right of the door entrance. The pile in the corner contained a soiled insulin safety syringes box, and 6 unopened pen needle boxes. The remainder of the floor was very soiled with scattered spills and debris. During an interview with LPN 6, he indicated the floor was not maintained in a clean manner and items should not be stored on the floor. During an interview on 7/14/23 at 2:49 p.m., the DON indicated the Medication Storage Room on the 200 Unit was not maintained in a clean manner. During an interview on 7/14/23 at 3:33 p.m., the DON indicated loose medications should have been removed from the medications carts. Treatment carts and Nursing Supply Closets were required to be kept locked when they were unattended.		carts, and treatment carts. **How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** DNS/designee will be responsible for monitoring compliance for securing medication carts, properly storing of medications and securing supply/storage rooms for at least 6 months. The results of these audits will be reviewed by the QA committee. The facility, through the QAPI program, will review, update, and/or develop any needed plan of action to sustain substantial compliance.	

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	A current, undated, facility policy titled "Medication Storage in the Facility," provided by the Administrator on 7/13/23 at 11:30 a.m., indicated the following: "...Policy...Medications and biologicals are stored safely, securely, and properly... Procedure... 2. ...Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access...13. Outdated, contaminated, or deteriorated medication and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if a current order exists. 14. Medication storage areas are kept clean, well lit, and free of clutter...." 3.1-25(j) 3.1-25(m) 3.1-19-(aa)(3)			
F 0880 SS=F 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,			

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

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	§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. A. Based on record review and interview, the facility failed to implement a water-borne pathogen prevention plan. This deficient practice had the potential to impact 49 of the 49 facility residents. B. Based on observation, interview, and record review, the facility failed to utilize infection prevention and control strategies regarding implementation of transmission-based precautions for a resident with an antibiotic-resistant bacterial infection for 1 of 6 residents reviewed for infection control. (Resident 12) Findings include: A. During an observation on 7/10/23 at 10:37 a.m., no resident rooms on the 600 Unit had Transmission Based Precaution (TBP) signs posted. Readily available Personal Protective Equipment (PPE) was not observed in the 600 Unit hallway. During an observation on 7/11/23 at 12:18 p.m., no resident rooms on the 600 Unit had TBP signs up, and there was no readily available PPE.	F 0880	**1: What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** A Water-borne Pathogen Prevention Plan was initiated. Transmission based Precautions and appropriate Personal Protective Equipment was implemented for Resident 12 isolation. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** The alleged deficient practice had the potential to affect all residents who reside in the facility. All residents were audited for appropriate Transmission based Precautions; no additional residents identified to need Transmission based Precautions.	08/18/2023

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	Resident 12's clinical record was reviewed on 7/11/23 at 4:43 p.m. Diagnoses included history of urinary tract infections and benign prostatic hyperplasia with lower urinary tract symptoms. A physician order, dated 5/9/23, indicated contact isolation due to ESBL (extended spectrum beta-lactamase) in the urine. A urine culture result, dated 2/10/23, indicated the resident was positive for ESBL. A quarterly Minimum Data Set, dated 4/21/23, indicated the resident had mild cognitive impairment. He required extensive assistance of two staff members for bed mobility, transfers, toileting, personal hygiene, and bathing. The resident was always incontinent of urine. A current care plan, dated 5/13/23, indicated the resident required contact isolation due to a a Multi-Drug Resistant Organism (ESBL) in the urine. Interventions included the following: instruct family/visitors/caregivers to wear a disposable gown and gloves during physical contact with the resident. Discard PPE in appropriate receptacle and wash hands before leaving the room and utilize isolation precautions as ordered. During an observation on 7/12/23 at 12:34 p.m., no resident rooms on the 600 Unit had TBP signs up, and there was no readily available PPE During an observation on 7/14/23 at 3:10 p.m., no resident rooms on the 600 Unit had TBP signs up, and there was no readily available PPE. During an interview on 7/14/23 at 3:12 p.m.,		All residents were assessed for water-borne illness with no concerns noted. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** An all staff inservice was conducted with education provided on the following policies: Personal Protective Equipment Policy / Infection Prevention and Control Policy / Water-borne Pathogen Prevention Plan DNS/designee will complete random daily monitoring to ensure that appropriate PPE is available, for all residents requiring Transmission based Precautions daily 5 days a week for 4 weeks, 3 days a week for 4 weeks and 2 days a week for 4 weeks, then monthly in QAPI for 3 months. ED/designee will ensure completion of Water-borne Pathogen Prevention Plan is completed and implemented as according to federal/state regulation. and reviewed by the QA committee quarterly ongoing. **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ED/designee will be responsible	

