STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155795	A. BUILDING 00 B. WING	12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AVALON SPRINGS HEALTH CAMPUS	2400 SILHAVY ROAD VALPARAISO, IN 46383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review and interview, the facility failed to ensure a resident was assessed for self-medication administration prior to leaving medications at the bedside for 1 of 1 random observations of medications left at bedside. (Resident 7) Finding includes: On 12/13/22 at 12:52 p.m., Resident 7 was observed lying in bed. There was a plastic medicine cup on her bedside table with a blue pill in it. The resident indicated she did not know what it was. The resident's record was reviewed on 12/13/22 at 1:27 p.m. The resident was admitted on 3/30/22. Diagnoses included, but were not limited to, Alzheimer's dementia. The current Social Aspects Care Plan indicated the resident had moderate cognitive impairment which was anticipated to progress due to the nature of the disease process. There was no self-medication assessment. Interview with RN 1 on 12/13/22 at 1:03 p.m., indicated the resident was not assessed for self-medication administration. The RN went to the resident's room, and indicated the medication was no longer there, the resident had taken it. 3.1-11(a)	F 0554	Preparation of 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 in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure with Complaint (IN00378658, IN00386505) Survey on 12/19/2022. Please accept this plan of correction as the provider's credible allegation of compliance. Due to scope and severity of the deficiencies, Avalon Springs Health Campus is requesting Paper Compliance. Resident 7 had no negative outcome from medication left at bedside. No other residents have self-administration assessments completed. Nurses and QMAs will receive in-service regarding not leaving medications at bedside for residents without	01/13/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Crystal Wray	Executive Director	01/06/2023

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			Self-Administration Assessment in place. DHS/Designee will audit 3 residents weekly for medications left at bedside, covering all shifts for six months, then quarterly thereafter until 100% compliance is achieved. QAPI to make changes and/or recommendations as needed.	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social,			

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	religious, and community activities that do not interfere with the rights of other residents in the facility. Based on interview, observation, and record review, the facility failed to honor a resident's food preferences for wanting his diet upgraded for 1 of 1 residents reviewed for choices. (Resident 44) Finding includes: On 12/12/22 at 10:18 a.m., Resident 44 was observed sitting up in bed watching television. He indicated he was on a mechanical diet and not sure why. He did not like his food ground up and had asked multiple times for someone to explain to him why he had to have his food prepared this way. He further indicated he had speech therapy "a while ago" and had never had a problem chewing or swallowing his food his whole life. He indicated he asked for a hamburger every day and they would tell him he could only have one ground up. The only other food he could choose from that he liked was a toasted peanut butter sandwich. On 12/13/22 at 1:15 p.m., Resident 44 was observed sitting up in bed. The resident could be heard from the hallway telling a CNA that he wanted a hamburger for lunch. CNA 2 told the resident he could have a hamburger if it was ground up. He then asked for a salad and the CNA told him he could not have that either. He told the CNA he had never had a problem eating food his whole life and wanted to speak to someone about getting the food he wanted. CNA 2 asked the resident if he wanted his toasted peanut butter sandwich and he said, "I guess if that's the only thing I can have". The CNA left the room.	F 0561	Diet was upgraded for resident 44. Other residents were audited for diet choices and upgraded as indicated. Nursing department will receive in-service regarding notifying physician, and speech therapy when residents desire diet changes. DHS/Designee will audit three residents weekly for diet choices for six months, then quarterly thereafter until 100% compliance is achieved. QAPI to make changes and/or recommendations as needed.	01/13/2023

