STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155502	A. BUILDING 00 B. WING	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF OWENSVILLE	7336 W STATE ROAD 165 OWENSVILLE, IN 47665

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with Investigation of Complaint IN00431350 Survey dates: March 25, 26, 27, 28, 29, & April 1 & 2, 2024 Facility number: 000328 Provider number: 155502 AIM number: 100287960 Census Bed Type: SNF/NF: 51 Total: 51 Census Payor Type: Medicare: 7 Medicaid: 40 Other: 4 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 11, 2024.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective April 26, 2024, to the state findings of the Recertification and State Licensure Survey conducted on April 2, 2024.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which			

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

Melinda Preusz | Executive Director | 04/25/2024

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	results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part,			

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	and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to notify the physician and resident representative of changes in a resident's medical status for 2 of 4 residents reviewed for weight loss. The physician was not notified of a resident's refusal of food and the resident's representative was not notified of significant weight loss or a newly identified pressure injury. (Resident 46, Resident 45) Findings include: 1. On 3/27/24 at 1:46 P.M., Resident 46's Power of Attorney (POA) indicated Resident 46 was hospitalized in January for a pressure ulcer. They indicated they were not told about the pressure ulcer or that the resident had a weight loss until the resident was transferred to the hospital. On 3/28/24 at 10:25 A.M., Resident 46's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and stage 4 pressure ulcer of sacral region. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 2/3/24, indicated Resident 46 had severe cognitive impairment, had no pressure injuries, had a surgical wound, and had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. A facility weights and vitals summary indicated Resident 46 was weighed on the following dates: 9/9/23 at 2:54 A.M. Resident 46 weighed 150.4 pounds (lbs). 10/9/23 at 11:30 A.M. Resident 46 weighed 140 lbs., a 6.9% weight loss since 9/9/23	F 0580	F - 580 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the clinical record of the resident identified as resident 46 has been reviewed by the nutritional risk team, which includes the facility's registered dietitian. Interventions have been reviewed and updated to address the resident's current weight loss issues as well as an appropriate care and treatment plan for the current pressure wound. The clinical record now reflects that the resident's physician and/or nurse practitioner along with the resident's representative have been updated on the resident's condition and the current plan of care. It should also be noted that there was documentation in the clinical record at the time of the survey supporting the fact that the resident's representative had been notified of the pressure ulcer on 12-28-23, 01-04-24 and again upon the resident's return on 01-13-24. The facility's dietitian along with the nutritional risk team will continue to monitor the resident's condition weekly and update the physician and the resident's representative when changes occur. *2.) The corrective action taken for*	04/26/2024

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	11/3/23 at 8:08 A.M. Resident 46 weighed 144.8 lbs. 12/1/23 at 8:44 A.M. Resident 46 weighed 145 lbs. 1/4/24 at 10:31 A.M. Resident 46 weighed 115.6 lbs., a 20.28% weight loss since 12/1/23 The clinical record lacked notification to the physician, Registered Dietitian (RD), or family of the 6.9% weight loss on 10/9/23. The clinical record lacked notification to the RD or the family regarding the 20.28% weight loss on 1/4/24 The following nursing progress notes, dated 11/18/23 through 12/14/23, indicated the resident had poor appetite and food intakes: 11/18/23 12:50 A.M. - "Refused snack tonight". 11/20/23 7:03 P.M. - "Resident did not eat breakfast but ate lunch and supper. Resident up in her recliner watching TV". 11/21/23 2:43 P.M. - "Has not been out of bed today. Appetite remains poor. Offer snacks between meals. Fluids encouraged. No behaviors this shift". 11/22/23 12:22 A.M. - "Resident has not been out of her bed so far this shift. No snacks this evening but did drink some water with her medications". 11/22/23 12:50 P.M. - "Resident ate 75% of breakfast, and 0% of lunch. Resident continues to sleep most of the day. Snacks offered between meals, and staff continues to encourage resident to increase her intake of fluids". 11/24/23 2:05 P.M. - "Resident has been awake off and on all throughout this shift so far. Resident ate 25% of breakfast and 100% of lunch. No behaviors noted. Staff continues to encourage resident to increase her intake of fluids". 11/28/23 1:14 P.M. - "Resident continues with decreased appetite. Resident ate 0% of breakfast		*those residents found to have been affected by the deficient practice is that* the resident identified as resident 45 no longer resides at the facility. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit has now been conducted of all resident's weights to identify any significant weight variances. There is now documentation to support that the dietitian, physician and the respective resident's representative have been notified of the weight variances along with notification of the new interventions put in place to address the current weight variances. The facility has also conducted a housewide review of all residents with pressure ulcers. The physician, dietitian and the respective resident's representative have been updated on the current condition of those ulcers as well as the current plan of care. These notifications have been documented in the residents' clinical records. The nutritional risk team which includes the registered dietitian, will continue to review weight variances weekly as well as those residents with pressure ulcers weekly and notify the physician/nurse practitioner and the resident's representatives of any significant change in	

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	and 50% of lunch. Staff continues to encourage resident to increase her intake of fluids, and snacks offered between meals". 12/1/23 1:57 P.M. - "Residents appetite continues to remain poor. Ate 25% of breakfast and lunch. Staff continues to encourage resident to increase her intake of fluids. Snacks offered. Resident continues to sleep throughout most of the day". 12/3/23 11:57 A.M. - "Residents appetite continues to remain poor. Staff continues to encourage resident to increase her intake of fluids. Snacks offered. Resident continues to sleep throughout most of the day". 12/4/23 11:18 A.M. - "In bed at this time appetite remains unchanged". 12/6/23 1:42 P.M. - "Up in chair at bedside transferred with 2 assist. Gait unsteady. Appetitei [sic] remains unchanged". 12/7/23 1:51 P.M. - "Resident up in recliner earlier this shift with 2 assist. Appetite remains unchanged. Resident took medications". 12/8/23 12:31 A.M. - "Refused PM (night) meds. Appetite poor". 12/9/23 1:30 P.M. "Resident continues with poor appetite". 12/10/23 1:48 P.M. "Resident has been sleeping in bed most of the morning. Did wake up to eat lunch". 12/11/23 12:53 P.M. - "Resident is resting in recliner at this time. Resident did eat 50% of breakfast and lunch. No complaints of pain noted. Staff continues to encourage fluids". 12/12/23 11:59 A.M. - "Up in recliner for meal at this time. Staff encouraging and cuing her to eat". 12/13/23 2:18 P.M. - "Resident continues with poor appetite. Is bedridden most of the time. No behaviors noted". 12/14/23 2:23 P.M. - "Resident continues with poor appetite. Is bedridden most of the time. No behaviors noted".		condition and/or change in the plan of care. F – 580 (continued) *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses and QMAs on the facility policy related to Notifications of Change in Condition. The staff has been re-educated on their responsibilities of notifying the resident's physician/nurse practitioner and the resident's representative of any changes in condition including weight variances and/or the development and/or change in pressure ulcer condition. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the nursing documentation to ensure that the physician and the resident's representative are notified of any changes in the resident's condition, including weight variances and/or development and/or change in a pressure ulcer. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then	

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	The clinical record lacked any progress notes from 12/16/23 to 1/16/24 related to loss of appetite, weight loss, nutritional status, or notification of poor appetite or food intake to the physician, RD, or family. A Pressure Wound Weekly assessment, dated 12/28/23, identified a new stage 2 pressure ulcer on the buttocks measuring 2.2 cm (centimeters) in length, 0.5 cm in width, and 0.2 cm in depth. The note indicated the facility left a message for the POA. A nursing progress note, dated 1/4/24 at 10:36 A.M., indicated the resident was lethargic and not eating, and the NP saw the resident and gave new orders to obtain labs for CBC, CMP, TSH (thyroid-simulating hormone), and T4 (thyroxine) the next morning. A review of the census indicated the resident was hospitalized from 1/6/24 to 1/13/24. A hospital history of present illness note, dated 1/6/24, indicated Resident 46 was evaluated for sepsis due to a large, unstageable decubitus ulcer (pressure ulcer) that was acquired at the facility. It was noted that family was present during the evaluation and stated they were not aware the ulcer was present. A hospital discharge summary, dated 1/13/24, indicated the resident's discharge diagnoses included, but were not limited to, sepsis due to decubitus ulcer, severe hypernatremia due to notable dehydration, decubitus ulcer present on admission, and severe malnutrition present on admission. The resident was discharged back to the facility and was admitted to hospice on		quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	1/13/24.2. On 3/28/24 at 9:11 A.M., Resident 45's clinical record was reviewed. Resident 45 diagnoses included, but were not limited to, dysphagia and hemiplegia. The most recent Quarterly MDS Assessment was completed on 3/6/24, and indicated Resident 45 was moderately cognitively impaired, and was total dependent on assistance from staff with eating, mobility, transfers, and toileting. Current active physician orders included, but were not limited to: Enteral Feed four times a day; Give 240 cc (equivalent of ml) (milliliter) of Jevity 1.5 after meals if consumes < 50% and at bedtime. Start date 6/14/23. Current care plans included, but were not limited to: I will take diet as ordered; Peg tube enteral feedings as ordered. Start date 2/26/24 Diet as ordered; Weight as ordered; Registered dietician evaluation as needed; Notify MD of any concerns. Start date 6/13/23. The most recent recorded weight in 3/18/24 indicated Resident 45 weighted 72 pounds. Weight recorded six months prior on 9/21/23 indicated a weight of 85.6 pounds. The total weight loss for the past 6 months indicated Resident 45 had a weight loss of 15.89%. The following dates, during the 6 month weight loss period of 15.89%, indicated Resident 45 did not receive the full amount of Jevity feeding ordered, or did not receive it at all, with no notification documented between the facility and the dietician, or the facility and the physician. 1/31/24 8 A.M. no feeding administered; 1/31/24 5			

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	P.M. 100 ml 2/1/24 8 P.M. 60 ml 2/2/24 1 P.M. 100 ml; 2/2/24 5 P.M. 100 ml; 2/2/24 8 P.M. 100 ml 2/5/24 1 P.M. 200 ml 2/10/24 8 P.M. 120 ml 2/14/24 8 P.M. 120 ml 2/15/24 8 A.M. 120 ml; 2/15/24 1 P.M. 120 ml 3/4/24 5 P.M. no feeding administered 3/13/24 8 P.M. 120 ml 3/19/24 8 A.M. 120 ml, 3/19/24 1 P.M. 120 ml; 3/19/24 5 P.M. 120 ml 3/20/24 8 A.M. 120 ml, 3/20/24 1 P.M. 120 ml; 3/20/24 5 P.M. 120 ml; 3/20/24 8 P.M. 60 ml 3/21/24 8 A.M. 120 ml, 3/21/24 1 P.M. 120 ml; 3/21/24 5 P.M. 120 ml; 3/21/24 8 P.M. 120 ml 3/24/24 1 P.M. 120 ml; 3/24/24 5 P.M. 120 ml During an interview on 4/1/24 at 1:47 P.M., the Director of Nursing stated sometimes Resident 45 will tell staff she is full before a feeding is complete and if the full amount of feeding is not administered, it should be documented why the full amount was not administered. In an interview on 4/1/24 at 12:13 P.M., the Director of Nursing (DON) indicated that families were notified if a resident experienced significant weight loss and those notifications were charted in the weight change note. On 4/2/24 at 12:28 P.M., the DON provided a current Weight Assessment and Intervention policy, undated, that indicated "Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietician in writing. Unless notified of significant weight change, the dietitian will review the unit weight record monthly to			

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	follow individual weight trends over time. The threshold for significant weight unplanned and undesired weight loss will be based on the following criteria: 1 month - 5% weight loss is significant; great than 5% is severe ... Undesirable weight change is evaluated by the treatment team whether or not the criteria for "significant" weight change has been met. The evaluation includes ... the resident's calorie, protein, and other nutrient needs compared with resident's current intake ... Care planning for weight loss or impaired nutrition ...includes the physician, nursing staff, the dietitian ...and the resident's legal surrogate". On 4/2/24 at 12:28 P.M., the DON provided a current Change in a Resident's Condition or Status policy, undated, that indicated "Our facility promptly notifies the resident, his or her attending, physician, and the resident representative of changes in the resident's medical/mental condition and/or status ... The nurse will notify the resident's attending physician or physician on call when there has been a ... significant change in the resident's physical/emotional/mental condition; ... refusal of treatment or medications two (2) or more consecutive times; ... A "significant change" of condition is a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff...requires interdisciplinary review and/or revision to the care plan ... Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: there is a significant change in the resident's physical, mental, or psychosocial status". 3.1-5(a)(2)			