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	Qualified Medication Aide (QMA) 4 indicated she was familiar with the resident's on the 600 unit. None of the residents on the the 600 unit were in any transmission based precautions, such as contact isolation or enhanced barrier precautions. Gowns were not required to provide care for any residents on the 600 Unit. During an interview on 7/14/23 at 3:17 p.m., Certified Nurse's Aide (CNA) 5 indicated she was familiar with the residents on the 600 Unit. None of the residents on the 600 unit were on specific precautions such as contact precautions or enhanced barrier precautions. When residents required specific precautions, a sign was placed on the resident's door to tell the required precautions, as well as a canister for PPE outside the resident's room in the hallway. Otherwise, the PPE was locked in a closet up front. A key would have to be obtained to access the PPE if it wasn't outside the resident's room. All urinals on the 600 unit could be emptied without wearing a gown. During an interview on 7/14/23 at 3:33 p.m., the DON indicated Resident 12 was in contact isolation precautions for ESBL in the urine. The facility should have had the following things in place: a contact isolation sign on his room door, a PPE canister outside his room with readily available PPE, and staff should have worn a gown and gloves to provide his care. Contact precautions should have been implemented by the DON or any other nurse if she was not in the building. Failure to place a resident in contact isolation as indicated was a risk for spreading infection to other residents. A current facility policy, dated 8/2022, titled "Personal Protective Equipment," and provided by the Assistant Vice President of Clinical		for the monitoring compliance of Transmission based Precautions and Water-borne Pathogen Prevention Plan implementation for no less than 6 months. The results of these audits will be reviewed by the QA committee. The facility, through the QAPI program, will review, update, and/or develop any needed plan of action to sustain substantial compliance.	

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	Operations on 7/14/23 at 4:27 p.m., indicated the following: "...Policy Interpretation and Implementation 1. Personnel who perform tasks that may involve exposure to blood/body fluids are provided appropriate personal protective equipment [PPE]... 3. Not all tasks involve the same risk of exposure, or the same risk of exposure, or the same kind or extent of protection. The type of PPE required for a task is based on: a. The type of transmission-based precaution... 4. ...PPE required for transmission-based precautions is maintained outside and inside the resident's room... 7. Visitors and residents who are asked to comply with transmission-based precautions are educated on the proper use of PPE and provided with equipment...." B. During an interview on 7/14/23 at 11:13 a.m., the Maintenance Supervisor indicated he did a monthly review of the drain line and ice machines but did not document this information on any forms. He tried to remember when he last completed each task. He did not know when the last water sample was sent out for (legionella and/or water born pathogen) testing, or if it was indicated. The new administration had started the process to utilize a computerized environmental auditing tool for streamlining and documentation of maintenance, testing, and cleaning. During an interview on 7/14/23 at 12:06 a.m., the DON and AVP (Assistant Vice President of Corporate Clinical Services) indicated no resident had signs or symptoms of legionella infection. The AVP of clinical services indicated the city of Anderson did test the water during the last annual survey. In a follow-up interview on 7/14/23 at 12:27 p.m., the Maintenance Supervisor indicated he did not have a written plan for water management or a			

