STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 12, 13, 14, 15, and 16, 2021. Facility number: 000476 Provider number:155446 AIM number: 100290870 Census Bed Type: SNF/NF: 69 Total: 69 Census Payor Type: Medicare: 8 Medicaid: 52 Other: 9 Total: 69 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality reivew completed April 19, 2021	F 0000		
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview and record review, the facility failed to ensure a dialysis resident was assessed and monitored for 1 of 1	F 0698	The facility has educated all nurses on appropriate orders for dialysis residents and ensuring	05/04/2021

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

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	dialysis residents reviewed. Resident 33 Findings include: On 4/14/21 at 2:30 p.m. the record of Resident 33 was reviewed. Diagnoses included, but were not limited to end stage renal disease. The quarterly Minimum Data Set Assessment, dated 2/10/21, indicated the resident had moderately impaired cognition and fair decision making skills. A plan of care, dated 11/9/2020, to address dialysis on Tuesday, Thursday, Saturday indicated: Check and change dressing daily at access site, document; observe for signs of infection to access site: redness, swelling, warmth or drainage. On 4/15/21 at 3:40 p.m., Resident 33 was observed in her room and was interviewed. She indicated her dialysis access site was on her right forearm A physician order, dated 12/5/20 indicated to complete Pre/Post dialysis evaluation every Tuesday, Thursday, and Saturday (two times a day). The medication administration record (MAR) and treatment administration record (TAR) for April 2021 was reviewed on 4/13/21 at 2:40 p.m. The following was scheduled: Open and complete Pre/Post dialysis evaluation every Tuesday, Thursday, and Saturday; two times a day every Tuesday, Thursday, Saturday. The original date of the order was noted to be 12/05/2020. Documentation was lacking on the current MAR		pre and post dialysis forms are filled out prior to leaving and immediately upon return from dialysis center and monitored daily Monday thru Friday using QAPI Dialysis care audit tool. The Director of Nursing or designee will continue to monitor daily 5 days a week for a total of 4 weeks. Thereafter the Director of Nursing or designee will monitor monthly for 5 months. Upon review in QAPI if audit remains 95% or greater auditing will cease. The facility will add this process to its QAPI program. Potential to affect 2 residents. Resident orders were immediately audited and corrected, and assessment of resident dialysis site was performed. All orders, care plans, and evaluations were audited and corrected per policy. All new admissions on dialysis will be reviewed in clinical meeting with IDT team to ensure all orders, care plans, and evaluations are in place per policy.	

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	and TAR of the dialysis access site having been assessed for the thrill (a rumbling sensation) and bruit (a rumbling sound). On 4/14/21 at 2:30 p.m., the "Dialysis Pre/Post Communication Records" were reviewed between 3/23/21 to 4/13/21. The "Post" section of the form was to include the following information: Post-dialysis access site and observation: location, post-dialysis dressing intact, thrill present, bleeding present, swelling present, pain present, redness present and describe any abnormal observations. The records completed on the following dates lacked documentation of the "Post" portion of the form having been completed: 3/23/21, 4/6/21 and 4/13/21. There was no documentation to indicate the resident had refused to have this assessment completed. On 4/15/21 at 11:00 a.m., the Director of Nursing (DON) was interviewed. She indicated the facility had difficulty having the dialysis facility complete the "post" portion of the Dialysis Communication Record. On 4/15/21 at 2:41 p.m., the DON provided a copy of current policy and procedure for "Dialysis Care" dated 7/2020. The policy included the following: For the resident's receiving treatment at an off-site facility the following will be completed: Assess and document vital signs upon return, Assess access sites and ensure dressings are clean, dry and intact if applicable; assess bruit and thrill (if applicable). On 4/15/21 3:35 p.m., Nurse 7 was interviewed. She indicated when a resident returned from dialysis, she would check their vital signs,			

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	performed an assessment, verify the dressing to the fistula was intact, clean and/or dry and assess the thrill and bruit. She indicated she documented the post dialysis assessment in the progress notes. On 4/16/21 at 8:55 a.m., Nurse 5 was interviewed. She indicated the pre dialysis assessment was completed by the nurse sending the resident to dialysis. She indicated when the resident returned from dialysis, the post dialysis form does not return with the resident. On 4/16/21 at 9:50 a.m., the DON was interviewed. She indicated the following: She had spoken with the Nurse Practitioner (NP) who indicated the resident was to have thrill and bruit as well as the dressing to the fistula checked every shift. She indicated this would be documented on the TAR. The DON indicated the care plan addressing the resident was to have the dressing on her fistula changed daily, was from the former company. The NP indicated facility staff were not to change the dressing. The DON indicated the facility coordinated care with the dialysis unit by phoning them when needed. The "pre" portion of the Dialysis Communication Record was to be completed by the facility nurse prior to the resident going to dialysis, and the "post" portion of the form was to be completed by dialysis staff after the resident finished their treatment. Frequently, the "Post" portion of the dialysis communication form was not returned to the facility by dialysis. When this was the case, she would call dialysis and obtain the information to complete the "post" section of the form. She then entered this information on the "Dialysis Pre/Post Communication Record" in the facility system. She indicated she had reviewed the resident's progress notes from			

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	3/23/21 to 4/14/21 and there was no documentation the resident had been assessed on return from dialysis. She indicated her staff were to complete an assessment upon the resident's return to the facility in the progress notes. She had reviewed the progress notes from 3/23/21 to 4/14/21 and documentation was lacking of a post dialysis assessment upon the resident's return to the facility. 3.1-37(a)			
F 0732 SS=D Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.			

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	§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview and record review the facility failed to post the nursing staff information daily in a place accessible to residents. Findings include. Observation throughout the facility on 4-12-21 at 10:40 a.m., the nurse staffing information was not observed to be posted. Observation throughout the facility on 4-14-21 at 2:30 p.m., the nurse staffing information was not observed to be posted. Observation throughout the facility on 4-15-21 at 3:50 p.m. the nurse staffing information was not observed to be posted. The Interim Executive Director was interviewed on 4-16-21 at 9:50 a.m. He did not believe the nursing schedules were posted. The Director of Nursing (DON) was interviewed on 4-16-21 at 9:55 a.m. She had not seen the Nurse Staff Posting, but should have been posted near the main entry. The facility's Scheduler was	F 0732	The facility has posted daily the Nurse staffing Information in a readily accessible area. The Director of Nursing and Scheduler have been educated on the requirement. The ED or designee will monitor daily for 5 days a week for a total of 4 weeks. Thereafter the ED or designee will monitor monthly for 5 months. The facility will add this process to its QAPI program. Potential to affect no residents.	05/04/2021

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	responsible to complete the posting daily. The Nurse Staff Postings for 4-9-21 through 4-16-21 were provided. She indicated the Nurse Staff Postings were in the Schedulers office. The DON did not know why they were not posted in the facility. On 4-16-21 at 1:59 p.m., the DON provided the facility's a current policy, titled, "Posting Direct Care Daily Staffing Numbers," which had a revision date of July 2016. The policy indicated, "...Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents...1. Within two (2) hours of the beginning of each shift, the numbers of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format...."			
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			

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	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 observation, interview, and record review, the facility failed to ensure medications were destroyed or returned in a timely manner, for 2 of 5 medication/treatment carts observed. (Resident 8, Resident 59) Findings include: 1. During an observation on 4-16-21 at 10:15 a.m., the medication cart located in the 200 hall, a medication for Resident 59 was located in the side compartment of cart. The medication of Fluticasone (nasal spray) was inside a plastic bag with no open date. Nurse 5 indicated, the resident was discharged on 4-5-21. During an observation on 4-16-21 at 10:40 a.m., of a treatment cart located on the Harmony unit, a medication of Valproic Acid (anti-seizure medication) 250 mg (milligrams, a measurement of dosage)/5 ml (milliliter, a liquid measure of	F 0755	The facility has educated all nurses on removing medications/treatments from medication carts immediately upon resident discharge from facility and returning to the pharmacy or destroying within 72 hours. The Director of Nursing or designee has monitored the medication and treatment carts weekly for such medications/treatments using QAPI audit tool Medication Storage review. The Director of Nursing or designee will monitor weekly for a total of 4 weeks. Thereafter the Director of Nursing or designee will monitor monthly for 5 months. Upon review in QAPI if audit remains 95% or better then auditing will cease. All	05/04/2021

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	dose) for Resident 8 who was discharged on 4-1-21 was observed to be present in the cart. Nurse 5 was interviewed on 4-16-21 at 12:29 p.m. Nurse 5 indicated all discontinued medications should be placed in a tub in the medication room. The weekend supervisor Then completed the medication return form. If the medication could not be returned, the form was completed to indicate the medication had been destroyed. If the medication was not sent with the discharged resident, the medication should be immediately destroyed or returned to the pharmacy. Nurse 5 indicated the facility had 30 days to return or destroy the medication. Nurse 6 was interviewed on 4-16-21 at 12:45 p.m. Nurse 6 indicated all nurses are able to return medication. The Pharmacy form should be filled out and sent along with the medication being returned to the pharmacy. Medication would be sent with a discharged resident. If the medication was not sent with the discharged resident, the medication should be destroyed or returned to pharmacy. 2. On 4/16/21 at 10:30 a.m., the Harmony Unit was observed with Nurse 4 working at the medication cart. Nurse 4 was interviewed. She indicated the unit had one medication cart and the overflow medications were kept in the bottom drawer of the medication cart. Then an observation of the treatment cart was completed. Observed in the treatment cart, was a bottle of Valproic Acid (a liquid medication used to treat seizures and bipolar disorders). Nurse 4 looked at the name on the bottle of this medication. She indicated the person named had been discharged 2 weeks prior. On 4/16/21 at 2:40 p.m. the Director of Nursing		medication carts, treatment carts, and medication rooms were audited and were not affected by deficient practice. Medications were immediately removed from carts and destroyed or returned to pharmacy per policy. Potential to affect no residents.	

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	(DON) was interviewed. She indicated the medication Valproic Acid was actually in the "over flow cart." She indicated the reason the staff had kept this medication was because this resident had been discharged to a sister facility on 4/1/21. The DON indicated the facility was saving this medication for the resident so she didn't have to pay for additional medication. The nurses were to destroy or return medication for discharged residents. The nurses should be making sure the carts were clean. Their policy did not state how long the medication could be kept for discharged residents. A policy dated 2-1-2018, was provided by DON on 4-16-21 at 12:50 p.m., titled " Medication Returns, Credits, and Destruction". The policy indicated, "...To ensure a uniform process for returns, destruction, and proper facility credit for medication(s) in accordance with State and Federal regulations...." A policy dated 4-2019, was provided by DON on 4-16-21 at 2:00 p.m., titled "Discarding and Destroying Medications." The policy indicated, "...Medications will be disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous wastes and controlled substances...." 3.1-25(a)(b)(1)(c) 3.1-25(r)			
F 0761 SS=D 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			

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	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, interview and record review, the facility failed to ensure medications and treatments were dated and labeled for 3 of 5 medication/treatment carts and 2 of 2 medication rooms observed. Findings include: 1. On 4/16/21 at 10:40 a.m., treatment cart on the Harmony Unit was observed with Nurse 4. A four ounce bottle of hydrogen peroxide (mild antiseptic used on skin to prevent infection) was opened, and had no resident name on it. Nurse 4 indicated the opened bottle of hydrogen peroxide should have been labeled with a resident's name. Nurse 4 was unsure which resident the opened bottle of hydrogen peroxide belonged to.	F 0761	The facility has educated all nurses on labeling and dating all medications on medication carts. The Director of Nursing ensured Drug Expiration dating policy was reviewed and available in the front of each Narcotic binder for reference. The Director of Nursing or designee has monitored the medication and treatment carts weekly to ensure all medications/treatments are dated using QAPI audit tool Medication Storage review. All medication carts, treatment carts, and medication rooms were audited and were not affected by	05/04/2021

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	2. On 4/16/21 at 10:45 a.m., the Harmony Unit medication room was observed. In the refrigerator, an opened vial of Aplisol (used for intradermal administration as an aid in the diagnosis of tuberculosis) was observed with no open date. The expiration date on the vial was 2/22. Nurse 4 indicated this vial should have been dated with the date it had been opened. On 4/16/21 at 11:20 a.m. the West Hall medication room was observed with Nurse 5. In the refrigerator, an opened vial of Aplisol was observed with no open date. The expiration date on the vial was 2/22. Nurse 5 indicated the Aplisol vial should have been dated when it was opened. On 4/16/21 at 12:50 p.m., the Director of Nursing (DON) was interviewed. She indicated the nurses were to destroy or return medication when the resident was discharged from the facility. She was unsure who the hydrogen peroxide belonged to from the treatment cart on the Harmony Unit. They didn't currently have any residents on the Harmony Unit ordered to use hydrogen peroxide. A copy of the "Drug Expiration Dating" form, dated 2/1/2018 was reviewed. The document indicated the expiration date for Aplisol was 28 days from the date opened. 3.1-(o)		deficient practice. Medications were immediately removed from carts and destroyed or returned to pharmacy per policy. The Director of Nursing or designee will monitor weekly for a total of 4 weeks. Thereafter the Director of Nursing or designee will monitor monthly for 5 months. Upon review in QAPI if audit remains 95% or better auditing will cease. Potential to affect no residents.	
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 -			

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	§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, interview, and record review, the facility failed to ensure sanitary practices were followed in the kitchen for 67 of 69 residents who ate their meals from the facility kitchen. Findings include: An observation of the facility kitchen on 4/12/21 at 9:17 a.m., indicated the top of the DM's (Dietary Manager) facemask was placed below her bottom lip, the top of Cook 1's facemask was placed below her nose and the top of Dietary Aide 1's facemask was placed just at her bottom lip. An interview with the DM on 04/12/21 at 9:35 a.m., indicated the staff just wear surgical masks in the kitchen. The DM, Cook 1, and Dietary Aide 1 were all observed to re-position their	F 0812	The facility has educated all CTMs that reside in the Dietary Department on the proper and safe way to wear a facemask per CDC guidelines. The Dietary Manger or designee will monitor this daily for 5 days a week for a total of 6 weeks. Thereafter the Dietary Manager or designee will monitor monthly for a total of 6 months. The facility will review this process in its QAPI program. This Deficiency had the Potential to affect 67 of 69 residents with the proposed POC no new residents will be affected. A return demonstration on donning and doffing PPE was completed on 5/10/21 for all staff residing in the dietary department, a return	05/04/2021

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	155446	A. BUILDING 00 B. WING	04/16/2021

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	masks to cover their mouth and nose completely. An observation in the facility kitchen on 4/14/21 at 9:47 a.m., indicated Dietary Aide 2 was observed in the dish washing room without a facemask donned. She was doing dishes from the breakfast meal. Dietary Aide 2's facemask was observed in her back pocket. An observation in the facility kitchen on 4/14/21 at 11:03 a.m., indicated Dietary Aide 2 had her facemask donned with the top of her facemask placed below her chin, with her mouth and nose exposed. Dietary Aide 2 was observed to be preparing drinks for the lunch meal. In an observation in the facility kitchen on 4/14/21 at 11:10 a.m., Cook 1 was observed with her facemask donned below her chin with her mouth and nose exposed. Cook 1 was observed to puree peas and meatballs. Her facemask was not covering her mouth and nose. At 11:30 a.m., Cook 1 was observed to pull up her facemask to cover her mouth and nose. In an observation in the facility kitchen on 4/14/21 at 11:49 a.m., Dietary Aide 2 was observed to have her facemask below her nose. Dietary Aide 2 was observed to cover the plated food with the dome cover. Then Dietary Aide 2 was observed to place the trays in the Cambro (insulated cart for holding meal trays) with her facemask below her nose. An observation was conducted in the facility kitchen with the Interim ED (Executive Director) on 4/15/21 at 12:26 p.m. Dietary Aide 2 was observed with her facemask not covering her nose and upper lip.		demonstration was completed on the same day.	

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	An interview with the Interim ED on 4/15/21 at 2:04 p.m., indicated the facility had reeducated staff how to wear facemasks. This was just an error on this staff's part and an isolated incident. The facility did not have a policy on the use of facemasks, but the facility followed current CDC (Center for Disease Control) guidance. The Interim ED provided a current pictorial guidance from the CDC on Facemask Do's and Don'ts for Healthcare Personnel dated June 2, 2020. The guidance indicated "...when wearing a facemask, don't do the following: Don't wear your facemask under your nose or mouth...." An interview with the DON (Director of Nursing) on 4/17/2021 at 3:00 p.m., indicated there were 2 residents in the building who had orders for NPO (nothing by mouth). There were 67 residents who ate their meals from the facility kitchen. 3.1-21(i)(3)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure water temperatures in resident rooms were maintained below recommended temperature levels on the 100/200 hall for 8 occupied resident bathrooms which effected 17 residents. (Confidential Resident 2, Confidential Resident 3) Findings include:	F 0921	The facility upon notification of high-water temperatures immediately on the same day called Northside plumbing. They set mixing valve back to 114 degrees. On the next day the facility Maintenace Director noticed that mixing valve	05/04/2021

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	On 4/12/21 from 11:38 a.m. to 12:00 p.m., the following water temperatures were obtained by the Interim ED with the thermometer he calibrated in a glass of ice water. Room 109/111: 122.9 F Room 110/112: 121.8 F Room 114/116: 122.4 F Room 117: 121.2 F Room 123: 123.6 F Room 201: 124.5 F Room 202/204: 123.8 F Room 210: 125.4 F On 4/12/21 at 11:50 a.m., Confidential Resident 2 interview was conducted. The resident indicated the water in their bathroom was not too hot. On 4/12/21 at 11:55 a.m., Confidential Resident 3 interview was conducted. The resident indicated the water in their bathroom was not too hot. On 4/12/21 at 12:00 p.m., the Interim ED was interviewed. He indicated when he held his hand in the running stream of water in room 201, it did feel hot. On 4/12/21 at 12:24 p.m., the Maintenance Supervisor provided a copy of the preventative maintenance program, dated 3/22/21 - 3/26/21 and 4/5/21 to 4/9/21. He indicated he checked the water temperatures of each unit weekly as instructed by this program. The logs indicated the water temperatures of resident rooms ranged between 114.9 F to 117.7 F for the dates provided. These logs were completed for the time frames indicated. He indicated this program served as his policy and procedure for		was leaking and called Northside Plumbing out to replace the leaking valve. Staff have been educated to notify Immediately the Maintenanc e Director of Executive Director upon complaint or observation of high-water temps. The Maintenace Director or designee will monitor facility water temperatures two times a day 5 days a week for 3 weeks. Thereafter the Maintenace Director or designee will monitor 1 time a day 5 days a week for 6 weeks. The final monitoring will be 1 time a week for 8 weeks by the Maintenance Director or designee. The facility will review this process in its QAPI program. The facility will monitor in QAPI for 3 consecutive months and if a threshold of 100% compliance is achieved the facility will go back to its previous preventive maintenance schedule. The Maintenace Director will use audit form created to monitor temperatures. This deficiency had the Potential to affect 17 residents, with the proposed plan in place no new residents will be affected.	

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	checking water temperatures. On 4/12/21 at 2:19 p.m., the Director of Nursing (DON) was interviewed. She indicated the mobility status and cognitive status of the following residents in the following rooms: Room 109/Room 111 (shared bathroom): three residents total, one was independently mobile and cognitive impaired. Room 110/Room 112: three residents total, one was independently mobile and cognitively impaired. Room 114/116: three residents total, one was independently mobile and independent cognition Room 117: private room, one resident not independently mobile Room 123: two residents total, one independently mobile with independent cognition Room 201: private room, one resident independently mobile, independent cognition Room 202/204: three total residents, two residents independently mobile and independent cognition Room 210: private room, one resident not independently mobile On 4/12/21 at 2:30 p.m. the Maintenance Supervisor was interviewed. He indicated water temperatures in resident rooms and/or showers should not be over a temperature of 120 F. When he was made aware of water temperatures over 120 F, a plumber was called, then set the mixing valve to 116 F. The same mixing valve serviced both the 100 and 200 halls. After the plumber turned down the temperature of the mixing valve, he rechecked several of the temperatures. The preventative maintenance program instructs him to test a random resident room and/or resident shower on each unit once a week. Currently the system had not had a place for him to document			

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	the room numbers of those rooms and/or showers he had taken water temps in, so he hand wrote them. The company informed him recently how to log the room numbers of the random rooms he checked water temperatures in for his tracking purposes. On 4/12/21 at 3:27 p.m., the Maintenance Supervisor was interviewed. He indicated he was continuing to monitor the water temperatures after the plumber had turned down the temperature of the mixing valve earlier today. He indicated the water temperatures for room 201 was coming down and had a temp of 123 F and room 117 had a temp of 116 F. On 4/13/21 at 9:47 a.m., the Maintenance Supervisor was interviewed. He indicated he had checked the water temps on the 100 and 200 halls until around 5:30 p.m. on 4/12/21 and the temps were down to 120 F in room 201 and 210. He indicated the other rooms were below 120 F but above 114 F. On 4/16/21 at 1:50 p.m., the Maintenance Supervisor was interviewed. He indicated currently he had checked all the rooms on the 100 and 200 hall every day due to the higher water temps on 4/12/21. The mixing valve was now set at 114 F and they would monitor it closely daily on the 100/200 halls for a month. He indicated the preventative maintenance for the mixing valves was monitoring the water temperatures. He indicted by putting the room numbers of the random rooms he checked on the preventative maintenance program, he can more closely monitor the water temps, track and trend them. 3.1-19(f)			

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