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F 0641 SS=E Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record review, the facility failed to ensure the MDS (Minimum Data Set) Assessment was completed accurately for 4 of 17 residents reviewed for resident assessment. (Resident 46, Resident 22, Resident 5, Resident 45) Findings include: 1. On 3/28/24 at 9:06 A.M., Resident 46 was observed in her room. She appeared to be around 5 feet tall. On 3/28/24 at 10:25 A.M., Resident 46's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and stage 4 pressure ulcer of sacral region. A Quarterly MDS (Minimum Data Set) Assessment, dated 12/16/23, indicated that Resident 46 had severe cognitive impairment, a formal assessment scale was used that indicated the resident was not at risk for pressure ulcers, and the resident was 74 inches (in) tall. A Significant Change MDS Assessment, dated 1/20/24, indicated Resident 46 had severe cognitive impairment, a formal assessment scale was not used to assess for risk of pressure ulcers, the resident was at high risk for pressure ulcers, and the resident was 74 in tall. The most recent Quarterly MDS Assessment, dated 2/3/24, indicated Resident 46 had severe cognitive impairment, did not have any pressure	F 0641	F – 641 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a corrected MDS has now been submitted for the resident identified as resident 46. All information provided on the new assessment is accurate based on the resident's condition. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a corrected MDS has now been submitted for the resident identified as resident 22. All information provided on the new assessment is accurate based on the resident's condition. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a corrected MDS has now been submitted for the resident identified as resident 5. All information provided on the new assessment is accurate based on the resident's condition. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* although the resident identified as resident 45 no longer resides at the facility, a corrected MDS has now been	04/26/2024

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	injuries, had a surgical wound, had a weight loss of 5% or more in the last month or loss of 10% or more in last 6 months, had a weight gain of 5% or more in the last month or gain of 10% or more in last 6 months, and was 74 in tall. A facility weights and vitals summary indicated Resident 46 was measured on the following dates: 9/11/23 at 2:56 P.M., Resident 46 measured 61 in tall. 10/10/23 at 3:56 P.M., Resident 46 measured 74 in tall. A facility weights and vitals summary indicated Resident 46 was weighed on the following dates: 9/9/23 at 2:54 A.M. Resident 46 weighed 150.4 pounds (lbs). 9/15/23 at 3:08 P.M. Resident 46 weighed 154.6 lbs. 9/25/23 at 11:30 A.M. Resident 46 weighed 154 lbs. 10/9/23 at 11:30 A.M. Resident 46 weighed 140 lbs. 11/3/23 at 8:08 A.M. Resident 46 weighed 144.8 lbs. 12/1/23 at 8:44 A.M. Resident 46 weighed 145 lbs. 1/4/24 at 10:31 A.M. Resident 46 weighed 115.6 lbs. 1/16/24 at 11:28 A.M. Resident 46 weighed 128 lbs. 2/26/24 at 10:00 A.M. Resident 46 weighed 114.2 lbs. A Quarterly Braden Scale Assessment, dated 12/16/23, indicated the resident was at risk for pressure ulcers. An Admission Braden Scale Assessment, dated 1/13/24, indicated the resident was at very high risk for pressure ulcers. A Pressure Wound Weekly assessment, dated 12/28/23, identified a new stage 2 pressure ulcer on the buttocks measuring 2.2 cm (centimeters) in		submitted for the resident and accurately reflects the resident's condition at that time. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit of all current MDSs has now been completed to ensure each MDS assessment contains accurate information based on the resident's condition. All MDS information on the most current MDSs is now complete and accurate. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all members of the interdisciplinary team on the facility policy related to accurate completion of the MDS. Each team member was re-educated on their responsibility on ensuring that all information entered into the MDS accurately reflects the resident's current condition/needs. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the accuracy of the information entered into the resident's MDS. The tool will monitor to ensure that the information accurately reflects the resident's current condition/needs. This tool will be	

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	155502	A. BUILDING 00 B. WING	04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	length, 0.5 cm in width, and 0.2 cm in depth. A Pressure Wound Weekly Assessment, dated 1/4/24, indicated the pressure ulcer was worsening and measured 2.5 cm in length, 2 cm in width, and 0 cm in depth. The resident was sent to the hospital for treatment and evaluation on 1/6/24. A hospital discharge summary, dated 1/13/24, indicated the resident's discharge diagnoses included, but were not limited to, sepsis due to decubitus ulcer (pressure ulcer) and decubitus ulcer present on admission. The resident had a surgical debridement of the ulcer on 1/8/24. A clinical readmission assessment, dated 1/13/23 at 12:31 P.M., indicated the resident had a stage 4 pressure ulcer on the coccyx above the buttocks measuring 10 cm in length, 10 cm in width, and 3 cm in depth with slough in the wound bed and heavy bloody drainage on the dressing. A care plan, initiated 1/13/24, indicated the resident had a stage 4 pressure ulceration to the sacral region following a surgical debridement. A skin/wound note, dated 2/7/24 at 10:58 A.M., indicated "After reviewing RAI [Resident Assessment Instrument] for MDS it was determined that wound to resident's coccyx should be documented as a surgical wound present upon re-admit on 1/13/24. Resident went out to hospital with SDTI [Soft Damage Tissue Injury] at which time hospital debrided and wound had significantly changed upon readmission. Prior assessments struck-out and corrected to be nonpressure. Correct assessment completed 2/6/24".		completed by the MDS coordinator and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	During an interview on 4/2/24 at 10:20 A.M., the MDS Coordinator indicated the following MDS assessment items were marked in error: Quarterly 12/16/23 - should indicate the resident was at risk for pressure ulcers. The resident was not 74 inches tall. The resident should be closer to 61 or 62 inches tall, but the clinical record was wrong and she was unsure exactly how tall the resident was. Significant Change 1/20/24 - should indicate a formal assessment was completed. The resident was not 74 inches tall. Quarterly 2/3/24 - should indicate the resident had 1 stage 4 pressure injury and no surgical wounds. Should indicate the resident only had a weight loss. Weight gain was marked in error. The resident was not 74 inches tall. At that time, the MDS Coordinator indicated the facility followed the RAI User Manual. 2. On 4/1/24 at 11:32 A.M., Resident 22's clinical record was reviewed. Resident 22's diagnoses included, but were not limited to, type 2 diabetes mellitus, major depressive disorder, and hypertension. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 1/5/24, indicated Resident 22 was cognitively intact and required limited assistance of 1 staff for mobility and transfers. The MDS Assessment indicated Resident 22 had received tube feedings while at the facility. During an interview on 4/2/24 at 10:41 A.M., the MDS Coordinator stated Resident 22 was not receiving tube feedings, and that MDS Assessment was marked in error. 3. On 3/27/24 at 01:53 P.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, aphasia. The most recent			

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	Annual MDS Assessment, dated 1/16/24, indicated Resident 5 had moderate cognitive impairment, and required extensive assistance of 2 staff for mobility, transfers, and toileting, and required supervision of 1 staff while eating. The MDS Assessment indicated Resident 5 was receiving a mechanically altered diet and was not edentulous. During an interview on 3/25/24 at 12:54 P.M., Resident 5 was observed having no teeth. During an interview on 4/2/24 at 11:22 A.M., the MDS Coordinator confirmed Resident 5 was edentulous, and the MDS Assessment was marked in error. 4. On 3/28/24 at 9:11 A.M., Resident 45's clinical record was reviewed. Resident 45 diagnoses included, but were not limited to, dysphagia and hemiplegia. The most recent Quarterly MDS Assessment was completed on 3/6/24, and indicated Resident 45 was moderately cognitively impaired, and was total dependent on assistance from staff with eating, mobility, transfers, and toileting. The MDS Assessment indicated Resident 45 had not experienced hallucinations. Current care plans included, but were not limited to: Resident has Hallucinations at times, sees snakes in her bed. Dated 1/22/24. During an interview on 4/2/24 at 11:50 A.M., the MDS Coordinator stated that Resident 45 does experience hallucinations and that it is documented in progress notes as well as updated in the care plan, and the MDS Assessment was marked in error.			

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	The RAI User Manual 3.0 indicated "surgical debridement of a pressure ulcer does not create a surgical wound. Surgical debridement is used to remove necrotic or infected tissue from the pressure ulcer in order to facilitate healing. A pressure ulcer that has been surgically debrided should continue to be coded as a pressure ulcer".			
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility	F 0657	F - 657	04/26/2024

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	failed to ensure care plan conferences were conducted in a timely manner every 3 months and revised with changes for 9 of 12 residents and revised reviewed for care plans. (Resident 8, Resident 4, Resident 34, Resident 46, Resident 49, Resident 11, Resident 5, Resident 45, Resident 4) Findings include: 1. On 3/23/24 at 8:43 A.M., Resident 8's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, major depressive disorder, and unspecified mood (affective) disorder. The current Quarterly MDS(Minimum Data Set) Assessment dated 1/31/24. Indicated Resident 8 was mildly cognitively impaired and required extensive assistance with transfer and mobility. Care plan conferences were documented for 11/3/23 but lacked a care plan conference for the next 3 months due in January of 2024. During an interview on 4/2/24 at 11:09 A.M. the MDS coordinator indicated a care conference should have been done in January 2024, but was missed. During an interview on 4/01/24 at 9:25 A.M., the DON (Director of Nursing) indicated there should be a care plan conference upon admission and with quarterly assessments. On 4/2/24 at 3:02 P.M., BOM (Business Office Manager) provided a current nondated policy "Care Planning- Interdisciplinary Team. " The policy indicated " resident care plans are developed to timeframes... based on resident assessments..."2. On 3/27/24 at 1:21 P.M.,		*1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a care plan conference has now been conducted for the resident identified as resident 8. Care plan conferences will continue to be provided for this resident at least every three months and more often if warranted. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a care plan conference has now been conducted for the resident identified as resident 41. Care plan conferences will continue to be provided for this resident at least every three months and more often if warranted. *3.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a care plan conference has now been conducted for the resident identified as resident 5. Care plan conferences will continue to be provided for this resident at least every three months and more often if warranted. *4.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 45 no longer resides at the facility. *5.) The corrective action taken for*	

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	Resident 41's clinical record was reviewed. Resident 41 was admitted on 4/7/22. Diagnoses included, but were not limited to, anoxic brain damage, rheumatoid arthritis, and multiple sclerosis. The most recent Quarterly MDS Assessment was completed on 1/27/24, and indicated Resident 41 had total dependency on 2 staff for transfers, mobility, eating, and toileting, and was unable to assess cognitive function. Care conferences for the past year were held on 4/12/23, 1/22/24, and 3/27/24. 3. On 3/27/24 at 01:53 P.M., Resident 5's clinical record was reviewed. Resident 5 was admitted on 2/1/14. Diagnoses included, but were not limited to, aphasia. The most recent Annual MDS Assessment, dated 1/16/24, indicated Resident 5 had moderate cognitive impairment, and required extensive assistance of 2 staff for mobility, transfers, and toileting. Care conferences for the past year were held on 3/15/23. 4. On 3/28/24 at 9:11 A.M., Resident 45's clinical record was reviewed. Resident 45 was admitted on 6/13/23. Resident 45 diagnoses included, but were not limited to, dysphagia and hemiplegia. The most recent Quarterly MDS (Minimum Data Set) Assessment was completed on 3/6/24, and indicated Resident 45 was moderately cognitively impaired, and was total dependent on assistance from staff with eating, mobility, transfers, and toileting. Care conferences for the past year were held on 12/6/23. 5. On 4/1/24 at 11:32 A.M., Resident 22's clinical		*those residents found to have been affected by the deficient practice is that* a care plan conference has now been conducted for the resident identified as resident 22. Care plan conferences will continue to be provided for this resident at least every three months and more often if warranted. *6.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a care plan conference has now been conducted for the resident identified as resident 4. Care plan conferences will continue to be provided for this resident at least every three months and more often if warranted. *7.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a care plan conference has now been conducted for the resident identified as resident 34. Care plan conferences will continue to be provided for this resident at least every three months and more often if warranted. *8.) The corrective action taken for those residents found to have been affected by the deficient practice is that* a care plan conference has now been conducted for the resident identified as resident 46. Care plan conferences will continue to	