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	On 12/14/22 at 12:00 p.m., Resident 44 was observed sitting in a wheelchair in the Main Dining Room waiting to be served for lunch. The resident asked a staff member for a hamburger. The staff member told him he could only have a hamburger if it was cut up due to his diet. The resident told the staff member he did not want the hamburger cut up. The staff member asked him if he would like a toasted peanut butter sandwich. The resident once again said, " I guess if that's the only thing I can have". He once again told a staff member he wanted to talk to someone about his diet. Record review for Resident 44 was completed on 12/14/22 at 2:26 p.m. Diagnoses included, but were not limited to, stroke, dementia, malnutrition, and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 9/16/22, indicated the resident was moderately cognitively impaired. The resident required supervision of 1 person for eating. The resident had no swallowing disorder and was on a mechanically altered diet. A Care Plan for Nutrition, dated 6/22/22 and revised 12/13/22, indicated the resident had impaired swallowing requiring a mechanically altered diet. An intervention included to obtain consults as needed in example from dietary and Speech Therapy. A Speech Therapy Discharge Note, dated 7/19/22, indicated the resident had reached maximum potential with skilled services. The resident received mechanical soft/chopped textures for oral intake and thin liquids.			

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	Interview with CNA 2 on 12/13/22 at 1:17 p.m., indicated the resident couldn't have a salad because he was "old" and could not chew and swallow it right. The Dietician wanted him on mechanical soft foods. She further indicated he complained daily about not wanting the food he was served so he usually ate a toasted peanut butter sandwich. Interview with the Evening Supervisor on 12/13/22 at 1:18 p.m., indicated the resident was on mechanical soft due to swallowing issues. She was unsure the last time he had a swallow study completed or which the last time he was evaluated by Speech Therapy. She indicated he complained "a lot" about not wanting to have his food ground up. They would tell him daily it was because therapy wanted him to have a mechanical diet. Interview with Speech Therapist on 12/15/22 at 10:31 a.m., indicated the last time she saw the resident in therapy she believed was in June 2022. When the resident ended therapy, she recommended he was on a mechanical altered diet due to chewing and swallowing issues. Nursing would have to come and tell therapy if the resident wanted to be re-evaluated again for a diet upgrade. Since then she had not received any orders from nursing that the resident had wanted his diet upgraded. Interview with the Director of Nursing (DON) on 12/15/22 at 10:55 a.m., indicated she was unaware the resident was wanting his diet upgraded and that nursing should have let therapy know if he had been complaining about wanting other types of foods. Therapy would then have to do an evaluation to see if the resident's diet could be upgraded.			

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	3.1-3(u)(3)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure Physician orders for labs were completed or completed in a timely manner and a skin discoloration was identified and monitored for 1 of 5 residents reviewed for respiratory care (Resident 56), 1 of 2 residents reviewed for non-pressure skin conditions (Resident 7) and 1 of 5 residents reviewed for unnecessary medications. (Resident 28) Findings include: 1. Resident 56's record was reviewed on 12/13/22 at 9:27 a.m. The resident was admitted on 9/20/22. Diagnoses included, but were not limited to, acute and chronic respiratory failure and congestive heart failure. The Admission Minimum Data Set assessment, dated 9/24/22, indicated the resident had severe cognitive impairment. A Physician's Note, dated 12/7/22, indicated to have a BMP (basic metabolic panel), CBC (complete blood count), and Magnesium labs	F 0684	Labs were drawn for resident 56 on next lab day. Assessment was completed and appropriate event opened for resident 7. Blood cultures were drawn for resident 28. Other residents were audited for skin impairment. Events initiated with physician and family notification as indicated. Other residents were audited for lab results. Physician notified. Nursing staff will receive in-service regarding obtaining labs as ordered, and documenting skin impairment as indicated. DHS/Designee will audit three residents weekly for lab results, and skin impairment documentation covering all shifts for six months, then quarterly thereafter until 100% compliance is achieved. QAPI to make changes and/or recommendations as needed.	01/13/2023

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	drawn. There were no results for the above labs. There was no indication the labs had been ordered or completed. The Director of Nursing indicated she would look into it. Interview with RN 3 on 12/14/22 at 1:25 p.m., indicated nurses did their own lab draws and they were picked up on midnight shift by pharmacy. Interview with the Director of Nursing on 12/14/22 at 9:18 a.m., indicated the Physician would put his orders in his notes. The orders had not been entered or completed until 12/13/22. 2. On 12/13/22 at 12:52 p.m., Resident 7 was observed in bed. She had a dark brown/ blackish discoloration approximately eight centimeters round on her right forearm. The resident indicated she did not know what it was or what had happened. The resident's record was reviewed on 12/13/22 at 1:27 p.m. The resident was admitted on 3/30/22. Diagnoses included, but were not limited to, Alzheimer's dementia. There was no documentation regarding the discoloration in the Progress Notes. Interview with RN 1 on 12/13/22 at 1:03 p.m., indicated she was not aware the resident had a skin discoloration. Interview with the Director of Nursing (DON) on 12/13/22 at 1:55 p.m., indicated there were no skin events recorded for the resident. The current policy, "Bruise, Rash, Lesion, Skin			