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	schedule for identifying and monitoring possible opportunistic pathogens in the facility water system. The 100 hallway was under construction and those water lines could possibly hold water and accumulating pathogens. He had not been in the area of the hallway for weeks. A current facility policy, dated 5/2023, titled "Water Borne Pathogen Prevention Policy", and provided by the Administrator on 7/14/23 at 3:10 p.m., indicated the following: "...Policy: Facilities will utilize preventative measures to ensure inspection, cleaning and disinfection is completed for specific equipment to reduce the risk of legionella bacteria and other water-borne pathogens. Procedure: 1. The facility will conduct a risk assessment to identify where legionella and other opportunistic waterborne pathogens could grow and spread in facility water system...6. Cleaning and testing protocols will be followed and reported during the QAPI meeting, and what corrective actions were taken if needed...." As of the time of exit on 7/14/23 at 5:30 p.m., a water-borne pathogen prevention plan had not yet been provided by the facility. 3.1-18(a) 3.1-18(b)(2)			
F 9999 Bldg. 00	3.1-14 PERSONNEL (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and	F 9999	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Employee Files for CNA 50, CNA 56, CNA 57, QMA 59, CNA 54,	08/18/2023

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	any convictions in accordance with IC 16-28-13-3. (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (7) Documentation of orientation to the facility and to the specific job skills. (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (8) Signed acknowledgement of orientation to residents' rights. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. ... (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12)months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.		CNA 55, CNA 51, CNA 60, Cook 58, CNA 52, and Activity Assistant 60, have been audited and all required documents have been placed in the employee file. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** The alleged deficient practice had the potential to affect all employee files. An audit of all employee files is being conducted; any required documents that are not present will be completed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Education for all supervisors regarding Personnel files. ED/designee will complete 5 random employee file audits to ensure that appropriate required documents are available weekly for 4 weeks, bi-weekly for 4 weeks and then monthly for 4 months, with results of the audits provided to the QA Committee, when the substantial compliance has been met the audits will be moved to a quarterly on-going audit. **How the corrective action will**	

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	(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. This state rule is not met as evidenced by: A. Based on interview and record review the facility failed to complete reference checks for 4 of 5 newly hired employee records reviewed (CNA 50, CNA 56, CNA 57, and QMA 59) B. Based on interview and record review the facility failed to ensure employees received annual resident rights in-service training for 5 of 5 long-standing employees reviewed for resident rights training (CNA 54, CNA 55, CNA 51, CNA 60, and Cook 58). C. Based on interview and record review, the facility failed to ensure newly hired employees had general and specific job orientation for 5 of 5 employee records reviewed for orientation (CNA 50, CNA 52, CNA 56, CNA 57, and QMA 59). D. Based on interview and record review, the facility failed to ensure newly hired employees had signed acknowledgement of resident rights for 3 of 5 employee records reviewed for resident rights acknowledgement (CNA 50, CNA 52, and 56). E. Based on interview and record review, the facility failed to ensure newly hired employees had physical completed upon hire or within 30 days prior to employment for 5 of 5 employee records reviewed for physicals upon hire: (CNA 50, CNA 52, CNA 56, CNA 57, and QMA 59).		**be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ED/designee will be responsible for the monitoring compliance of personnel files for 6 months. The results of these audits will be reviewed by the QA committee. The facility, through the QAPI program, will review, update, and/or develop any needed plan of action to sustain substantial compliance.	

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	F. Based on interview and record review, the facility failed to ensure newly hired employees had 2- step Mantoux test upon hire and long standing employees had annual 2022-2023 TB screening for 10 of 10 employee records reviewed for TB testing (CNA 50, CNA 51, CNA 52, CNA 54, CNA 55, CNA 56, CNA 57, Cook 58, QMA 59, and Activity Assistant 60). Findings include: A. Employee Records were reviewed on 7/13/23 at 9:30 a.m. The following employee records lacked reference checks prior to employment: A1. CNA 50, start date 4/12/23, employee record lacked: a reference check. A2. CNA 56, start date 3/3/23, employee record lacked: a reference check. A3. CNA 57, start date 5/13/23, employee record lacked: a reference check. A4. QMA 59, start date 3/8/23, employee record lacked: a reference check. B. Employee Records were reviewed on 7/13/23 at 9:30 a.m. Long standing employees (employees who have worked for over one year), were reviewed for annual resident rights inservice training. The following employee records lacked verification of annual 22-23 Resident Rights training: B1. CNA 54, start date 9/20/21, employee record lacked: verification of annual resident rights training. B2. CNA 55, start date 8/1/21, employee record lacked: verification of annual resident rights training. B3. CNA 51, start date 8/1/21, employee record lacked : verification of annual resident rights training.			