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	record was reviewed. Resident 22 was admitted on 4/14/19. Diagnoses included, but were not limited to, type 2 diabetes mellitus, major depressive disorder, and hypertension. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 1/5/24, indicated Resident 22 was cognitively intact and required limited assistance of 1 staff for mobility and transfers. Care conferences for the last year were held on 4/3/23, 10/20/23, and 3/27/24. 6. On 3/27/24 at 12:23 P.M., Resident 4's clinical record was reviewed. Resident 4 was admitted to the facility on 8/16/23. Diagnosis included, but was not limited to, dementia. The most recent Quarterly MDS Assessment, dated 2/16/24, indicated Resident 4 had moderate cognitive impairment. The clinical record lacked documented care plan conferences after 11/15/23. 7. On 4/1/24 at 10:14 A.M., Resident 34's clinical record was reviewed. Resident 34 was admitted to the facility on 12/17/20. Diagnosis included, but was not limited to, dementia. The most recent Quarterly MDS Assessment, dated 12/18/23, indicated Resident 34 had severe cognitive impairment. The clinical record lacked documented care plan conferences between 9/26/23 and 3/20/24. 8. On 3/28/24 at 10:25 A.M., Resident 46's clinical record was reviewed. Resident 46 was admitted to the facility on 9/8/23. Diagnoses included, but were not limited to, Alzheimer's Disease and stage 4 pressure ulcer of sacral region. The most recent Quarterly MDS Assessment, dated 2/3/24, indicated Resident 46 had severe cognitive impairment.		be provided for this resident at least every three months and more often if warranted. F – 657 (continued) *9.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the care plan of the resident identified as resident 49 has now been revised and addresses the resident's weight variance issues. Interventions have been put in place to address those issues. A care plan conference has now been conducted for resident 49 so that all areas of concern have been reviewed with the resident and/or their representative. The resident's care plans will continue to be promptly updated to reflect any changes of condition. Care plan conferences will continue to be provided for this resident at least every three months and more often if warranted. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all care plans has been conducted. All care plans currently reflect each resident's needs/condition. All care plans have also now been	

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	The clinical record lacked documented care plan conferences after 10/16/23. 9. On 4/1/24 at 10:45 A.M., Resident 49's clinical record was reviewed. Resident 49 was admitted to the facility on 2/2/24. Diagnoses included, but were not limited to, dementia and diverticulitis of the intestine. The most recent Admission MDS Assessment, dated 2/8/24, indicated Resident 49 had severe cognitive impairment, required substantial/maximal assistance (helper does more than half) with eating, had no weight loss prior to admission, was 68 inches (in) tall, and weighed 142 pounds (lbs). Current physician orders included, but weren't limited to: Regular diet, Regular texture, Regular consistency, dated 2/2/24 Weekly weights for 4 weeks, dated 2/5/24 and discontinued on 3/4/24 Weekly weights for 4 weeks, dated 3/11/24 Monthly weight, dated 2/3/24 mirtazapine (an antidepressant that causes appetite stimulation) tablet 7.5 MG (milligrams) - Give 1 tablet by mouth one time a day for appetite, dated 3/8/24 A nutrition care plan, dated 2/2/24, indicated the resident would take his diet as ordered with supplements and vitamins as needed. A facility weights and vitals summary for Resident 49 indicated the following weights: 2/2/24 at 12:55 P.M. - 143.2 lbs 2/5/24 at 10:58 A.M. - 143.0 lbs 2/12/24 at 7:28 A.M. - 142.0 lbs 3/5/24 at 2:31 P.M. - 133.0 lbs, a 6.34% weight loss		reviewed with each resident and/or their representative and care plan conferences will continue to be conducted in conjunction with the completion of the MDS (every three months and more often if warranted). *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all members of the interdisciplinary team on the facility policy related to care plan timing and revision. Each staff member was re-educated on their responsibility on ensuring that the residents care plans are current and accurately reflect the resident's condition/needs. The staff was also re-educated on their responsibility on providing care plan conference for each resident at least every three months and more often if warranted. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the accuracy of the care plan and to ensure that there is documentation to support that care plan conferences have been provided for the resident and/or their representative at least every three months and more often if warranted. This tool will be completed by the MDS coordinator and/or their designee	

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	since 2/12/24 3/11/24 at 8:19 A.M. - 133.0 lbs 3/19/24 at 11:19 A.M. - 132.8 lbs 3/25/24 at 2:16 P.M. - 132.0 lbs A weight change note, dated 3/6/24 at 1:19 P.M., indicated "Down 9 pounds 1 month. Added house supplement bid [twice a day], weekly weight x 4. Wife here and aware of weight loss. Will encourage to go to dining room for meals and staff will assist with eating as he will allow". A weight change note, dated 3/27/24 at 7:55 A.M., indicated "Weight at 132 # [lbs] has been stable 4 [sic] last 4 weeks. Remains on Remeron [brand name for mirtazapine] to increase appetite. Encouraged to be out of room for meals. Will feed self with set up staff assists as needed". The care plan was not revised related to Resident 49's weight loss or new orders. In an interview on 4/1/24 at 12:13 P.M., the Director of Nursing (DON) indicated that significant weight loss would be added to the care plan once it was identified. On 4/2/24 at 12:28 P.M., the DON provided a current Weight Assessment and Intervention policy, undated, that indicated "The threshold for significant unplanned and undesired weight loss will be based on the following criteria: 1 month - 5% weight loss is significant; great than 5% is severe ... Care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident's legal surrogate. Individualized care plans shall address...the identified cause of weight loss".		weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	On 4/2/24 at 12:28 P.M., the DON provided a current Care Plans, Comprehensive Person-Centered policy, undated, that indicated "Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change". On 4/2/24 at 3:02 P.M., BOM (Business Office Manager) provided a current nondated policy "Care Planning- Interdisciplinary Team. " The policy indicated " resident care plans are developed to timeframes... based on resident assessments..." 3.1-35(d)(2)(B) 3.1-35(e)			
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure effective services were provided to prevent the development of a facility-acquired stage two	F 0686	F - 686 *1.) The corrective action taken for those residents found to have been affected by the deficient*	04/26/2024

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	pressure injuries for Resident 46 and Resident 9, who were admitted to the facility without pressure injuries, and were identified by the facility upon admission to be at risk to develop pressure injuries. This deficient practice resulted in Resident 46 developing a facility-acquired stage two pressure injury on the coccyx that deteriorated to an unstageable pressure injury with infection and required hospitalization for intravenous antibiotic therapy of wound-based sepsis, and surgical debridement of the facility-acquired unstageable pressure injury to a stage four pressure injury. This deficient practice resulted in Resident 9 developing a facility-acquired stage two pressure injury on the left heel that deteriorated to a stage three pressure injury. Findings include: 1. On 3/27/24 at 1:46 P.M., Resident 46's family member indicated Resident 46 was hospitalized in January 2024 for a pressure ulcer. They indicated they were not told about the pressure ulcer until the resident was transferred to the hospital and they weren't sure how the resident got the pressure ulcer. At the hospital the resident received antibiotics and treatment, and the pressure ulcer started to heal. They indicated that prior to the hospitalization the resident was "giving staff a hard time" and thought it was because the resident was in pain due to the pressure ulcer. They indicated that the resident was mobile when admitted to the facility but was no longer able to get around on her own. On 3/28/24 at 9:06 A.M., a Hospice Nurse was observed changing the dressing for Resident 46's pressure ulcer on her coccyx. The hospice nurse cleansed and packed the wound with a half sheet		*practice is that* the resident identified as resident 46 is now receiving the care and services for the treatment of their pressure wound. In addition, the care plan lists all interventions including turning and repositioning required in the treatment to aide in the healing of the pressure ulcer. The resident's pressure ulcer continued to be monitored with each dressing change. Any significant changes in the wound are documented in the clinical record and physician/representative is notified. A thorough description of the ulcer is documented in the clinical record weekly in accordance with facility policy. The resident is now receiving pain management upon any complaints of pain. The care plan is updated with any change in condition and/or any new interventions that are attempted in the healing of the pressure ulcer. It should also be noted that there is documentation in the clinical record that the resident's representative was notified of the pressure ulcer on 12-28-23, 01-04-24 and again upon the resident's return on 01-13-24. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 9 no longer resides at the facility. *The corrective action taken for the*	

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	of calcium alginate dressing (a highly absorbent dressing). At that time, the Hospice Nurse indicated the resident was admitted to Hospice upon return from the hospital in January. She further indicated the pressure injury was healing nicely. On 3/28/24 at 10:25 A.M., Resident 46's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and stage 4 pressure ulcer of sacral region, onset date 1/13/24. The Admission Minimum Data Set (MDS) Assessment, dated 9/15/23, indicated that Resident 46 had severe cognitive impairment, required extensive assistance of 2 staff for bed mobility, transfers, toileting, and bathing, and supervision of 1 staff for eating. The resident was frequently incontinent of bowel and bladder. No pressure ulcers were present. A formal assessment scale was used that indicated the resident was at high risk for pressure ulcers. The resident had no nutritional or swallowing issues. An Admission Braden Scale Assessment (a tool used to assess the resident's risk to develop pressure injuries), dated 9/8/23, indicated the resident was at high risk to develop a pressure injury. The tool did not include documentation related to turning and repositioning interventions. The admission physician orders, dated 09/08/2023, included, but were not limited to, the following orders: Turn and reposition approximately every 2 hours per Braden Scale. Pressure relieving/reducing mattress and device for chair.		*other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all residents has now been completed to identify those residents at moderate to high skin risks. Residents identified at moderate to high skin risks and/or currently have pressure ulcers have had their care plans reviewed and revised to ensure that all preventative interventions are in place to address their skin needs. Pain management has also been added to the care plans of those residents with current pressure ulcers. Residents with current pressure ulcers are now monitored with each dressing change and any significant changes in the condition of their wounds have been documented in the clinical record and the physician and resident representative notified of those changes. Thorough descriptions of each pressure ulcer is now being documented in the clinical record at least weekly in accordance with facility policy. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing staff on the facility's policies related to the prevention and treatment of pressure ulcers. The staff has	

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	A late loss ADLs (Activities of Daily Living) care plan, initiated 9/8/23, included an intervention to inspect the resident's skin weekly, observe for redness, open areas, scratches, cuts, and bruises, and report any concerns to the nurse. The comprehensive care plan lacked documentation related to the resident's risk for pressure ulcers. Weekly Skin Assessment every day shift every Friday, dated 9/15/23. Tylenol (a pain reliever) Oral Tablet 325 mg (milligrams) - Give 2 tablets by mouth every 6 hours as needed for pain or temperature, dated 11/15/23. A re-admission Physician's Note, dated 10/10/23, indicated the resident did not have any skin impairments. The Quarterly MDS Assessment, dated 12/16/23, indicated Resident 46 had severe cognitive impairment, was dependent (staff does everything) on staff for toileting and shower, required substantial/maximal assistance (staff does more than half) for bed mobility and transfers, and required supervision/touch assistance for eating. The resident was always incontinent of bowel and bladder. No pressure ulcers were present. A formal assessment scale was used that indicated the resident was not at risk for pressure ulcers. The resident had no nutritional or swallowing issues. A Quarterly Braden Scale Assessment, dated 12/16/23, indicated the resident was at risk for pressure ulcers. The Nursing Skilled evaluation reports, dated		been re-educated on their responsibilities in the care and treatment of those residents identified as being at skin risk. The staff was also reminded of their responsibility to document any changes in the pressure ulcer and to ensure prompt notification of the physician and the resident's representative is documented in the clinical record. The staff was also re-educated on pain management as it relates to pressure ulcer. F – 686 (continued) *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the effectiveness of the facility's pressure ulcer prevention and treatment program. The tool will monitor to ensure that all appropriate measures have been put in place for the prevention and/or treatment of pressure ulcers. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	12/16/23 through 01/03/2024, indicated skin assessments were completed by nursing staff twice daily and no skin impairment was observed. A partially-completed resident shower sheet/skin concern document, dated 12/26/23, did not include documentation to indicate skin issues were present. A Pressure Wound Weekly assessment, dated 12/28/23, identified a new stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough. May also present as an intact or open/ruptured serum filled blister) on the coccyx (the area that articulates with the sacrum at the top of the buttocks) that measured 2.2 cm (centimeters) in L (length) by 0.5 cm W (width) by 0.2 cm D (depth). The assessment indicated the wound bed contained no epithelial tissue, no granulation, no slough, no necrotic tissue, no drainage, no odor, and normal per-wound tissue. The Nurse Practitioner (NP) and the facility's wound nurse were notified on 12/28/23, and orders were received to cleanse the wound with Anasept (an antimicrobial skin and wound cleanser) and apply a foam dressing. The December 2023 TAR (treatment administration record) indicated that a weekly skin assessment was conducted on 12/1, 12/8, 12/15, 12/22, and 12/29 and that the resident's skin was intact with no new or existing skin issues. The December 2023 TAR indicated that the pressure wound was cleansed with Anasept and a foam dressing was applied once daily on day shift from 12/28/23 to 12/31/23. The December TAR did not include sufficient documentation to show the facility-acquired stage two pressure ulcer was			

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	effectively assessed by nursing staff daily between 12/28/23 and 01/03/24. The IDT (Interdisciplinary Team) progress notes, the plan of care, the nursing progress notes, and the wound nurse progress notes dated from 12/29/23 through 1/3/24, did not include documentation of the facility-acquired stage two pressure injury on the coccyx. On 4/2/24 at 12:28 P.M., assessments of the specific characteristics of the facility-acquired stage two pressure injury on the coccyx between 12/29/23 and 1/03/24 were requested. The facility was unable to provide documentation to determine that staff assessed the facility-acquired stage two pressure injury on the coccyx between 12/29/23 and 1/3/24. The January 2024 TAR indicated that a weekly skin assessment was conducted on 1/5/24 and that the resident's skin was intact with no new or existing skin issues. The record did not include documentation related to the specific characteristics facility-acquired stage two pressure injury on the coccyx initially identified on 12/28/23. The January 2024 TAR indicated that the facility-acquired stage two pressure wound was cleansed with Anasept and a foam dressing was applied once daily on day shift from 1/1/24 to 1/4/24. It did not include an assessment of the wound. A resident shower sheet/skin concern document, dated 1/2/24, indicated the resident had an open area, but did not include a nurse assessment related to the open area.			