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	Tear, Laceration Assessment Guidelines", was received from the DON on 12/13/22, indicated, "...May complete Bruise Event in EHR (electronic health record) by an RN/LPN if the bruise warrants documentation due to the extent and or location...."3. Record review for Resident 28 was completed on 12/16/22 at 10:02 a.m. Diagnoses included, but were not limited to, sepsis and COVID-19. The Admission MDS assessment, dated 11/15/22, indicated the resident was moderately cognitively impaired. The resident was discharged to the hospital on 11/21/22 due to sepsis. The resident returned to the facility on 11/28/22. A Hospital Progress Note, dated 11/27/22, indicated the resident had severe sepsis and the etiology was not clear. The hospital could not rule out pneumonia vs UTI (urinary tract infection) vs mild sacral cellulitis. A blood culture indicated E. coli (bacteria). The resident was to stay on meropenem (antibiotic) for 10 more days and have a follow up blood culture done in 2 weeks. The December 2022 Physician's Order Summary indicated orders for culture blood test (times 2) sets on 11/28/22, 11/29/22, and 12/13/22. The resident received meropenem 1 gram IV for UTI sepsis every 12 hours on 11/28/22 and discontinued on 12/8/22. A Progress Note, dated 12/13/2022 at 6:23 p.m., indicated a medical clinic was called to request a blood culture. The medical clinic claimed they were unable to do blood cultures. The Director of Nursing (DON) was notified.			

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	The record lacked any documentation the blood cultures had been completed as ordered or that the Physician was notified the blood cultures were not completed. Interview with the DON on 12/16/22 at 12:59 p.m. indicated they had been having problems getting the supplies needed to draw the blood cultures. She would have to look into whether or not the doctor was notified the blood cultures had not been completed since the resident returned from the hospital. Follow up interview with the DON on 12/19/22 at 11:50 a.m., indicated the supplies for the blood culture arrived to the facility that day. She could not provide any further documentation the Physician had been notified that the blood cultures had not been completed as ordered. 3.1-37(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;			

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	§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records not completed for residents with significant weight loss for 2 of 3 residents reviewed for nutrition. (Residents 53 and 49) Findings include: 1. On 12/13/22 at 12:58 p.m., Resident 53 was observed lying in bed with her eyes open. She had a plate of spaghetti on the bedside table in front of her. The silverware was still wrapped in a napkin and no drinks were observed on the table. At 1:25 p.m., Occupational Therapist (OT) 1 was observed assisting the resident up in bed to eat. At 1:29 p.m., OT 1 was observed bringing the resident a Styrofoam cup of liquid to her room. Interview with OT 1 at the time indicated she assisted the resident up in bed to eat. She indicated the resident told her she did not know her food was in the room. The resident had refused to get up in the wheelchair to eat. She was unsure why the resident did not have any drinks on her tray, so she went and got her a cup of milk. On 12/14/22 at 12:01 p.m., Resident 53 was observed sitting in the Main Dining Room eating lunch. At 12:20 p.m., the Employee Engagement Specialist (EES) was observed asking the resident if she was done with her lunch. The resident	F 0692	Resident 53 is no longer residing in facility Resident 49 had desired weight loss with no negative outcome. No other residents had negative outcome related to deficiency. All staff will receive in-service regarding documenting meal consumption accurately and consistently. DHS/Designee will audit three residents twice weekly for meal consumption covering all meals for six months, then quarterly thereafter until 100% compliance is achieved. QAPI to make changes and/or recommendations as needed.	01/13/2023