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	B4. Activity Aide 60, start date 8/1/21, employee record lacked: verification of annual resident rights training. B5. Cook 58, start date 8/1/21, employee record lacked: training, verification of annual resident rights training. C. Employee Records were reviewed on 7/13/23 at 9:30 a.m. The following employee records lacked general and specific job orientation: C1. CNA 50, start date 4/12/23, employee record lacked: verification of both general and specific job orientation. C2. CNA 52, start date 3/22/23, employee record lacked: verification of specific job orientation. C3. CNA 56, start date 3/3/23, employee record lacked: verification of both general and specific orientation. C4. CNA 57, start date 5/13/23, employee record lacked: verification of both general and specific orientation C5. QMA 59, start date 3/8/23, employee record lacked: Verification of specific job orientation. D. Employee Records were reviewed on 7/13/23 at 9:30 a.m. The following employee records lacked signed acknowledgement of resident rights: D1. CNA 50, start date 4/12/23, employee record lacked: signed acknowledgment of resident rights. D2. CNA 52, start date 3/22/23, employee record lacked: signed acknowledgement of resident rights. D3. CNA 56, start date 3/3/23, employee record lacked: signed acknowledgement of resident rights. E. Employee Records were reviewed on 7/13/23 at 9:30 a.m. The following employee records lacked employee physicals completed upon hire or within			

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	30 days prior: E1. CNA 50, start date 4/12/23, employee record lacked: an employee physical. E2. CNA 52, start date 3/22/23, employee record lacked: an employee physical. E3. CNA 56, start date 3/3/23, employee record lacked: an employee physical. E4. CNA 57, start date 5/13/23, employee record lacked: an employee physical. E5. QMA 59, start date 3/8/23, employee record lacked: an employee physical. F. Employee Records were reviewed on 7/13/23 at 9:30 a.m. The following employee records lacked two step Manitou testing upon hire and/or annual TB screening: F1. CNA 50, start date 4/12/23, employee record lacked: two step Manitou testing upon hire and/or screening for a positive converter. F2. CNA 52, start date 3/22/23, employee record lacked: two step Manitou testing upon hire and/or screening for a positive converter. F3. CNA 56, start date 3/3/23, employee record lacked: two step Manitou testing upon hire and/or screening for a positive converter. F4. CNA 57, start date 5/13/23, employee record lacked: two step Manitou testing upon hire and/or screening for a positive converter. F5. QMA 59, start date 3/8/23, employee record lacked: two step Manitou testing upon hire and/or screening for a positive converter. F6. CNA 54, start date 9/20/21, employee record lacked: annual 2022-2023 Manitou testing and/or an annual screening for TB. F7. CNA 55, start date 8/1/21, employee record lacked: annual 2022-2023 Manitou testing and/or an annual screening for TB. F8. CNA 51, start date 8/1/21, employee record lacked: annual 2022-2023 Manitou testing and/or an annual screening for TB.			

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	F9. Activity Aide 60, start date 8/1/21, employee record lacked: annual 2022-2023 Manitou testing and/or an annual screening for TB. F10. Cook 58, start date 8/1/21, employee record lacked: annual 2022-2023 Manitou testing and/or an annual screening for TB. During an interview on 7/13/23 at 11:30 a.m., the Corporate Business Office Manager indicated the facility did not have employee record information regarding: a. Reference checks for newly hired employees, b. Annual inserve training for resident rights, c. General and Specific job orientation, d. Resident rights acknowledgement for newly hired employees, e. Physicals for newly hired employees, f. Two-step TB testing upon hire, annual TB, and or TB screening. A current policy, effective 1/1/23, titled, "HR- 205: Personnel Records", provided by the Administrator on 7/13/23 at 12:25 p.m., indicated the following: "...Policy: A personnel file for each Employee will be created and maintained within the electronic system .... Removal of Documents: Documents are not to be removed from and employee's personnel file .... File Maintenance: The records pertaining to the medical conditions of an Employee shall be maintained in a separate file from the personnel file .... relevant information shall be provided to government officials investigating compliance with this section. TB skin tests and other state required health information should be maintained in a separate health file, if applicable...			

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	Contents: The following documents should be maintained in the personnel files: ...other documents as required by federal, state, and/or local law...."			