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	The nursing progress notes did not include sufficient documentation to show the facility-acquired stage two pressure ulcer was effectively assessed by nursing staff daily between 12/28/23 and 01/03/24. A Pressure Wound Weekly assessment, dated 1/4/24, indicated the pressure ulcer on the coccyx was worsening and measured 2.5 cm in length, 2 cm in width, and 0 cm in depth. The assessment indicated the wound bed contained 100% epithelial tissue, no granulation, no slough, no necrotic tissue, no drainage, no odor, and normal per-wound tissue. The NP was notified and orders were given to cleanse the wound with wound cleanser, pat dry, apply Medihoney (a gel used to treat wounds), and apply a bordered foam dressing A care plan, initiated 1/4/24, indicated the resident had a facility-acquired stage 2 pressure ulceration to inner buttocks with interventions to implement treatment as ordered, update the facility wound nurse, PCP (primary care physician), or NP of benefit of treatment plan or worsening with routine treatments, and weekly skin assessments. A Nursing Skilled Evaluation, dated 1/4/24 at 2:03 A.M., indicated Moisture Associated Skin Damage (MASD) was newly identified on the coccyx above the buttocks measuring 2 cm in length and 20 cm in width with slough in the wound bed and minimal bloody drainage on the dressing. The assessment indicated the resident experienced "episodic pain". Pain relieving interventions were not given at that time. A nursing progress note, dated 1/4/24 at 10:36 A.M., indicated the resident was lethargic and not eating, and the NP saw the resident and gave new			

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	orders to obtain labs for CBC (complete blood count), CMP (complete metabolic panel), TSH (thyroid-stimulating hormone), and T4 (thyroxine) the next morning. A Nursing Skilled Evaluation, dated 1/5/24 at 1:27 A.M., indicated the MASD on the coccyx above the buttocks measured 2 cm in length and 20 cm in width with slough in the wound bed and minimal bloody drainage on the dressing. The assessment indicated the resident experienced "episodic pain". Pain relieving interventions were not given at that time. A nursing progress note, dated 1/5/24 at 2:15 A.M., indicated the dressing on the coccyx was intact and there were no signs of discomfort. A resident shower sheet/skin concern document, dated 1/5/24, indicated the resident had an open area, but did not include a nursing assessment related to the open area. A nursing progress note, dated 1/6/24 at 12:48 A.M., indicated the wound was cleaned, and the dressing was changed and was intact. A Nursing Skilled Evaluation, dated 1/6/24 at 12:52 A.M., indicated the MASD on the coccyx above the buttocks measured 2 cm in length and 20 cm in width with slough in the wound bed and minimal bloody drainage on the dressing. The assessment indicated the resident experienced "episodic pain". Pain relieving interventions were not given at that time. A nursing progress note, dated 1/6/24 at 3:17 P.M., indicated the dressing to the coccyx was clean, dry, and intact.			

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	The nursing progress notes and skilled nursing evaluation reports, dated from 01/05/2024 at 1:28 A.M. through 01/06/2024 at 4:22 P.M., did not include sufficient documentation to determine the specific characteristics of the facility- acquired stage two pressure injury that deteriorated to an unstageable pressure injury. A nursing progress note, dated 1/6/24 at 4:23 P.M., indicated the resident had vomited on her gown and was observed having shallow breathes with a low blood pressure of 60/40 and a thready slow pulse at 26 beats per minute. The doctor was notified, and new orders were given to send the resident to the hospital for treatment and evaluation of the significant change in condition. A hospital admission summary, dated 1/6/24, indicated Resident 46 was admitted to the hospital for treatment of dehydration, acute hypernatremia (high sodium), acute kidney injury, altered mental status, and sepsis. It was noted that the resident had a large decubitus ulcer (pressure ulcer) with eschar (dead tissue) that was unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed.) The summary indicated new areas of pressure-related skin impairment, on the left shoulder, left ear, and right hip, were identified by hospital staff during a physical exam. The resident was admitted to the general medical floor to await transfer to another hospital and was started on IV (intravenous) Zosyn (an antibiotic medication). A laboratory report, dated 1/6/23, included, but was not limited to, the following blood level results: -Lactic Acid (a blood test to determine sepsis): 2.3 mmol/L (millimoles/Liter) therapeutic range: 0.5-2.0 mmol/L			

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	-Albumin (a blood test to determine liver and kidney function): 3.0 g/dL (grams/deciliter) therapeutic range: 3.4-4.8 g/dL -Sodium (a blood test to determine fluid and electrolyte balance): 157 meQ/L (milliequivalent/liter) therapeutic range: 136-145 meQ/L -Troponin (a blood test to determine heart damage): 203 ng/L (nanogram/Liter) therapeutic range: 0-13 ng/L A laboratory report, dated 1/7/23, included, but was not limited to, the following blood level results: -Lactic Acid (a blood test to determine sepsis): 2.3 mmol/L therapeutic range: 0.5-2.0 mmol/L -Albumin (a blood test to determine liver and kidney function): 2.8 g/dL therapeutic range: 3.4-4.8 g/dL -Sodium (a blood test to determine fluid and electrolyte balance): 157 meQ/L therapeutic range: 136-145 meQ/L -Troponin (a blood test to determine heart damage): 231 ng/L therapeutic range: 0-13 ng/L A hospital admission summary, dated 1/7/24, indicated Resident 46 was transferred to another hospital and admitted to the ICU (intensive care unit) with diagnoses of severe sepsis with the source of decubitus wound and decubitus ulcer. A hospital discharge summary, dated 1/13/24, indicated the resident's discharge diagnoses included, but were not limited to, sepsis due to decubitus ulcer and decubitus ulcer present on admission. The resident had a surgical debridement of the ulcer on 1/8/24 with a wound vac placed that was removed prior to discharge. The resident was discharged back to the facility and was admitted to hospice on 1/13/24.			

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	During an interview on 4/1/24 at 12:13 P.M., the Director of Nursing (DON) indicated Resident 46 developed a pressure ulcer on 12/28/23 that continued to worsen until she was transferred to the hospital on 1/6/24. She indicated that pressure ulcers were measured weekly but assessed daily during the dressing change and should be documented in the progress notes or the TAR. She indicated that the assessment in the Skilled Nursing Evaluations between 12/28/23 and 1/3/24 were not correct and most likely copied and pasted. At that time, she indicated that care plans were updated each morning during Interdisciplinary Team (IDT) meetings and when new orders were added. 2. During record review on 4/1/24 at 11:45 A.M., Resident 9 diagnoses included, but were not limited, to type II diabetes, dementia, heart failure, and chronic kidney disease. Resident 9's most recent Quarterly MDS (Minimum Data Set) assessment, dated 1/19/24, indicated that the resident had severe cognitive impairment, required extensive assistance with ADL's (activities of daily living) and mobility, was always incontinent of bowel and bladder, and had an unhealed stage III pressure area. A nurse's note dated 10/12/23 at 9:56 A.M., indicated that Resident 9 had arrived at the facility in a wheelchair. Resident 9 was taken to her room and transferred to her bed. A skin assessment was completed, and no open areas were noted. An admission Braden scale completed on 10/12/23 indicated that Resident 9 was at risk for pressure. Resident 9's physician orders included, but were not limited to:			

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	Cleanse area on left heel with wound cleanser and apply Medi-honey to wound bed. Cover with dry dressing daily, one time a day for wound (started 10/20/23). Float heels at all times, every shift for wound (started 10/20/23). House supplement 4 ounces three times a day, with meals (started 1/11/24). Left Heel: Cleanse with wound cleanser, pat dry. Pack wound bed with collagen sheet moistened with normal saline. Apply bordered gauze dressing. Secure with Kerlix (gauze bandage) as needed. Initial and date every day shift for wound care and as needed for soiled or dislodged dressing (started 3/13/24). Resident 9's care plan included, but was not limited to: I am at risk for impairment to skin integrity due to fragile skin, incontinence. I will maintain or develop clean and intact skin by the review date (revised 10/19/23). I have a stage 3 pressure area to left heel (initiated 10/20/23). Interventions included weekly skin assessments. A weekly wound assessment dated 10/20/23 at 1:41 P.M., indicated a facility-acquired stage two pressure ulcer on Resident 9's left heel that measured 3 cm (centimeters) L (length) x 4 cm W (width) x 0.3 cm D(depth) (Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and			

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	may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present). The assessment indicated the wound bed contained 100% granulation tissue with no odor and well-defined edges. A wound assessment dated 10/31/23 indicated a facility-acquired stage 3 pressure ulcer on Resident 9's left heel that measured 3 cm L x 3.5 cm W x 0.1 cm D (Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed). The assessment indicated the wound bed contained 10% granulation tissue and 90% slough with no odor and a moderate amount of serosanguinous drainage with rounded wound edges. A wound assessment dated 11/7/23 indicated a facility-acquired stage 3 pressure ulcer on Resident 9's left heel that measured 2.4 cm L x 2.4 cm W x 0.1 cm D. The assessment indicated the wound bed contained 25% granulation tissue and 75% slough with no odor and a moderate amount of serosanguinous drainage with rounded wound edges. A wound assessment dated 11/14/23 indicated a facility-acquired stage 3 pressure ulcer on Resident 9's left heel that measured 2.2 cm L x 2 cm W x 0.1 cm D. The assessment indicated the			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wound bed contained 25% granulation tissue and 75% slough with no odor and a moderate amount of serosanguinous drainage with rounded wound edges. A wound assessment dated 11/21/23 indicated a facility-acquired stage 3 pressure ulcer on Resident 9's left heel that measured 2 cm L x 2 cm W x 0.1 cm D. The assessment indicated the wound bed contained 25% granulation tissue and 75% slough with no odor and a moderate amount of serosanguinous drainage with rounded wound edges. Weekly wound assessment records, dated between 11/21/23 and 12/26/23 did not contain wound documentation including, but not limited to, measurements and specific wound characteristics to show staff effectively assessed the facility-acquired stage three pressure injury to Resident 9's left heel. A wound assessment dated 12/26/23 indicated a facility-acquired stage 3 pressure ulcer on Resident 9's left heel that measured 1.5 cm L x 1.2 cm W x 0.3 cm D. The assessment indicated the wound bed contained 90% granulation tissue and 10% slough with no odor and a moderate amount of serosanguinous drainage with rounded wound edges. A wound assessment dated 1/2/24 indicated a facility-acquired stage 3 pressure ulcer on Resident 9's left heel that measured 1.5 cm L x 1.5 cm W x 0.5 cm D. The assessment indicated the wound bed contained 90% granulation tissue and 10% slough with no odor and a moderate amount of serosanguinous drainage with rounded wound edges.			