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	indicated yes and the EES removed and discard the resident's lunch plate. Interview with the EES at the time of the observation indicated she was unaware how much food the resident had consumed. She was also unaware the resident's meal intakes were supposed to documented. Record review for Resident 53 was completed on 12/13/22 at 1:04 p.m. Diagnoses included, but were not limited to, fracture of left ileum, dementia, and malnutrition. The Admission Minimum Data Set (MDS) assessment, dated 11/7/22, indicated the resident was cognitively impaired. The resident's assistance level needed for eating was not marked. On 11/7/2022, the resident weighed 124 lbs. On 12/8/2022, the resident weighed 98 pounds which was a 20.97% loss. A Registered Dietician Note, dated 12/12/22 at 2:58 p.m., indicated due to the resident's underweight status, weight loss was not desirable. The resident received a regular diet with meal intakes variable, though mostly 26-50%. Marinol was ordered and may aid in increased appetite, Ensure supplement was ordered three times a day with good acceptance. She suggested to do weekly weights for 4 weeks for further weight monitoring. Staff may offer ice cream with lunch and dinner for added calories and protein. The December 2022 Physician's Order Summary (POS) indicated orders for the following: - Marinol (appetite stimulant) 2.5 mg (milligrams) prior to breakfast and lunch everyday - Intake and Output Care Assist Order to check breakfast, lunch, and dinner daily			

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	- Ensure supplement 237 ml (milliliters) three times a day The meal consumption log for November 2022 had 34 out of 81 meals with no value documented. The December 2022 log had 16 out of 39 meals with no value documented. Interview with the Director of Nursing on 12/14/22 at 12:29 p.m., indicated the staff should be documenting how much food the resident was eating at each meal. 2. On 12/13/22 at 1:00 p.m., Resident 49 was observed sitting in a wheelchair in her room eating lunch. The resident refused room entry and indicated her food was "fine". Record review for Resident 49 was completed on 12/14/22 at 1:30 p.m., Diagnoses included, but were not limited to, hypertension, dementia, depression, and anxiety. The Quarterly MDS assessment, dated 10/28/22, indicated the resident was cognitively impaired. The resident required supervision setup assistance for eating. The resident was on a mechanical diet and had weight loss which was not documented as physician prescribed. On 6/3/2022, the resident weighed 200 lbs. On 12/09/2022, the resident weighed 154 pounds which was a 23.00% loss. A Registered Dietician (RD) Note, dated 11/17/22 at 3:40 p.m., indicated the resident had weight loss. The resident was overweight and weight loss was not detrimental. The resident had an ordered diet of mechanical soft with fortified foods. Remeron (antidepressant) was ordered and			

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	ice cream was offered at lunch and dinner for additional calories. The resident did not like or want nutritional supplements. She had previously stated that she was happy with her weight loss. The RD suggested to continue present nutrition management. The December 2022 POS indicated orders for the following: - mirtazapine (antidepressant) 7.5 mg (milligrams) at bedtime for appetite stimulant - Diet: Regular, Mechanical Soft solids, thin liquids, fortified foods with meals (no shakes), ice cream with lunch and dinner - Intake and Output Care Assist Order to check breakfast, lunch, and dinner daily The meal consumption log for December 2022 had 18 out of 39 meals with no value documented. Interview with the DON on 12/14/22 at 2:48 p.m., indicated the weight loss was desired weight loss to the resident. Staff should be marking the resident's meal intakes. 3.1-46(a)(1)			
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.			