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	155502	A. BUILDING 00 B. WING	04/02/2024

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	A wound assessment dated 1/9/24 indicated a facility-acquired stage 3 pressure ulcer on Resident 9's left heel that measured 1.5 cm L x 1.3 cm W x 0.3 cm D. The assessment indicated the wound bed contained 90% granulation tissue and 10% slough with no odor and a moderate amount of serosanguinous drainage with rounded wound edges. A wound assessment dated 1/16/24 indicated a facility-acquired stage 3 pressure ulcer on Resident 9's left heel that measured 1.4 cm L x 1 cm W x 0.4 cm D. The assessment indicated the wound bed contained 50% granulation tissue and 50% slough with no odor and a moderate amount of serosanguinous drainage with rounded wound edges. A wound assessment dated 1/23/24 indicated a facility-acquired stage 3 pressure ulcer on Resident 9's left heel that measured 2 cm L x 1.5 cm W x 0.6 cm D. The assessment indicated the wound bed contained 50% granulation tissue and 50% slough with no odor and a moderate amount of serosanguinous drainage with rounded wound edges. A wound assessment dated 1/30/24 indicated a facility-acquired stage 3 pressure ulcer on Resident 9's left heel that measured 2 cm L x 1.6 cm W x 0.4 cm D. The assessment indicated the wound bed contained 75% granulation tissue and 25% slough with no odor and a moderate amount of serosanguinous drainage with rounded wound edges. A wound assessment dated 2/6/24 indicated a facility-acquired stage 3 pressure ulcer on Resident 9's left heel that measured 1.8 cm L x 0.6 cm W x 0.2 cm D. The assessment indicated the			

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	wound bed contained 75% granulation tissue and 25% slough with no odor and a moderate amount of serosanguinous drainage with rounded wound edges. Weekly wound assessment records, dated between 2/6/24 and 2/20/24 did not contain wound documentation including, but not limited to, measurements and specific wound characteristics to show staff effectively assessed the facility-acquired stage three pressure injury to Resident 9's left heel. A wound assessment dated 2/20/24 indicated a facility-acquired stage 3 pressure ulcer on Resident 9's left heel that measured 0.5 cm L x 0.5 cm W x 0.1 cm D. The assessment indicated the wound bed contained 100% granulation tissue with no odor and no drainage and well-defined wound edges. A wound assessment dated 2/27/24 indicated a facility-acquired stage 3 pressure ulcer on Resident 9's left heel that measured 0.5 cm L x 0.3 cm W x 0.1 cm D. The assessment indicated the wound bed contained 100% granulation tissue with no odor and no drainage and well-defined wound edges. A wound assessment dated 3/5/24 indicated a facility-acquired stage 3 pressure ulcer on Resident 9's left heel that measured 0.5 cm L x 0.5 cm W x 0.2 cm D. The assessment indicated the wound bed contained 100% granulation tissue with no odor and no drainage and well-defined wound edges. A wound assessment dated 3/12/24 indicated a facility-acquired stage 3 pressure ulcer on Resident 9's left heel that measured 0.5 cm L x 0.5			

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	cm W x 0.2 cm D. The assessment indicated the wound bed contained 100% granulation tissue with no odor and no drainage and well-defined wound edges. A wound assessment dated 3/19/24 indicated a facility-acquired stage 3 pressure ulcer on Resident 9's left heel that measured 0.3 cm L x 0.3 cm W x 0.1 cm D. The assessment indicated the wound bed contained 100% granulation tissue with no odor and no drainage and well-defined wound edges. On 4/2/24 at 12:28 P.M., the DON provided a current Pressure Ulcer Treatment policy, revised 11/1/17, that indicated "The pressure ulcer treatment program should focus on the following strategies: Assessing the resident and the pressure ulcer(s). Managing tissue loads. Pressure ulcer care. Managing bacterial colonization and infection. Operative repair of the pressure ulcer(s). Education and quality improvement. ... The following information should be recorded in the resident's medical record: ... Any change in the resident's condition. All assessment data (i.e., color, size, pain, drainage, etc.) when inspecting the wound". On 4/2/24 at 3:04 P.M., the DON provided a current Charting and Documentation policy, undated, that indicated "Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate". 3.1-40(a)(1) 3.1-40(a)(2)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility.			

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	§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure a Resident was provided restorative therapy services to prevent avoidable decline in range of motion and progression of muscle atrophy for 1 of 1 residents reviewed for mobility. (Resident 41) Findings include: On 3/27/24 at 1:21 P.M., Resident 41's clinical record was reviewed. Diagnoses included, but were not limited to, anoxic brain damage, rheumatoid arthritis, and multiple sclerosis. The most recent Quarterly MDS (Minimum Data Set) Assessment dated 1/27/24, indicated Resident 41 had total dependency on 2 staff for transfers, mobility, eating, and toileting, and was unable to assess cognitive function. The MDS Assessment indicated Resident 45 had	F 0688	F - 688 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 41 is now receiving range of motion exercises in an effort to prevent the development of further contractures to upper and lower extremities. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all residents has now been conducted to identify any resident with limited or decreased joint mobility. Each	04/26/2024

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	limitation in range of motion and impairment on both sides of upper and lower extremities but received zero minutes of restorative therapy. Current active physician orders included, but were not limited to: Up with assist and mechanical lift, dated 3/15/24. Turn and reposition approximately every 2 hours per Braden Scale every shift, dated 1/20/24. Current care plans included, but were not limited to: Potential for contracture r/t (related to) anoxic brain injury causing persistent vegetative state. PROM (passive range of motion) as tolerated. Refer to therapy/restorative as needed. Observe for increase in contractures. Notify Dr. as needed, revised 3/15/24. The clinical record lacked documentation of restorative nursing services or range of motion exercised provided to Resident 41 during the current year. During an observation on 03/27/24 at 1:44 P.M., Resident 41 was observed laying in bed with the bed in a high position; both hands contracted; both feet contracted and were resting on pillow with heels touching. During an interview on 03/28/24 at 1:38 PM, RN (Registered Nurse) 5 indicated Resident 41 should be receiving restorative nursing for range of motion in her upper and lower extremities, and that the restorative aid provides services Monday through Friday. During an interview on 04/02/24 at 11:25 A.M., CNA (Certified Nurses Aide) 3 stated Resident 41 was removed from restorative nursing in		resident identified with impaired mobility has now been placed on the appropriate restorative therapy program to address their mobility needs. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing staff on the facility's restorative nursing services policy and procedure. All staff was re-educated on their responsibility of providing restorative programs as indicated by the residents' plan of care based on the resident's current needs. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor each resident to ensure they are receiving the necessary restorative programs as identified in their plan of care. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	December due to COPD (chronic obstructive pulmonary disorder) but that she had not witnessed Resident 41 experiencing shortness of breath drop during range of motion exercises. On 4/2/24 at 9:55 A.M., the DON (Director of Nursing) provided a policy titled Restorative Nursing Services, that did not include a date, and indicated: Restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care. Restorative goals may include, but are not limited to supporting and assisting the resident in: maintaining physiological resources, and maintaining dignity. 3.1-42(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to provide adequate supervision and assistive devices to prevent falls for 1 or 1 resident reviewed for accidents. Care plans were not revised and new interventions were not implemented following falls. (Resident 4) Finding includes:	F 0689	F - 689 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 4 has had their fall history reviewed. The IDT team met and reviewed the resident's fall history and updated	04/26/2024

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	On 3/27/24 at 12:27 P.M., Resident 4's clinical record was reviewed. Resident 4 was admitted to the facility on 8/16/23. Diagnoses included, but were not limited to, dementia, chronic instability of knee, and repeated falls. The most recent full Admissions Minimum Data Set (MDS) Assessment, dated 8/23/23, indicated Resident 4 was cognitively intact, required extensive assistance of 1 staff for bed mobility, transfers, and toileting, required total assistance of 1 staff for bathing, had no behaviors, had a fall in the month prior to admission, and had a fall in the 2 to 6 months prior to admission. The most recent Quarterly MDS Assessment, dated 2/16/24, indicated Resident 4 had moderate cognitive impairment, required substantial/maximal assistance (staff does more than half) for bed mobility, transfers, toileting, and showering, had no behaviors, had 2 or more falls without injury since the prior assessment (on 11/22/23) and had 2 or more falls with injury (not major) since the prior assessment. An admission fall risk assessment, dated 8/16/23, indicated Resident 4 was at high risk for falls. The most recent quarterly fall risk assessment, dated 2/16/24, indicated Resident 4 was at high risk for falls. The admission comprehensive falls care plan, dated 8/16/23, included the following interventions: Call light within reach, dated 8/16/23 Non skid shoes or socks, dated 8/16/23 Use assistive device as needed, dated 8/16/23 The clinical record indicated Resident 4 sustained		the resident's care plan to include all appropriate fall prevention interventions in an effort to prevent future falls and/or falls with injury. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all residents related to fall risks has been conducted. Each resident's care plan has been reviewed and revised when warranted to ensure all appropriate fall risk interventions are in place in an effort to prevent future falls. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing staff on the facility's fall prevention policy and procedure. The staff was re-educated on their responsibilities to ensure all safety interventions are in place and that new interventions are added to the plan of care following each fall in an attempt to prevent future falls. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the effectiveness of the facility's fall prevention program. The tool will monitor to ensure that each resident identified as a fall	

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	14 falls from 9/11/23 to 3/30/24. Fall 1 9/11/23 at 8:00 P.M. Fall was not witnessed. The resident fell while bending over to pick a hanger up off the floor in her room. The new immediate intervention put in place was to encourage the resident to ask for assistance with getting clothing out of the closet. "Enc [encourage] to ask for assist with getting items out out [sic] of closet or off of floor" was added to the care plan on 9/12/23. There was no Interdisciplinary Team (IDT) note related to this fall. A nursing progress note, dated 9/13/23 at 1:57 A.M., indicated "Resident has been having pain in her right hip since her fall on 09/11/2023. MD [Medical Doctor] notified, order given for x-ray of right hip". A nursing progress note, dated 9/14/23 at 9:54 A.M., indicated "[name of triage] called, no further others from hip x-ray per MD. Hip x-ray was negative". Fall 2 9/21/23 at 8:30 A.M. Fall was witnessed. The resident was walking in the dining room without her walker and fell. The new immediate intervention put in place was to re-educate the resident to walk with her walker. "Continue to work with skilled services/transfer" and "Review of medications and changes due to complaints of dizziness" were added to the care plan on 9/22/23. Fall 3 9/27/23 at 8:15 A.M. Fall was not witnessed. The resident was attempting to transfer to her wheelchair unassisted, lost her balance, and fell hitting her head on the armrest of a chair. The		risk has a care plan related to fall safety with appropriate interventions in place in an attempt to prevent falls. The tool will also monitor to ensure that following each fall that the fall is reviewed by the IDT team and appropriate safety interventions are added following each fall in an attempt to prevent future falls. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	resident had a quarter sized hematoma on the right side of her forehead at the hair line with no bleeding. The new immediate intervention put in place was to encourage resident to slow down and do one task at a time, if dizzy move slow and/or rest, and use walker at all times. "Encourage to do one task at a time and slow down" was added to the care plan on 9/27/23. Fall 4 10/19/23 at 3:15 A.M. Fall was not witnessed. The resident was up walking in her room, lost her balance, and fell beside her bed hitting her head. The resident had a bruise on her forehead. The new immediate intervention put in place was non skid strips in front of bed and recliner. "Non skid strips beside bed and in front of rec liner [sic]" was added to the care plan on 10/20/23. There was no IDT note related to this fall. A nursing progress note, dated 10/19/23 at 3:57 P.M., indicated "NP [Nurse Practitioner] is wanting resident to go to the hospital to get checked out. Resident has a knot on top of her head from her fall". A nursing progress note, dated 10/19/23 at 4:12 P.M., indicated "Resident sent to [name of hospital] for treatment and eval [evaluation]". A nursing progress note, dated 10/19/23 at 10:40 P.M., indicated "Resident brought back to the facility by [name of family member] from the hospital. All scans done at the hospital were normal per nurse [name of nurse]". Fall 5 11/6/23 at 7:50 A.M. Fall was not witnessed. The resident tripped while attempting to open the blinds in her room. The resident had a laceration			

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	to her scalp on the top of her head that was bleeding. The new immediate intervention put in place was to remind the resident to ask for assistance with the blinds and to keep belongings put away and not stacked on the floor. "Offer to open blinds in am [morning]" was added to the care plan on 11/7/23. A nursing progress note, dated 11/6/23 at 9:10 A.M., indicated that orders were received to send the resident to the emergency room (ER) for evaluation and treatment. A nursing progress note, dated 11/6/23 at 12:10 P.M., indicated "Res returned from ER. 11 staples to be removed in 10 days". Fall 6 11/22/23 at 2:00 P.M. Fall was witnessed. The resident fell from the recliner to the floor while reaching for her tissue box. The new immediate intervention put in place was to use the reacher or call for staff to assist in picking things up. "Remind to use reacher or ask staff to pick up dropped items" was added to the care plan on 11/23/23. Fall 7 12/13/23 at 11:00 A.M. Fall was not witnessed. The resident was cleaning up her room and fell. The resident told staff she was upset because the housekeeper hadn't emptied out her trash yet. The new immediate intervention put in place was to ask housekeeping to take her trash out first. The care plan was not updated with a new intervention at that time. Fall 8 12/27/23 at 7:15 A.M. Fall was not witnessed. The resident fell while getting out of bed to get her			

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	phone. The resident complained of pain to her right knee and ankle and her right arm and shoulder. The new immediate intervention put in place was to instruct the resident to not get up unassisted and to use her call light. "Maintain bed in low position at night" and "gripper socks while in bed night shift to observe for placement" were added to the care plan on 12/28/23. Fall 9 12/28/23 at 3:45 P.M. Fall was not witnessed. The resident was attempting to get up out of bed and fell. There was no new immediate intervention put in place. "Re-arrange furniture in room for safety" was added to the care plan on 12/29/23. Fall 10 1/3/24 at 12:50 P.M. Fall was not witnessed. The resident fell while walking without her walker in her room. The new immediate intervention put in place was to use a chair alarm and re-educate the resident on using her walker. "Bed/chair alarm" was added to the care plan on 1/4/24. Fall 11 2/1/24 at 12:30 A.M. Fall was not witnessed. The resident turned off her bed alarm, went to the bathroom unassisted, and fell while getting back into bed hitting her head. The new immediate intervention put in place was to re-educate the resident to not shut off her bed alarm and call for assistance when needing to get up. "Educated res [resident] on safety and encouraged to use call light for assist with ADLs [activities of daily living]" and "review of alarms consult with therapy" were added to the care plan on 2/2/24. Fall 12 2/26/24 at 5:15 A.M. Fall was witnessed. The resident was observed trying to get in bed by			

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	raising her leg instead of turning around and sitting on the bed. The new immediate intervention put in place was to make sure she had shoes on while up with her cane. "Refer to therapy for alternate transfer mechanics" was added to the care plan on 2/26/24. A nursing progress note, dated 3/1/24 at 11:05 P.M., indicated "Refuses to leave pad alarm on and refuses to leave door open". Fall 13 3/4/24 at 10:30 A.M. Fall was not witnessed. The resident was bending over to wipe something off the floor and fell over. The new immediate intervention put in place was to move the pad alarm box out of the resident's reach and re-educate the resident to use the call light and let staff clean up any messes on the floor. "Encourage res to signal staff for assist" was added to the care plan on 3/4/24. Fall 14 3/30/24 at 10:00 A.M. Fall was witnessed. The resident attempted to get up from her recliner unassisted. The new immediate intervention was to remind the resident not to get up without assistance. "Therapy assessed and adjusted walker added new tennis balls on front" was added to the care plan on 4/1/24. In an interview on 4/1/24 at 12:13 P.M., the Director of Nursing (DON) indicated that IDT meetings happen each business day. If a resident fell, the fall got reviewed the next business day in the IDT meeting. The IDT reviewed all interventions each time a resident fell to make sure the interventions were appropriate. Interventions that were not relevant would be removed, and a new intervention appropriate and relevant to the			

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	155502	A. BUILDING 00 B. WING	04/02/2024

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	fall being reviewed would be added to the care plan. On 4/2/24 at 2:45 P.M., the DON provided a current Care Plans, Comprehensive Person-Centered policy, undated, that indicated "Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident's condition; when the desired outcome is not met...". 3.1-45(a)(2)			
F 0692 SS=G 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; §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.			

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	Based on observation, interview, and record review, the facility failed to provide nutritional care and services including failure to identify significant weight loss, failure to notify the physician of poor intakes, and failure to be reviewed by the Registered Dietician, for 1 of 4 residents reviewed for nutrition (Resident 46). This deficient practice resulted in the resident experiencing a 20% weight loss in 35 days, developing a facility-acquired stage two pressure injury on the 12/28/23 that deteriorated to an infected unstageable pressure injury, and requiring a hospitalization for sepsis, dehydration, and malnutrition. Finding includes: On 3/27/24 at 1:46 P.M., Resident 46's family member indicated they had not been notified by the facility about Resident 46's weight loss. They indicated the resident was hospitalized in January 2024 and they found out about the weight loss then. They indicated that Resident 46 was able to feed herself when she was admitted to the facility but had since declined and required staff to help her eat. They indicated she was able to eat finger foods easily. On 3/28/24 at 10:25 A.M., Resident 46's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and stage 4 pressure ulcer of sacral region. The Admission Minimum Data Set (MDS) Assessment, dated 9/15/23, indicated that Resident 46 had severe cognitive impairment, required extensive assistance of 2 (two) staff for bed mobility, transfer, toileting, and bathing, and required the supervision of 1 (one) staff for eating. The resident had no nutritional issues, swallowing	F 0692	F - 692 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the registered dietitian has now conducted an updated nutritional assessment of the resident identified as resident 46. Resident 46's care plan has been updated to address the resident's significant weight loss along with the resident's refusal of meals and poor intake. The physician has been updated on the resident's current nutritional status. In addition, a care plan conference has been conducted with the resident's representative. The resident's nutritional status along with the current interventions have been reviewed with the representative. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all resident's weights has been conducted to identify any additional residents with a significant weight variance. All residents with a significant weight variance have now been reviewed by the registered dietitian along with the members of the nutritional risk team to ensure that all appropriate nutritional interventions are in place and that the interventions have been added	04/26/2024

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	disorders, and had no weight loss in the past 6 months. The resident weighed 150 pounds (lbs.) and was 61 inches (in) tall. A Dehydration Risk Assessment, dated 9/8/23, indicated Resident 46 was at high risk for dehydration. Admission physician orders included, but were not limited to: Regular diet, Regular texture, Regular consistency, dated 9/8/23. Weekly weights x4 weeks every Fri dated 9/15/23. A Nutritional Risk Assessment, dated 9/15/23, indicated Resident 46 was at high risk for malnutrition. A nutrition and dietary note, dated 9/15/23 at 11:49 A.M., indicated "Initial nutrition risk assessment complete. High Risk. Dx. [diagnosis] of Alzheimer's. Current diet regimen is appropriate. Will continue to monitor weight, intake. RD [Registered Dietician] available as needed". The clinical record lacked a care plan related to a risk for weight loss or malnutrition. A facility weights and vitals summary report included the following measurements: 9/9/23 at 2:54 A.M. 150.4 lbs. (pounds) 9/11/23 at 2:56 P.M., 61 inches (in) length 9/15/23 at 3:08 P.M., 154.6 lbs. 10/9/23 at 11:30 A.M., 140 lbs. The weight warning indicated the resident had a 6.9% weight loss in a month. (The resident returned from the hospital on 10/10/23 and was weighed in the facility at 140 lbs. The facility entered the date 10/9/23 in error.) 11/3/23 at 8:08 A.M. 144.8 lbs. 12/1/23 at 8:44 A.M., 145 lbs.		to the care plan. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the registered dietitian and all nursing staff on the facility's policies related to nutritional assessments and weight assessment and intervention. All staff members have been re-educated on their individual responsibilities for ensuring that each resident's nutritional needs are being met in accordance with their individual plan of care. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor each resident identified with a weight variance concern to ensure that appropriate interventions are in place to meet those individual needs. The tool will monitor the resident's nutritional intake and determine if any additional interventions are warranted. The tool will also monitor to ensure that the R.D. is continuing to assess the resident with nutritional needs and make the necessary recommendation for interventions as warranted. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and	

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	1/4/24 at 10:31 A.M. 115.6 lbs., a 20.28% weight loss since 12/1/23. On 9/15/23, Resident 46 was transferred to a psychiatric hospital for treatment and evaluation of behaviors. The resident was transferred back to the facility on 10/10/23. Hospital discharge records, dated 10/10/23, indicated Resident 46 was treated for aggression and paranoia. A re-admission Dehydration Risk Assessment, dated 10/10/23, indicated Resident 46 was at high risk for dehydration. The clinical record lacked a Nutritional Risk Assessment and a Clinical Readmission Assessment on re-admission to the facility. The clinical record lacked notification to the provider, RD (Registered Dietitian), or family of the 6.9% weight loss. The clinical record lacked an assessment by the RD following this weight loss. A Care Conference Summary, dated 10/16/23 at 1:00 P.M., lacked documentation of a review of Resident 46's significant weight loss. The Interdisciplinary Team (IDT) notes lacked documentation to show that the resident's weight loss was reviewed or effective interventions were implemented to prevent further weight loss. Progress notes, the plan of care, and doctor's orders, dated between 11/3/23 and 11/8/2023, did not include documentation to show an intervention was immediately implemented to		then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	prevent further weight loss. The nursing progress notes, dated from 11/8/2023 at 3:38 P.M. through 11/17/2023 at 6:21 P.M, indicated Resident 46 had a poor appetite and food intake, had extremely dark-colored skin in the area below the eyes, and slept most of the time. The notes indicated the facility staff notified the NP (Nurse Practitioner) of the significant changes on 11/15/2023 and the MD (Medical Doctor) on 11/16/23. The notes did not include documentation to show the NP responded to the notification or to show the facility followed-up with the NP between 11/15/2023 and 11/16/2023. A laboratory report, dated 11/18/2023, included, but was not limited to, the following blood level results: -Albumin (a blood test to determine liver and kidney function): 3.7 g/dL (grams/deciliter) therapeutic range: 3.4-4.8 g/dL -Sodium (a blood test to determine fluid and electrolyte balance): 139 meQ/L (millequivalent/Liter) therapeutic range: 136-145 meQ/L The nursing progress notes, dated from 11/18/23 at 12:50 A.M. through 11/28/23 at 1:14 P.M., indicated Resident 46 had a poor appetite and food intake and slept most of the time. The notes did not include documentation to show notification to the provider or RD. The November 2023 Nutritional Intake form indicated the following: Breakfast consumption: 76-100% on 1 of 30 opportunities 51-75% on 7 of 30 opportunities			

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	26-50% on 4 of 30 opportunities 0-25% on 4 of 30 opportunities 4 of 30 opportunities were documented as resident refused. 1 of 30 opportunities was documented as not applicable. 9 of 30 opportunities were not documented. Lunch consumption: 76-100% on 1 of 30 opportunities 51-75% on 3 of 30 opportunities 26-50% on 4 of 30 opportunities 0-25% on 5 of 30 opportunities 5 of 30 opportunities were documented as resident refused. 12 of 30 opportunities were not documented. Dinner consumption: 76-100% on 1 of 30 opportunities 51-75% on 2 of 30 opportunities 26-50% on 2 of 30 opportunities 0-25% on 4 of 30 opportunities 2 of 30 opportunities were documented as resident refused. 19 of 30 opportunities were not documented. The clinical record lacked documentation of notification to the physician or dietitian related to the refusal of meals and poor food intake.			

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The nursing progress notes, dated from 12/1/23 at 1:57 P.M. through 12/14/23 at 2:23 P.M., indicated Resident 46 had a poor appetite and food intake and slept most of the time. The notes did not include documentation to show notification to the provider or RD.

A Quarterly MDS assessment, dated 12/16/23, indicated Resident 46 had severe cognitive impairment, required supervision or touch assistance for eating, had no weight loss, no swallowing disorder, and weighed 148 lbs.

A Quarterly Dehydration Risk Assessment, dated 12/16/23, indicated Resident 46 was at high risk for dehydration.

Nursing progress notes from 12/16/23 to 1/16/24 lacked documentation related to loss of appetite, weight loss, nutritional status, or notification of poor appetite or intake to the physician, RD, or family.

The December 2023 Nutritional Intake form indicated the following:

Breakfast consumption: 76-100% on 0 of 31 opportunities
51-75% on 1 of 31 opportunities
26-50% on 3 of 31 opportunities
0-25% on 13 of 31 opportunities
3 of 31 opportunities were documented as resident refused.
11 of 31 opportunities were not documented.

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	Lunch consumption: 76-100% on 0 of 31 opportunities 51-75% on 2 of 31 opportunities 26-50% on 0 of 31 opportunities 0-25% on 6 of 31 opportunities 2 of 31 opportunities were documented as resident refused. 21 of 31 opportunities were not documented. Dinner consumption: 76-100% on 0 of 31 opportunities 51-75% on 2 of 31 opportunities 26-50% on 1 of 31 opportunities 0-25% on 1 of 31 opportunities 1 of 31 opportunities were documented as resident refused. 26 of 31 opportunities were not documented. A care plan, dated 12/22/23, indicated the resident was at risk for weight loss due to dementia. Interventions included diet as ordered, record intake, labs as ordered, and notify Dr and family of changes. The clinical record lacked a care plan related to the resident's refusal of food or poor intake. A Pressure Wound Weekly assessment, dated 12/28/23, identified a new stage 2 pressure ulcer on the intergluteal cleft that measured 2.2 cm (centimeters) length by 0.5 cm width by 0.2 cm depth.			