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	Based on observation, record review, and interview, the facility failed to ensure Physician's orders were in place for residents receiving oxygen, and oxygen was in place as ordered for 3 of 5 residents reviewed for respiratory care. (Residents 43, 36 and 27) Findings include: 1. On 12/12/22 at 1:49 p.m. and 12/13/22 at 3:04 p.m., Resident 43 was observed in her bed. She had a nasal cannula in place and oxygen was flowing at 2 liters per minute (lpm). The resident's record was reviewed on 12/13/22 at 2:58 p.m. The resident was admitted on 9/29/22. Diagnoses included, but were not limited to, emphysema. The Admission Minimum Data Set assessment, dated 11/17/22, indicated the resident had moderate cognitive impairment. There was no Physician's order for oxygen. A Respiratory Care Plan indicated the resident had the potential for complications related to emphysema and to use oxygen as ordered. Interview with the Nurse Consultant on 12/14/22 at 11:48 a.m., indicated there had been no order in place for the resident's oxygen. 2. On 12/12/22 at 12:58 p.m., Resident 36 was observed lying in bed. The resident had oxygen in use via a nasal cannula and set at a flow rate of 3.5 liters. The resident indicated she was unsure how much oxygen she was supposed to be using. On 12/13/22 at 11:43 a.m., Resident 36 was observed lying in bed. The resident had oxygen	F 0695	Oxygen orders were obtained for residents 43 and 36. Oxygen was discontinued for resident 27. Other residents were audited for oxygen to ensure orders were in place. Nursing staff will receive in-service regarding administration of oxygen per policy including obtaining orders as indicated. DHS/Designee will audit three resident weekly for oxygen orders for six months, then quarterly thereafter until 100% compliance is achieved. QAPI to make changes and/or recommendations as needed.	01/13/2023

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	in use via a nasal cannula and set at a flow rate of 3.5 liters. Record review for Resident 36 was completed on 12/13/22 at 11:40 a.m. Diagnoses included, but were not limited to, heart failure and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 9/11/22, indicated the resident was cognitively intact. The resident required an extensive 2+ person assist with bed mobility. No oxygen therapy was marked. A Care Plan, dated 2/6/2020 and revised 12/13/22, indicated the resident had potential for cardiovascular distress related to a diagnosis of hypertension. An intervention included to administer oxygen per order. The record lacked any documentation for a Physician's Order for oxygen for the resident. Interview with RN 1 on 12/13/22 at 1:33 p.m., indicated she was unsure how much oxygen the resident was supposed to be using, but believed it to be 2 liters. She then looked into the resident's Physician's Orders and was unable to find an order for oxygen. She further indicated there should have been a Physician's Order for the oxygen. 3. On 12/12/22 at 10:54 a.m., Resident 27 was observed with no oxygen in place. There was no oxygen concentrator or equipment set up in her room. On 12/13/22 at 1:21 p.m., Resident 27 was observed lying in bed in her room with no oxygen in place. There was no oxygen concentrator or equipment set up in her room. Record review for Resident 27 was completed on			

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	12/14/22 at 11:07 a.m. Diagnoses included, but were not limited to, anxiety disorder, Alzheimer's disease, and dyspnea. The Quarterly Minimum Data Set (MDS) assessment, dated 10/25/22, indicated the resident was cognitively impaired, received oxygen therapy and hospice care. The Physician's Order Summary, dated 12/2022, indicated an order for oxygen 2 liters continuously per nasal cannula. The Medication Administration Record (MAR), dated 12/2022, indicated the resident had received the oxygen as ordered. Interview with the DON on 12/13/22 at 1:57 p.m., indicated she would check the resident's oxygen orders. A facility policy, titled, "Administration of Oxygen," received from the Director of Nursing as current, indicated "...1. Verify Physician's order for the procedure...17. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered..." 3.1-47(a)(6)			
F 0732 SS=C 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			

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	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. §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 record review and interview, the facility failed to ensure nurse staffing information was posted daily. This had the potential to affect all 55 residents residing in the facility. Finding includes: The December 2022 posted nurse staffing information was reviewed on 12/15/22 at 11:00 a.m.	F 0732	Nurse staffing was posted as required. No negative outcome resulted related to deficiency. Nursing administration team to receive in-service regarding posting nurse staffing seven days per week. DHS/Designee to audit for nurse	01/13/2023

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	There was no staffing information available for Saturday 12/3, Sunday 12/4, Saturday 12/10, or Sunday 12/11. Interview with the Director of Nursing on 12/15/22 at 11:35 a.m., indicated no one usually posted the required staffing information on the weekends.		staffing weekly for six months then quarterly thereafter until 100% compliance is achieved. QAPI to make changes and/or recommendations as needed.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure each resident ' s medication regimen was managed and monitored to promote or maintain the resident ' s highest practicable mental, physical, and psychosocial well-being	F 0757	Resident 47 had no negative outcome related to Clonidine unavailable. Physician ordered medication changes after blood pressure monitoring with Clonidine	01/13/2023

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	related to a blood pressure medication not administered as ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident 47) Finding includes: Record review for Resident 47 was completed on 12/13/22 at 11:42 a.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, hyperlipidemia, and stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 11/28/22, indicated the resident was cognitively impaired. A Care Plan, dated 2/24/22 and revised on 12/13/22, indicated the resident had a potential for cardiovascular distress related to diagnosis of atrial fibrillation, hypertension, and hyperlipidemia. An intervention included to give medications as ordered. The December 2022 Physician's Order Summary indicated an order for clonidine (blood pressure medication) patch 0.1 mg (milligrams) weekly. Special instructions included to remove old patch prior to placing new one every Friday. The November and December 2022 Medication Administration Records indicated the resident had not received the clonidine patch as ordered on the following days: - 11/18/22: not administered/refused - 11/25/22: not administered; drug item unavailable - 12/2/22: not administered; drug item unavailable - 12/9/22; not administered; drug item unavailable. There was no documentation to indicate the facility was monitoring the resident's blood		on hold. Other residents will be audited for unavailable medications. Nurses and QMAs will receive in-service regarding notifying pharmacy and physician when medications unavailable. DHS/Designee will audit three residents weekly for unavailable medications and notification for six months, then quarterly thereafter until 100% compliance is achieved. QAPI to make changes and/or recommendations as needed.	

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	pressure since he had not received his blood pressure patch since November. There was no documentation to indicate the Physician or pharmacy was notified that the facility did not have the resident's patches. Interview with the Director of Nursing on 12/16/22 at 9:48 a.m., indicated she had spoken with the doctor and told him about the resident not receiving the clonidine patch. The doctor indicated to hold the patch x 2 weeks and check the blood pressure twice a day. She further indicated they had just checked the residents blood pressure and it was within normal limits. The facility should have notified the doctor and pharmacy if the resident had not received his patch and the nurses should have been monitoring his blood pressure. 3.1-48(a)(6)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and			

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	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. §483.80(a)(4) A system for recording			

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	incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to not wearing personal protective equipment (PPE) correctly when entering a transmission based precaution (TBP) isolation room, not completing hand hygiene prior to donning PPE, not removing PPE correctly after exiting a TBP isolation room, and not completing hand hygiene after doffing PPE for random observations of infection control. (Rooms 114, 113, 115, and 110) Findings include: 1. During a random observation on 12/13/22 at 9:41 a.m., RN 2 was observed preparing to pass medications to the resident in Room 114. There were signs on the door that indicated the resident was in droplet/contact isolation. RN 2 was observed to be wearing an N95 mask and a face shield. She stopped outside the room door and removed her face shield. She donned a gown and put a surgical mask over her N95 mask. She then put her face shield back on, donned gloves, and entered the room. She had not performed hand	F 0880	Room 114, 113, 115 and 110 are no longer in isolation and had no negative outcome related to deficiency. Other residents were audited for isolation requirements. RN 2 and CNA 1 will be in-serviced with return demonstration on how and when to don and doff PPE including, but not limited to, mask, respirator devices, gloves, gown, and eye protection. RN 2 and CNA 1 will be in-serviced with return demonstration, for hand hygiene (hand washing and ABHS) and understand when to perform hand hygiene when entering or exiting a transmission based precaution (TBP) isolation room. Staff will be in-serviced on proper donning and doffing of PPE and proper hand hygiene when entering or exiting a transmission based precaution (TBP) isolation room.	01/13/2023

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	hygiene prior to donning the PPE. At 9:43 a.m., RN 2 was observed exiting the room. She doffed the gown, gloves, surgical mask, and face shield. She kept the same N95 mask on. She used hand sanitizer and obtained a new face shield. The resident was in isolation due to being COVID-19 positive. 2. During a random observation on 12/13/22 at 9:49 a.m., CNA 1 was observed delivering breakfast to the resident in Room 113. There were signs on the door that indicated the resident was in droplet/contact isolation. CNA 1 was observed to be wearing an N95 mask and face shield. She stopped outside the room door and donned a gown and gloves, then entered the room. She had not performed hand hygiene prior to donning the PPE. At 9:51 a.m., CNA 1 was observed exiting the room. She doffed the gown and gloves. She kept the same N95 mask and face shield on. She had not performed hand hygiene after doffing the PPE or cleaned her face shield. The resident was on isolation for COVID-19 symptoms and C. Diff (clostridium difficile, a bacterial infection). 3. During a random observation on 12/13/22 at 9:53 a.m., RN 2 was observed delivering breakfast to the resident in Room 115. There were signs on the door that indicated the resident was in droplet/contact isolation. RN 2 was observed to be wearing an N95 mask and a face shield. She stopped outside the room door and removed her face shield. She donned a gown and gloves and put a surgical mask over her N95 mask. She then put her face shield back on and entered the room. She had not performed hand hygiene prior to donning the PPE. As RN 2 exited the room, she doffed the gown, gloves, surgical mask, and face shield. She kept the same N95 mask on. She used hand sanitizer and obtained a new face shield.		IP/DHS/Designee will audit three employees weekly for proper don and doff of PPE and proper hand hygiene when entering or exiting a transmission based precaution (TBP) isolation room for 6 months and then quarterly thereafter until 100% compliance is achieved. QAPI to make changes and/or recommendations as needed. A DPOC will be completed and include: A. Systemic 1. Conduct a Root Cause Analysis (RCA) with Infection Preventionist (IP) with input from the facility Medical Director/IP/DON. a. Identify the root cause resulting in the facility's failure. This includes the Who, What, Where, When, and Why questions. Information regarding RCA can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf b. Develop solutions and systemic changes that need to be taken to address the root cause. Return the solutions and systemic changes with the DPOC documentation. 2. Review the LTC infection control self-assessment to determine if it is an accurate	

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	The resident was in isolation due to being COVID-19 positive. 4. During a random observation on 12/13/22 at 10:04 a.m., CNA 1 was observed delivering breakfast to the resident in Room 110. There were signs on the door that indicated the resident was in droplet/contact isolation. CNA 1 was observed to be wearing and N95 mask and face shield. She stopped outside the room door and donned a gown and gloves, then entered the room. She had not performed hand hygiene prior to donning the PPE. At 10:08 a.m., CNA 1 was observed exiting the room. She doffed the gown and gloves. She kept the same N95 mask and face shield on. She had not performed hand hygiene after doffing the PPE or cleaned her face shield. The resident was in isolation due to being COVID-19 positive. CNA 1 then went to answer the call light for Room 106. Interview with the Director of Nursing (DON) on 12/13/22 at 1:57 p.m., indicated she would provide the current facility policies related to transmission-based precautions and hand hygiene. A facility policy, titled, "COVID-19 Guidelines for PPE," received from the Director of Nursing as current, indicated "... Facemasks for Health Care Providers...When used for care of a resident in isolation, facemasks should be removed and discarded after the resident care encounter and a new one should be donned..." A facility policy, titled, "Guideline for Handwashing/Hand Hygiene" received from the Director of Nursing as current, indicated "...3. Health Care Workers shall use hand hygiene at times such as...d. After removing gloves..."		reflection of the nursing home. Make changes as needed to make accurate and submit with the DPOC documentation. B. Training: 1. After the RCA and LTC infection control assessment has been completed, implement training to all staff. a. Training may be provided by the DON, IP or Medical Director with documentation of completion. b. Training will be targeted toward appropriate staff/residents. c. Return the training documents with the DPOC documentation. C. Monitoring: Monitoring of approaches to ensure Infection Control Practices are maintained. 1. The IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA, daily or more often as necessary for 6 weeks and until compliance is maintained. 2. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified in B1 as above. This will occur for 6 weeks and until compliance is maintained. D. Quality Assurance and Performance Improvement (QAPI):	

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	3.1-18(b)		1. The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	