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	A Quarterly Braden Scale Assessment, dated 12/16/23, indicated the resident was at risk for pressure ulcers. The clinical record lacked referral to the RD for assessment and review. A Pressure Wound Weekly assessment, dated 1/4/24, indicated the stage 2 pressure ulcer was worsening and measured 2.5 cm length by 2 cm width by 0 cm depth. Nursing progress notes and the weight change alert lacked notification to the RD or the family regarding this significant weight loss. The clinical record lacked an assessment by the RD following this weight loss. The Interdisciplinary Team (IDT) notes between 1/4/24 and 1/6/24 lacked documentation to show that the resident's weight loss was reviewed or effective interventions were implemented to prevent further weight loss. A nursing progress note, dated 1/4/24 at 10:36 A.M., indicated the resident was lethargic and not eating, and the NP saw the resident and gave new orders to obtain labs for CBC (complete blood count), CMP (comprehensive metabolic panel), TSH (thyroid-stimulating hormone), and T4 (thyroxine) the next morning. A nursing progress note, dated 1/6/24 at 4:23 P.M., indicated the resident had vomited on her gown and was observed having shallow breathes with blood pressure at 60/40 mm/Hg (millimeters/Mercury) and a thready pulse of 26 beats per minute. The doctor was notified, and			

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	new orders were given to send the resident to [name of hospital] for treatment and evaluation. A hospital admission summary, dated 1/6/24, indicated Resident 46 was admitted to the hospital for treatment of dehydration, acute hypernatremia (high sodium), acute kidney injury, altered mental status, and sepsis. It was noted that the resident had a large decubitus ulcer (pressure ulcer) on the coccyx with eschar (dead tissue) that was unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed). A physical exam also indicated the resident had pressure areas on the left shoulder, left ear, and right hip. The resident was admitted to the general medical floor to await transfer to another hospital and was started on IV (intravenous) Zosyn (an antibiotic medication) and given IV fluids for hydration. A second set of labs, dated 1/7/24, included lactic acid at 2.3, troponin at 231, sodium at 157, and albumin at 2.8. A laboratory report, dated 1/6/23, included, but was not limited to, the following blood level results: -Lactic Acid (a blood test to determine sepsis): 2.3 mmol/L (millimoles/Liter) therapeutic range: 0.5-2.0 mmol/L -Albumin (a blood test to determine liver and kidney function): 3.0 g/dL therapeutic range: 3.4-4.8 g/dL -Sodium (a blood test to determine fluid and electrolyte balance): 157 meQ/L therapeutic range: 136-145 meQ/L -Troponin (a blood test to determine heart damage): 203 ng/L (nanogram/Liter) therapeutic range: 0-13 ng/L A laboratory report, dated 1/7/23, included, but was not limited to, the following blood level results:			

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	-Lactic Acid (a blood test to determine sepsis): 2.3 mmol/L (millimoles/Liter) therapeutic range: 0.5-2.0 mmol/L -Albumin (a blood test to determine liver and kidney function): 2.8 g/dL therapeutic range: 3.4-4.8 g/dL -Sodium (a blood test to determine fluid and electrolyte balance): 157 meQ/L therapeutic range: 136-145 meQ/L -Troponin (a blood test to determine heart damage): 231 ng/L (nanogram/Liter) therapeutic range: 0-13 ng/L A hospital admission summary, date 1/7/24, indicated Resident 46 was transferred to another hospital and admitted to the ICU (intensive care unit) with diagnoses of severe sepsis with the source of decubitus wound, severe hypernatremia, notable dehydration, acute kidney injury, elevated troponin, and decubitus ulcer. A hospital discharge summary, dated 1/13/24, indicated the resident's discharge diagnoses included, but were not limited to, sepsis due to decubitus ulcer, severe hypernatremia due to notable dehydration, decubitus ulcer present on admission, and severe malnutrition present on admission. The resident had a temporary weighted feeding tube placed on 1/11/24 for comfort feedings. The feeding tube was removed prior to discharge. The resident also had a surgical debridement of the ulcer on 1/8/24. The resident was discharged back to the facility and was admitted to hospice services on 1/13/24. A clinical readmission assessment, dated 1/13/23 at 12:31 P.M., indicated the resident had a stage 4 pressure ulcer on the coccyx and was taking nutrition and hydration orally.			

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	The clinical record lacked a Nutritional Risk Assessment on re-admission to the facility. Re-admission physician orders related to nutrition included: Mechanical Soft diet, Mechanical Soft texture, Regular consistency for comfort feeding, dated 1/13/23. On 3/28/24 at 12:23 P.M., Resident 46 was observed sitting in a Broda chair (high backed wheelchair) in her room with a lunch tray on the bedside table in front of her. No bites had been taken of the meal. There were no staff present. 75% of the supplementary shake was gone. At 12:30 P.M., Registered Nurse (RN) 5 entered the room and asked if the resident was done. The resident indicated she was not done yet. RN 5 offered the resident the dessert cup and left the room. The resident picked up the dessert cup and attempted to dump it out onto her plate. The dessert did not come out and the resident put the cup aside. The resident picked up her plastic fork, stabbed the potatoes and salmon onto the fork, attempted to get the fork to her mouth, but was unable, and put the fork down. The resident closed her eyes. In an interview on 4/1/24 at 12:13 P.M., the DON indicated that residents were weighed weekly for four weeks upon admission and then monthly with vitals. Weight reports were generated and reviewed on Tuesdays following completion of weekly weight measurement to determine who had significant weight loss. If a resident had unplanned weight loss, they were referred to the dietician. For residents who were weighed monthly, weekly weights would be started if staff noticed the resident appeared to be losing weight. Families were notified if a resident experienced			

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	significant weight loss and those notifications were charted in the weight change note. Significant weight loss would be added to the care plan once it was identified. At that time, she indicated Resident 46 should have been triggered for significant weight loss upon her return from the hospital on 10/10/23 but didn't see where she was and was not sure how she got missed. She indicated that the weight on 10/9/23 was a data entry error and was intended to read 10/10/23. She indicated that staff in December consistently charted the resident had a poor appetite, but could not find notification to the provider, the RD, or the family. The resident liked to be left alone to eat and often refused meals, but sometimes ate better if staff encouraged her. The resident really liked her supplements, soda, orange juice, and was able to pick up cups on her own. The DON was unable to find a care plan related to the refusal of food or risk of malnutrition and weight loss, prior to 12/22/23. On 4/2/24 at 10:55 A.M., RN 5 indicated that Resident 46 needed setup assistance and encouragement to eat. She liked her shakes and used plastic utensils because they were lighter, and she did not have difficulty using them. She preferred to eat in her room. On 4/2/24 at 9:55 A.M., the DON provided a current Nutritional Assessment policy, undated, that indicated "The Dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission and as indicated by a change in condition that places the resident at risk for impaired nutrition ... The multidisciplinary team shall identify, upon the resident's admission and upon his or her change of condition, the following situations that place the resident at increased risk			

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	for impaired nutrition ... Increased need for calories and/or protein - onset of exacerbation of diseases or conditions that result in a hypermetabolic state and an increased demand for calories and protein (e.g., ...wounds)[sic] ...". A comprehensive nutritional assessment was requested on 4/2/24 at 9:57 A.M., and the Director of Nursing (DON) indicated a nutritional risk assessment was conducted on 9/15/2023, and no documentation could be provided to show further nutritional risk assessments were performed." On 4/2/24 at 12:28 P.M., the DON provided a current Weight Assessment and Intervention policy, undated, that indicated "Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietician in writing. Unless notified of significant weight change, the dietitian will review the unit weight record monthly to follow individual weight trends over time. The threshold for significant weight unplanned and undesired weight loss will be based on the following criteria: 1 month - 5% weight loss is significant; great than 5% is severe ... Undesirable weight change is evaluated by the treatment team whether or not the criteria for "significant" weight change has been met. The evaluation includes ... the resident's calorie, protein, and other nutrient needs compared with resident's current intake ... Care planning for weight loss or impaired nutrition ...includes the physician, nursing staff, the dietitian ...and the resident's legal surrogate". 3.1-46(a)(1)			

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F 0727 SS=C Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to ensure at least 8 consecutive hours of registered nurse (RN) coverage during 3 days in a review period from 10/1/23 to 12/31/23. RN coverage was lacking on weekends. Finding includes: During a review of the facility's daily staffing reports on 4/1/24 at 9:10 A.M., the facility lacked 8 consecutive hours of RN coverage on 10/1/23, 10/29/23, and 12/30/23. During an interview on 4/1/24 at 10:37 A.M., the DON (Director of Nursing) indicated being unable to provide any proof that an RN was in the facility on 10/1/23, 10/29/23, and 12/30/23. On 4/2/24 at 3:04 P.M., the Business Office Manager (BOM) supplied an undated facility policy titled Staffing, Sufficient and Competent Nursing. The policy included, "Our facility	F 0727	F - 727 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents have the potential to be affected by this deficient practice. The facility now has appropriate staffing to ensure there are eight consecutive hours of RN coverage daily seven days a week. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. The facility now has appropriate staffing to ensure there are eight consecutive hours of RN coverage	04/26/2024

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	provides sufficient numbers of nursing staff with appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment... 3. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week..." 3.1-17(b)(3)		daily seven days a week. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the DNS and staffing scheduler on the facility's policy related to RN coverage for eight consecutive hours seven days a week. The DNS and staffing scheduler have been re-educated on their responsibility to ensure that the facility has eight consecutive hours of RN coverage daily, seven days a week. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the nursing schedule to ensure there is eight consecutive hours of RN coverage in the facility seven days a week. This tool will be completed by the Executive Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its-			

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	§483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate of greater than 5 percent for 1 of 5 residents (Resident 44) observed during medication pass. Two (2) medication errors were observed during 27 opportunities for error in medication administration. This resulted in a medication error rate of 7.41 percent. Finding includes: During an observation on 3/25/24 at 9:37 A.M., RN 5 was preparing Resident 44's medications, included but were not limited to, Divalproex sodium ER (extended release) 500 mg (milligrams) 1 tablet, and Gabapentin 600 mg 1 tablet. RN 5 then crushed all tablets using a pill crusher and added them to a cup of applesauce. RN 5 then proceeded into Resident 44's room and administered the medications to the resident. During record review on 3/25/24 at 11:00 A.M., Resident 44's physician orders, included but were not limited to, Divalproex sodium ER, 500 mg tablet PO (oral administration), Gabapentin 600 mg tablet PO, and may crush medications as allowed by pharmacy and give together in food of choice (started 7/13/23). During an interview on 3/28/24 at 12:41 P.M. the MDS (Minimum Data Set) nurse indicated extended-release medications and Gabapentin tablets should not be crushed but should be administered whole due to the way the medication is absorbed by the body. Some medications are delivered from the pharmacy with a "do not crush" notice attached.	F 0759	F - 759 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the resident identified as resident 44 is now receiving their medications in accordance with acceptable practices related to medication administration. No additional medication errors have occurred. The staff member identified as RN 5 has been re-educated on medication administration. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. All residents are now receiving their medications in accordance with acceptable practice of medication administration and no additional medication errors have occurred. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses and QMAs on the facility's policies related to medication administration. All licensed nurses and QMAs were reminded to follow the manufacturer guidelines on what medications can and cannot be crushed for	04/26/2024

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	On 03/28/24 at 1:20 P.M., the director of nursing (DON) supplied a do not crush list from the facility pharmacy titled, Oral Medication That Should Not Be Crushed or Altered , dated 1/2022. The do not crush list included, "...Generally, medications which should not be crushed fall into one of the following categories: Extended-Release Products... Recommendations 1. It is not advisable to crush certain medications... Divalproex ER tablet (Reasons/Comments) Extended Release... (Gabapentin) tablet (Reasons/Comments) Extended Release..." 3.1-25(b)(9)		administration. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor medication administration. The tool will monitor to ensure that each medication is administered in accordance with the manufacturer guidelines related to what medications can and cannot be crushed. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility			

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	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 proper handling of tableware and hand hygiene during 1 of 2 observations of dining. Staff handled a resident's coffee mug by placing their thumb on the inside rim of the mug when refilling the mug, and staff failed to perform hand hygiene after coming in contact with residents while providing dining services. (Resident 16, Resident 6, Resident 42, Resident 21) Finding includes: During a dining observation on 3/25/24 at 11:56 A.M., Activities 4 was placing a clothing protector on Resident 16. Activities 4 then pulled Resident 16's hair through the back of the clothing protector, patted the resident's arm, then per Resident 16's request, Activities 4 took the resident's coffee mug and carried it by placing a thumb inside the rim of the mug. Activities 4 filled the mug with coffee and returned it to Resident 16's table. At 12:05 P.M., Activities 4 was changing the television channel with a remote control next to Resident 6 and Resident 42's table. Activities 4 then placed one hand on the shoulder of Resident 6 and another hand on Resident 42's shoulder. Without performing hand hygiene, Activities 4 served Resident 21 their meal, and per Resident 21's added tarter sauce to Resident 21's	F 0812	F - 812 *The corrective action taken for those residents found to have been affected by the deficient practice is that* the residents identified as residents 16, 6, 42 and 21 are now receiving meal service by staff members that are adhering to the facility's policies on meal service and preventing foodborne illnesses – employee hygiene and sanitary practices. The staff member identified as activities 4 has now been re-educated on these policies and is demonstrating sanitary practices during meal service. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. All residents are now receiving meal service by staff members who demonstrate proper sanitary practices during meal service. *The measures that have been put into place to ensure that the deficient practice does not recur is*	04/26/2024

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	plate and placed a napkin on Resident 21's lap. Then without performing hand hygiene, went back to Resident 6 and adjusted the oxygen tubing on the resident's face. During an interview on 3/28/24 at 1:03 P.M., RN 5 indicated when assisting in the dining room to pass food trays, staff should not touch utensils or cups where a resident's mouth may come in contact, and that staff should perform hand hygiene after coming in direct contact with a resident or after passing every third tray. On 3/28/24 at 1:45 P.M., the BOM (Business Office Manager) supplied an undated facility policy titled Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices. The policy included, Food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness... Gloves and Direct Food Contact... 9. ...hands are washed (and gloves are replaced:) a. after direct contact with residents..." 3.1-21(i)(2) 3.1-21(i)(3)		*that* a mandatory in-service has been provided for all staff members on the facility's policies related to hand hygiene, meal service and preventing foodborne illnesses – employee hygiene and sanitary practices. All staff have been re-educated on their responsibility to ensure meal service is provided for each resident by staff members that are following sanitary practices in accordance with facility policy. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the staff performance in providing sanitary meal service. The tool will monitor to ensure that proper hand hygiene is demonstrated by staff when serving meals and that sanitary measures are followed by the staff in the handling of tableware while serving the residents meals. This tool will be completed by the Food Service Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	
F 0842 SS=D	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information			

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Bldg. 00	§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in			

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	compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on observation, interview ,and record review, the facility failed to ensure resident records were complete and accurate for 1 of 1 resident reviewed for dental and 1 of 3 residents reviewed for pressure ulcers and nutrition. (Resident 46, Resident 5) Findings include: 1. On 3/28/24 at 10:25 A.M., Resident 46's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and stage	F 0842	F - 842 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the clinical record of the resident identified as resident 46 has been updated and now reflects accurate information regarding the resident's current condition. The information related to the resident's current height, weight and condition of the	04/26/2024

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	4 pressure ulcer of sacral region. The most recent Quarterly Minimum Data Set (MDS) Assessment, dated 2/3/24, indicated Resident 46 had severe cognitive impairment, did not have any pressure injuries, had a surgical wound, weighed 128 pounds (lbs.), and was 74 inches (in) tall. A review of the census indicated Resident 46 was on hospital leave from 9/15/23 to 10/10/23. A review of the weights and vitals summary indicated the following weights and height: 9/11/23 at 2:56 P.M., Resident measured 61 inches (in) 9/25/23 at 11:30 A.M. Resident 46 weighed 154 lbs. 10/9/23 at 11:30 A.M., Resident 46 weighed 140 lbs. 10/10/23 at 3:56 P.M., Resident 46 measured 74 in. A Pressure Wound Weekly assessment, dated 12/28/23, identified a new stage 2 pressure ulcer on the buttocks measuring 2.2 cm (centimeters) in length, 0.5 cm in width, and 0.2 cm in depth. Nursing Skilled Evaluations were completed once a shift (twice daily) from 12/28/23 through 1/3/24 and indicated there were no skin issues. A resident shower sheet/skin concern document, dated 12/26/23, was not completely filled out and did not indicate if any skin issues were present. A Pressure Wound Weekly assessment, dated 12/28/23, identified a new stage 2 pressure ulcer on the buttocks measuring 2.2 cm in length, 0.5 cm in width, and 0.2 cm in depth. A Nursing Skilled Evaluation, dated 1/4/24 at 2:03		pressure ulcer are now accurately documented in the clinical record. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the current dental status of the resident identified as resident 5 has now been entered into the clinical record. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* a housewide audit of all current clinical records has been conducted to identify any additional discrepancies in documentation. All clinical records now contain complete and accurate information on the resident's current condition/status. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all licensed nurses and QMAs on the facility's policy related to accuracy of the clinical record. The staff was re-educated on their responsibility to ensure that all resident information was documented accurately and in a timely manner into the clinical record in accordance with facility policy. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to	

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	A.M., indicated Moisture Associated Skin Damage (MASD) was newly identified on the coccyx above the buttocks measuring 2 cm in length and 20 cm in width. A Nursing Skilled Evaluation, dated 1/5/24 at 1:27 A.M., indicated the MASD on the coccyx above the buttocks measured 2 cm in length and 20 cm in width. A Nursing Skilled Evaluation, dated 1/6/24 at 12:52 A.M., indicated the MASD on the coccyx above the buttocks measured 2 cm in length and 20 cm in width. A hospital admission assessment, dated 1/6/24, indicated the pressure wound on the resident's coccyx measured 6 cm in length and 5 cm in width. The December 2023 TAR (Treatment Administration Record) indicated a weekly skin assessment was conducted on 12/1, 12/8, 12/15, 12/22, and 12/29 and that the resident's skin was intact with no new or existing skin issues. The January 2024 TAR indicated that a weekly skin assessment was conducted on 1/5/24 and that the resident's skin was intact with no new or existing skin issues. In an interview on 4/1/24 at 12:13 P.M., the Director of Nursing (DON) indicated she was unsure why weights for Resident 46 were entered on 9/25/23 and 10/9/23 while the resident was not in the facility, and that the weight on 10/9/23 was probably a data entry error and was intended to read 10/10/23. She indicated Resident 46 developed a pressure ulcer on 12/28/23 that continued to worsen until she was transferred to the hospital on 1/6/24. She indicated that the		monitor the documentation in the clinical record to ensure that the documentation accurately reflects the resident's current condition and needs. The tool will monitor to ensure that all of the resident's current conditions are accurately described in the clinical record and that all areas of concern have been appropriately addressed. This tool will be completed by the Director of Nursing and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted.	

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	assessment in the Skilled Nursing Evaluations between 12/28/23 and 1/6/24 and weekly skin assessments documented in the TAR were not correct and most likely copied and pasted from one shift to the next.2. On 3/27/24 at 01:53 P.M., Resident 5's clinical record was reviewed. Diagnoses included, but were not limited to, aphasia. The most recent Annual MDS Assessment, dated 1/16/24, indicated Resident 5 had moderate cognitive impairment, required extensive assistance of 2 staff for mobility, transfers, and toileting, and required supervision of 1 staff while eating. Current active physician orders included, but were not limited to: Regular diet, Mechanical Soft texture, Regular consistency, add gravy to meats, no bread. Dated 3/19/24. Current care plans included, but were not limited to: I have full upper and low dentures; but tend to only wear the top denture. Dated 1/27/23. Coordinate arrangements for dental care, transportation as needed/as ordered. Monitor/document/report any s/sx (signs/symptoms) of oral/dental problems needing attention: Pain (gums, toothache, palate), Abscess, Debris in mouth, Lips cracked or bleeding, Teeth missing, loose, broken, eroded, decayed, Tongue (black, coated, inflamed, white, smooth), Ulcers in mouth, Lesions. Dated 1/27/23. During an observation on 3/25/24 at 12:54 P.M., Resident 5 was observed with no teeth, and stated she did not have her dentures anymore and was not able to eat well without them. A progress note dated 8/19/22 at 11:18 A.M.,			

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	stated Resident 5 had all teeth removed on 8/18/22. During an interview on 03/28/24 at 12:57 P.M., the Social Services Director indicated Resident 5 had been taken to get dentures multiple times but loses them often; documented communication between the facility and Resident 5's family regarding lost dentures was unable to be provided. On 4/2/24 at 3:04 P.M., the DON provided a current Charting and Documentation policy, undated, that indicated "Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate". 3.1-50(a)(1) 3.1-50(a)(2)			
F 0851 SS=F Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct			

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	care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by			

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	CMS, but no less frequently than quarterly. Based on record review and interview, the facility failed to electronically submit to CMS (Center for Medicare and Medicaid Services) required information regarding direct care staffing for the first Fiscal Quarter from 10/1/23 thru 12/31/23. Finding Includes: During a review of the facility's PBJ (Payroll Based Journal) Staffing Data Report Casper Report 1705D on 3/25/24 at 11:15 A.M., the staffing data report included, "Failed to Submit Data for the Quarter" 10/1/23 thru 12/31/23. During an interview on 3/28/24 at 12:20 P.M., the BOM (business office manager) indicated the payroll based journal information is automatically generated and is the responsibility of outside staff to ensure the information is submitted to CMS timely. On 3/28/24 at 1:24 P.M., the BOM supplied an undated facility policy titled Reporting Direct Care Staffing Information (Payroll-Based Journal). The policy included, "...9. Direct care staffing is submitted on the schedule specified by CMS, but no less frequently than quarterly. 10. Staffing information is collected daily and reported for each fiscal quarter no later than 45 days after the end of the reporting quarter..."	F 0851	F – 851 *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents have the potential to be affected by the deficient practice. The facility administrator is now responsible for the submission of the PBJ information in accordance with the CMS schedule and will no longer be submitted by an outside resource. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. The facility administrator will now be responsible and is submitting the PBJ information in accordance with the CMS schedule. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the facility executive director on the facility policy related to the submission of the PBJ information to CMS in accordance with their established schedule. The facility Executive Director will now be responsible for the submission of this information to CMS. *The corrective action taken to*	04/26/2024

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			monitor to ensure the deficient practice will not recur is that a Quality Assurance tool has been developed and implemented to monitor compliance with the submission of the PBJ information to CMS. This tool will be completed quarterly by the Clinical Director of Operations. The completion of this tool will be on-going in conjunction with the CMS schedule.	
F 0912 SS=D Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; Based on observation, interview, and record review, the facility failed to provide at least 80 square feet (sq ft) per resident in double occupancy rooms and 100 sq ft in single occupancy rooms. This was evidenced in 1 of 34 rooms. (Room 31) Finding includes: During the entrance conference interview on 3/25/24 at 9:12 A.M., the Director of Nursing (DON) indicated the facility had a room size waiver for room 31 to have 3 residents in the room. On 3/27/24 at 9:22 A.M., room 31 was observed with 2 beds with a measurement of 15 feet 10 inches long by 13 feet 6 inches wide, which would result in 71.25 square feet per resident for 3 residents in the room.	F 0912	F – 912 D *The corrective action taken for those residents found to have been affected by the deficient practice is that* there were no specific residents identified to be affected by this deficient practice as there are only two residents in this room and not three. The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that the facility is submitting a room waiver as the facility wants to maintain the license for that bed but is not placing three residents in that room. The measures that have been put	04/26/2024

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	The room size was verified by Maintenance 5 on 3/27/24 at 12:50 P.M. 3.1-19(l)(2)(A)		into place to ensure that the deficient practice does not recur is that the facility will continue to submit a room waiver annually to maintain the license for that bed. The corrective action taken to monitor to ensure the deficient practice will not recur is that the Executive Director will maintain a file of the submitted room waiver annually.	
F 0919 SS=D Bldg. 00	483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. Based on observation, interview, and record review, the facility failed to ensure the resident call system was functioning in 3 of 11 room call systems observed. A resident's bathroom call system was not functioning, and a resident's pull cord located on the bathroom call system was broken. (Room 20, Room 31, Room 9) Finding includes: 1. During an observation on 3/26/24 at 9:15 A.M., Resident 21's restroom call system was observed to not be functioning in room 20. A sign was hanging by Resident 21's restroom door that reminded the resident to call for assistance.	F 0919	F - 919 *1.) The corrective action taken for those residents found to have been affected by the deficient practice is that* room 20 restroom call light system for the resident identified as resident 21 has now been repaired and is functioning properly. *2.) The corrective action taken for those residents found to have been affected by the deficient practice is that* the call system pull cord in the restroom of room 31 has now been repaired and is	04/26/2024

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	On 3/26/24 at 2:30 P.M., RN (Registered Nurse) 5 was informed of Resident 21's restroom call system not functioning. 2. During an interview on 3/27/24 at 12:40 P.M., Maintenance 5 indicated Room 20's call system had been repaired on 3/26/24 and a check had been completed on all resident's rooms call systems the morning of 3/27/24. A call system in room 19's restroom was also not functioning when checked, however, no residents use that restroom. The call system pull cord was broken in room 31's restroom and had been repaired. Maintenance 5 indicated the call system checks were not completed routinely but that maintenance relied on staff to report to them when a call system is not properly functioning. During an interview on 3/27/24 at 12:58 P.M., QMA (Qualified Medicine Aide) 9 indicated Resident 21 uses the restroom in Room 20 and occasionally transfers herself to the restroom. During an interview on 3/28/24 at 1:15 P.M., Resident 152 indicated he uses the restroom in room 31 and the pull cord was broken but had been fixed the day prior. Resident 152 indicated he could reach the switch to activate the call system, but due to the cord being broken, he had to reach over his wheelchair and the switch was not easily reached. On 3/28/24 at 1:24 P.M., the BOM (Business Office Manager) supplied an undated facility policy titled, Call Systems, Residents. The policy included, "Residents are provided with a means to call staff for assistance through a communication system that directly calls for a staff member or a centralized workstation... 1. Each resident is		functioning properly. The call system in the room identified as room 19 has also been repaired and is functioning properly. *The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. A housewide audit of all call light system pull stations and their pull cords have now been checked and all are functioning properly. *The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all staff on the facility's call light system policy. The staff has been re-educated on their responsibility to ensure that all call light system failures are promptly reported to the maintenance department and that they are responsible for ensuring that the effected resident is provided with a hand bell to summon assistance until the repair can be made. *The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the functioning of the facility's call light system. This tool will monitor the proper functioning of the call light system in the resident's rooms,	

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	provided with a means to call staff directly for assistance from his/her bed, from toileting/ bathing facilities and from the floor... 3. The resident call system remains functional at all times... 5. The resident call system is routinely maintained and tested by the maintenance department..." 3.1-19(u)(1)		bathrooms and shower rooms. This tool will be completed by the Maintenance Supervisor and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted	