STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155484	A. BUILDING 00 B. WING	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SOUTHWOOD HEALTHCARE CENTER	2222 MARGARET AVE TERRE HAUTE, IN 47802

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00384798. Complaint IN00384798 - Unsubstantiated due to lack of evidence. Survey dates: July 18, 19, 20, 21, 22, 25, and 26, 2022. Facility number: 000564 Provider number: 155484 AIM number: 100285610 Census Bed Type: SNF/NF: 106 Total: 106 Census Payor Type: Medicare: 4 Medicaid: 80 Other: 22 Total: 106 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 4, 2022.	F 0000		
F 0550 SS=E Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility,			

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

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	including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, and record review, the facility failed to ensure residents' dignity while dining for 4 randomly observed residents during dining (Residents 2, 33, 68, and	F 0550	Facility respectfully request a desk review for paper complianc. F550-	08/25/2022

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	87) and the facility failed to ensure a resident's dignity when care was being provided for 1 randomly observed resident during a shower (Resident 33). Findings include: 1a. Resident 33's clinical records were reviewed on July 26, 2022 at 11:00 a.m. Resident 33's diagnoses included but were not limited to cerebral palsy. The most current quarterly Minimum Data Set (MDS) assessment, dated May 13, 2022, indicated Resident 33 was moderately cognitively impaired and required extensive assistance of 1 staff to eat. During an observation of meal assistance, on July 18, 2022 at 12:00 p.m., a Certified Nursing Assistant (CNA) was assisting Resident 33 while eating. Resident 33 was in their room and seated in a wheelchair. The CNA stood while assisting with food intake. No other seating was observed to be present in the resident's room. During an observation of meal assistance, on July 22, 2022 at 12:00 p.m., a Licensed Practical Nurse (LPN) was assisting Resident 33 while eating. Resident 33 was in their room and seated in a wheelchair. The LPN stood while assisting with food intake. No other seating was observed to be present in the resident's room. 1b. Resident 2's clinical records were reviewed on July 26, 2022 at 11:15 a.m. Resident 2's diagnoses included, but were not limited to, Huntington's disease. The most current quarterly Minimum Data Set Assessment; dated April 11, 2022; indicated Resident 2 was moderately cognitively impaired and required extensive assistance of 1 staff to eat.		Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The provided education to the staff members assigned to Resident 33, 87,68 and 2 on 8/125/22 utilizing Resident Rights policy to focus on dining procedure and providing care with dignity. The facility ensured there was adequate seating in all dining rooms for residents and staff. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected. No other residents were affected. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The facility will complete in-servicing for all staff utilizing the Resident Right's Policy by 8/25/22 to ensure staff are seated while assisting residents with meals and discussing care needs in manner the preserves integrity. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DON/Designee will conduct audits on all units throughout the facility five times a week on random shift to ensure resident rights are maintained at all times as evidenced by staff seated while assisting residents with meals and resident care information being	

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	During an observation of meal assistance, on July 22, 2022 at 7:45 a.m., a CNA. was assisting Resident 2 while eating. Resident 2 was in their room and positioned in a low to the floor bed. The head of the bed was raised. The CNA stood while assisting with food intake. No other seating was observed to be present in the resident's room. 1c. During a continuous dementia dining room observation, on 7/18/22 from 12:06 p.m. to 12:25 p.m., Certified Nursing Assistant (CNA) 12 assisted Residents 87 and 68 to eat. Residents 87 and 68 were sitting at the same table. CNA 12 stood between them and alternated assisting them with bites of food. CNA 12 did not sit down during this observation but remained standing. During an interview, on 7/25/22 at 9:13 a.m., CNA 12 indicated she normally worked the dementia unit. She should have sat down next to residents as she assisted them to eat, but sometimes there were not enough chairs available in the dining room. During an interview on July 25, 2022 at 11:05 a.m., the Director of Nursing (DON) indicated staff were to be seated while assisting residents to eat their meals. Training for "dignity while dining" was provided to the staff. On July 25, 2022 at 11:15 a.m.; the DON provided the facility's current Nurse Aide Orientation/Training Guide (un-dated). A review to the guide indicated, on page 5, orientation and/or dignity while dining training was taught. 2. Resident 33's clinical records were reviewed on July 26, 2022 at 11:00 a.m. Resident 33's diagnoses include but were not limited to cerebral palsy. The most current quarterly Minimum Data Set (MDS)		discussed 1:1 with staff or resident in close proximity. If corrective action is needed the DON/Designee with complete 1:1 re-education immediately. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.	

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	assessment, dated May 13, 2022, indicated Resident 33 was moderately cognitively impaired and required staff assistance for bathing/showers. During an observation on, July 21, 2022 at 11:20 a.m., indicated a staff opened the 200 hall shower room door, stood at the opened door and loudly requested to a second staff, nearby the nurse station, to bring (Resident 33's first name) "brief and butt cream." 3.1-3(a)			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on record review and interview, the facility failed to prevent resident to resident altercations resulting in injury for 3 of 3 residents reviewed for abuse (Residents 87, 98, and 101). Findings include: 1. Resident 87's record was reviewed 7/21/22 at 10:12 a.m. A quarterly Minimum Data Set (MDS)	F 0600	Facility respectfully request a desk review for paper compliance. F600- Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident 87 remains in 1:1. No further incidents have	08/25/2022

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	assessment, dated 6/16/22, indicated the resident had a severe cognitive impairment. Diagnoses on the resident's profile included but were not limited to Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), unspecified psychosis (a mental disorder characterized by a disconnection from reality) not due to a known physiological condition, anxiety disorder unspecified, and intermittent explosive disorder (repeated, sudden episodes of impulsive, aggressive, violent behavior or angry verbal outbursts). A Medication Administration Record (MAR), dated January 2022, indicated the resident required one on one staff supervision each shift. A nurse's note, dated 1/18/22, indicated the nurse removed Resident 87 from his room related to an altercation with his roommate, Resident 98. Resident 98 stated Resident 87 attempted to take his stuff, and there was a disagreement which escalated. Resident 87 had a small abrasion to the left hand. A non-pressure skin note, dated 1/18/22, indicated the abrasion on the resident's left hand was bruised and bleeding. An Indiana Department of Health (IDOH) incident report, dated 1/18/22, indicated Residents 87 and 98 had a disagreement where Resident 87 allegedly made contact with Resident 98's chin, and Resident 98 allegedly made contact with Resident 87's left hand. The residents were immediately separated and no longer roommates. Follow-up indicated Resident 87's medications were reviewed and adjusted, and he remained on		occurred with resident 87 and residents 98 and 101 since March 2022. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected. No other resident were affected. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Re-education has been provided to all staff utilizing Indiana Abuse and Neglect Policy. Staff will be instructed to send resident to ER for evaluation if behaviors cannot be de-escalated by facility staff and notify MD and family. Activities department will review Abuse and Neglect with Resident Council at next meeting to ensure residents understand the abuse policy as well. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The ED/DON/Designee will audit all reportable resident to resident altercations to ensure 1:1 care is provided for appropriate resident until cleared by MD and/or resident is sent to ER for aggressive behaviors. If any corrective action is needed ED/DON/Designee will immediately re-educate staff with 1:1 in-servicing. The results of the audit	

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	one on one staff supervision. An interdisciplinary team (IDT) follow up note, dated 1/19/22, indicated the resident had an altercation with his roommate while trying to take his belongings. Residents were separated, and Resident 87 was on one on one supervision. A nurse's note, dated 2/27/22, indicated the resident was aggressive with toileting, punched the aides, and was resistant to care. A MAR, dated 3/1/22 to 3/20/22, indicated the resident required one on one staff supervision each shift. A nurse's note, dated 3/19/22 at 11:00 a.m., indicated Resident 87 was ambulating in the dining room when he was approached by Resident 101. Resident 87 made contact with Resident 101. The residents were immediately separated, and both residents had to be sat down on the floor. Resident 87 had no injuries. A nurse's note, dated 3/19/22 at 1:08 p.m., indicated the resident scratched, bent wrist backwards, and spit on staff who attempted to separate the resident altercation. An IDOH incident report, dated 3/19/22, indicated Resident 87 was ambulating down the hall with staff when Resident 101 walked towards him, and he made contact with her shoulder and hand. Staff was present and immediately separated the residents. Resident 101 had discoloration to the shoulder and hand. Follow-up indicated Resident 87 was referred for inpatient psychiatric services. A care plan, goal target dated 10/16/22, indicated the resident had the potential to yell out at staff,		observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendations.	

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	use inappropriate language, throw items, be resistive to care, refuse to put on shoes, argumentative with other residents and staff related to intermittent explosive disorder and unspecified psychosis not due to a known physiological condition. Interventions included but were not limited to use one on one supervision until further notice and when resident became agitated intervene before agitation escalated by guiding away from source of distress, if response was aggressive staff to calmly walk away and approach later. 2. Resident 98's record was reviewed on 7/25/22 at 10:00 a.m. An annual Minimum Data Set (MDS) assessment, dated 1/15/22, indicated the resident was cognitively intact. A nurse's note, dated 1/18/22, indicated the nurse intervened when Resident 98 and his roommate, Resident 87, got into an altercation that started with arguing and escalated to shouting and injury. The resident had a small abrasion to his chin. The roommate was trying to take Resident 98's belongings. 3. Resident 101's record was reviewed on 7/25/22 at 10:30 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 2/3/22, indicated the resident had a severe cognitive impairment. A nurse's note, dated 3/19/22, indicated Resident 101 was ambulating in the dining room, approached Resident 87, and he made contact with her. Both residents had to be sat down on the floor and separated. Bruising was noted to Resident 101's right hand and left clavicle. During an interview, on 7/22/22 at 10:12 a.m., the Executive Director (ED) indicated Resident 87 was			

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	not involved in any further resident to resident altercations since March 2022. The altercation in March 2022 was witnessed, and staff immediately separated the residents. The resident remained on one on one supervision. He was normally pleasant but became explosive quickly and without much warning. During an interview, on 7/22/22 at 11:46 a.m., the Resident Services Director indicated Resident 87 was on one on one staff supervision at the time of the resident to resident altercation in March 2022. He required one on one supervision related to previous aggressive behaviors. Staff informed her there had been an altercation between Resident 87 and Resident 101 which occurred quickly. The staff member assigned to one on one with the resident immediately intervened, and Resident 87 was also aggressive with that staff member. The resident was referred for inpatient psychiatric treatment. The resident was social at times but became aggressive suddenly. During an interview, on 7/22/22 at 2:25 p.m., Qualified Medication Aide QMA 14 indicated she witnessed the altercation between Residents 87 and 101 in March 2022. There was a staff member assigned to Resident 87 for one on one supervision that day related to his intermittent explosive disorder. She was not sure who was assigned to him. The residents were in the dining room, Resident 87 stood up suddenly, and reached out running into Resident 101. He often reached out and grabbed at people. On 7/18/22 at 2:00 p.m., the ED provided a document titled, "INDIANA Abuse & Neglect...," and indicated it was the policy currently being used by the facility. The policy indicated, "...Definitions: ...Abuse: In Indiana, the willful			

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	infliction of injury...resulting in physical harm...Physical Abuse: In Indiana, is defined as a willful act against a resident by another resident...Policy: ...It is the intent of this facility to prevent abuse, mistreatment...of residents...Procedure: ...V. Investigation of Incidents: ...f. In the event the alleged abuse involves a resident-to-resident altercation, the residents will be placed in separate areas by the staff and the appropriate physical assessments will be completed on each resident...." 3.1-37(a)(1)			
F 0641 SS=A 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 record review and interview, the facility failed to ensure accurate coding on Minimum Data Set (MDS) assessments for 3 of 24 Residents' MDS assessments reviewed (Residents 102, 89, and 13). Findings include: 1. Resident 102's closed record was reviewed on 7/26/22 9:41 a.m. The census indicated the resident had been admitted to the facility on 5/23/22 and discharged on 6/9/22. An admission Minimum Data Set (MDS), dated 5/28/22, indicated the resident had no cognitive deficit and had participated in the assessment. A care plan, dated 5/24/22, indicated the resident wished to discharge back to her home with home health care. Intervention included, but were not	F 0641	Facility respectfully requests a desk review for paper compliance. **F 641** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident H102, 89 are discharged from the facility. Resident 13's MDS was modified to code for level 2 and was submitted. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: The Regional MDS Director will review	08/25/2022

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	limited to, the resident would be discharged to appropriate location based upon physical/cognitive status with a target date of 6/9/22. A Social Services (SSD) progress note, dated 5/24/22 at 12:34 p.m., indicated the resident was a new admit. Plans were to remain short term and return home. A SSD note, dated 6/8/22 at 3:30 p.m., indicated the resident would be discharging to home on 6/9/22. A nurse progress note, dated 6/9/22 at 3:09 p.m., indicated the resident discharged to home with her daughter. A discharge, return not anticipated MDS, dated 6/9/22, indicated the resident's discharge had been unplanned. During an interview, on 7/26/22 at 10:43 a.m., the MDS Coordinator indicated she could not figure out why she had coded the resident's discharge MDS incorrectly. She may have gotten the resident confused with another resident's MDS. On 7/26/22 at 11:08 a.m., the MDS Coordinator provided a document titled, "Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual," dated October 2019, and indicated it was the policy currently being used by the facility. The policy indicated, "...Section A0310: Types of Assessment...Coding Instructions for A0310G, type of Discharge...Code 1 if type of discharge is a planned discharge...." 2. Resident 89's record was reviewed on 7/22/22 at		each resident with a diagnosis requiring a level 2 to ensure coding is correct on the MDS. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** The Regional MDS Director or designee will re-educate the facility MDS Coordinator on the guideline for accurate coding of the MDS per the RAI guidelines. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audit for all dialysis residents will be conducted by the Regional MDS Director or designee weekly times 8 weeks, then monthly times 4 months to ensure compliance: review each resident receiving dialysis to ensure the most recent MDS is coded correctly for receiving dialysis services. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	11:44 a.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems which include periods of agitation), psychotic disorder with hallucinations (a condition where a person loses touch with reality that includes when a person hears, sees and, in some cases, feels, smells or tastes things that do not exist outside their mind but can feel very real to the person affected by them), and delusional disorder (psychosis with an unshakable belief in something that's untrue). A significant change Minimum Data Set (MDS) assessment, dated 5/18/22, indicated the resident had severe cognitive deficit and a Patient Health Questionnaire (PHQ9) (a nine item depression scale of the patient health questionnaire) of 99 related to interview unable to be completed. A staff assessment had not been completed. A quarterly MDS assessment, dated 6/27/22, indicated severe cognitive deficit and PHQ9 of 99 related to no response to any questions. A staff assessment had not been completed. During an interview, on 7/25/22 at 11:11 a.m., the MDS Coordinator reviewed the MDS assessments, dated 5/18/22 and 6/27/22, and indicated both had indicated the resident gave no answer to the PHQ9 questions, and verified the staff assessment had not been completed. The staff assessment should have been completed according to Resident Assessment Instrument (RAI) manual guidance regarding PHQ9 assessments. On 7/25/22 at 11:12 a.m., the MDS Coordinator			

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	provided a document titled, "Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual," dated October 2019, and indicated it was the policy currently being used by the facility. The policy indicated, "...Section D0300: Total Severity Score...Coding Instructions...If symptom frequency is blank for 3 or more items, the interview is deemed NOT complete. Total Severity Score should be coded as "99"and the Staff Assessment of Mood should be conducted...." 3. Resident 13's record was reviewed on 7/26/22 at 11:30 a.m. The profile indicated the resident's diagnoses included, but were not limited to, bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and unspecified dementia without behavioral disturbance (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems). A Preadmission Screening and Resident Review (PASRR), dated 1/8/21, indicated the resident met the criteria for PASRR Level 2 (an evaluation which determines if the mental retardation or other mental health related condition needs of the individual can be met in a Nursing Facility or if the individual requires Specialized Services) based on their diagnoses of bipolar disorder and dementia without behavioral disturbance. An annual minimum data set (MDS) assessment, dated 12/22/21, indicated the resident was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or related condition. During an interview, on 7/26/22 at 10:14 a.m., the			

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	155484	A. BUILDING 00 B. WING	07/26/2022

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	Director of Nursing (DON) indicated the resident was a current active Level II. She believed it should have been coded on the MDS, but she was not positive. During an interview, on 7/26/22 at 11:23 a.m., the MDS Coordinator indicated the most recent comprehensive MDS assessment, dated 12/22/21, for the resident had been coded incorrectly. It should have indicated the resident was considered by the state to be a Level II PASRR. On 7/26/22 at 11:23 a.m., the MDS Coordinator provided a document titled, "Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual," dated October 2019, and indicated it was the policy currently being used by the facility. The policy indicated, "...Section A1500: Preadmission Screening and Resident Review (PASRR)...Coding Instructions: ...Code 1, yes if PASRR Level 2 screening determined that the resident has a serious mental illness and or Intellectual Disability (ID)/Developmental Disability (DD) or related condition...." 3.1-31(c)(3) 3.1-31(c)(8)			
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			

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	to prevent accidents. Based on record review and interview, the facility failed to ensure cleaning chemicals were safely managed to prevent a resident from ingesting them for 1 of 4 residents reviewed for accidents (Resident 41). Findings include: Resident 41's record was reviewed on 7/20/22 at 10:39 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 5/20/22, indicated the resident had a severe cognitive impairment. Diagnoses on the resident's profile included, but were not limited to, non-Alzheimer's dementia (a group of thinking and social symptoms that interferes with daily functioning) and psychotic disorder other than schizophrenia (a mental disorder characterized by a disconnection from reality). Census information indicated the resident admitted to the facility on 10/27/21 to the general resident area and moved to the dementia unit on 5/25/22. A nurse practitioner (NP) note, dated 1/10/22, indicated the NP was notified by nursing staff the resident had eaten her own stool after having repeated bowel movements. A care plan, initiated 1/14/22, indicated the resident had pica (craving and chewing substances that have no nutritional value) and was at risk for complications. The care plan lacked documentation of any interventions to keep cleaning chemicals away from the resident. A Medication Administration Record (MAR),	F 0689	Facility respectfully request a desk review for paper compliance. F689 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: On 3/17/22 Poison Control was notified and determined that the ingested fluid were diluted enough that the resident should not be affected and resident showed no signs of illness. The facility re-evaluated declining cognitive status on 5/20/22 and determined resident was appropriate to move to a Dementia unit. The facility re-educated the Kitchen staff immediately. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents that attend meal service in the dining room have the potential to be affected. No other residents were found to be affected. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Dietary manager will re-educate all kitchen staff using Hazardous Materials Policy to ensure cleaning chemicals are within reach during use and immediately secured when not in use by 8/25/22.	08/25/2022

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	dated March 2022, indicated a behavior monitoring record was initiated, on 3/17/22, related to resident was unable to control the impulse to place unusual items in her mouth. Interventions included offer food and fluids when resident was roaming and to encourage the resident to participate in activities. The record lacked documentation the resident was monitored for this behavior prior to 3/17/22. A nursing note, dated 3/17/22 at 10:14 a.m., indicated the resident was observed to have eaten her own feces and the physician was notified. An interdisciplinary team (IDT) follow up note, dated 3/17/22 at 11:32 a.m., indicated an incident occurred on 3/17/22 at 9:00 a.m. The resident entered the dining area, picked up a bucket of cleaning water, attempted to drink it, and spilled it down the front of her shirt. The root cause of the incident was poor safety awareness and an oral fixation of putting unusual items into her mouth. Interventions to prevent further occurrence were offer food and fluids when roaming and encourage participation in activities. Staff intervened and removed the bucket from the area. The kitchen staff were provided education regarding leaving items in the dining room. A nursing note, dated 3/17/22 at 11:36 a.m., indicated the resident was in the dining room, wheeling about, picked up a bucket of cleaning solution, attempted to drink, and spilled it down the front of her shirt. The staff was unable to determine if the resident ingested the cleaning solution. No oral concerns were noted. Poison control was notified and determined fluid was diluted enough it should not have affected the resident. The kitchen staff was educated regarding environmental safety.		How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Dietary Manager/ Designee will conduct audits every meal for 4 weeks, then 10 meals per week for 4 weeks, then 5 meals per week for 4 months to ensure cleaning chemicals are kept within reach of staff member while in use and immediately secured when cleaning is completed. If corrective action is needed Dietary manager/Designee will immediately re-educate staff member. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.	

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During an interview, on 7/20/22 at 2:40 p.m., the Executive Director (ED) indicated at the time of the incident, on 3/17/22, a kitchen staff member was cleaning up the dining room after a meal. There was a bucket of diluted chemical used to wipe and sanitize the tables. During that time Resident 41 was able to grab the bucket.

During an interview, on 7/21/22 at 9:40 a.m., the Director of Nursing (DON) indicated the resident had a history of putting nonfood items in her mouth prior to the incident in March 2022. There was a care plan initiated for pica in January 2022. The resident had eaten her own feces and diaper rash ointment, and often put things in her mouth. The behavior monitoring on the MAR was not initiated until the incident on 3/17/22. She was not sure of any safety measures put into place when the pica care plan was initiated in January 2022.

On 7/20/22 at 3:06 p.m., the ED provided the safety data sheet for, "FOOD CONTACT QUAT SANITIZER," and indicated it was the chemical being used to clean in the dining room on 3/17/22. The sheet indicated, "...Signal Word: Danger. Hazard Statements: Harmful if swallowed or in contact with skin. Causes severe skin burns and eye damage...."

On 7/21/22 at 11:50 a.m., the Regional Director of Clinical Operations (RDCO) provided a document titled, "Hazardous Materials Storage," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: ...The purpose of this policy is to provide guidance for the use of the handling and storage of hazardous materials on the nursing unit...Safe hazard storage in the provision of care and services by staff may include but is not limited to

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	proper handling/disposal of hazardous materials, chemicals, and waste. Supervision and/or containment of hazards are needed to protect residents from harm caused by environmental hazards...Procedure: I. Hazardous materials: a. Hazardous materials include any item (chemical, physical...) that poses a threat and/or potential harm to humans...b. Hazardous materials may include but are not limited to: i. Chemicals: 1. Cleaning and disinfecting products (...liquids)...II. General care of hazardous materials in the facility: a. Hazardous materials will be stored according to manufacturer's recommendation including but not limited to: ...iii. Out of reach of those who are unfamiliar with the material or who might inadvertently become exposed or injured...b. Discussion will include limiting cognitively impaired resident access to areas that contain potentially dangerous materials and the need for locked storage for safety...." 3.1-45(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based observation, interview, and record review, the facility failed to ensure proper cleaning and	F 0695	Facility respectfully request a desk review for paper compliance. F695	08/25/2022

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	storage of nebulizer equipment and failed to ensure resident's breath sounds, Sp02 (oxygen saturation reading), heart rate, and respiratory rate were assessed before and after a nebulizer treatment for 3 of 3 residents reviewed for respiratory care (Residents 37, 100, and 60). Findings include: 1. On 7/18/22 at 2:41 p.m., Resident 37's spouse indicated Resident 37 received nebulizer treatments (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) at 5:30 p.m. daily and she assisted him with the breathing treatments. The nebulizer machine was observed on the nightstand table in the resident's room with the nebulizer mask unbagged, lying on top of the nebulizer machine. On 7/20/22 at 2:14 p.m., Resident 37 was observed lying in bed awake and visiting with his spouse. The unbagged nebulizer mask was observed sitting on top of the nebulizer machine on the nightstand table. Spouse indicated Resident 37 usually got one nebulizer treatment a day, before she left the facility for the day. On 7/21/22 at 11:56 a.m., Resident 37 was observed lying in bed, eating a popsicle with his spouse at the bedside. The unbagged nebulizer mask was observed sitting on top of the nebulizer machine on the nightstand table. On 7/22/22 at 11:11 a.m., Resident 37 was observed lying in bed with eyes closed. The unbagged nebulizer mask was observed sitting on top of the nebulizer machine on the nightstand table. Resident 37's record was reviewed on 7/22/22 at		Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: On 7/25/22 Resident 37, 100, and 60 were given new nebulizer equipment. On 8/15/22 Facility added respiratory assessment order for pre and post nebulizer to plan of care. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents with nebulizer orders have the potential to be affected. On 8/15/22 facility conducted an audit to ensure all residents with nebulizers have pre and post assessment orders and were given new nebulizer equipment. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The facility will complete in-servicing for all licensed nurses utilizing the Nebulizer Treatment policy by 8/25/22. The DON/Designee will observe return demonstration from all licensed nurses for administration of a nebulizer treatment to ensure policy is followed during administration and equipment is cleaned and stored properly. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DON/Designee will observe five nurses per week for four	

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	11:48 a.m. Diagnoses included but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting the left dominant side (paralysis of partial or total body function on one side of the body due to damage to the brain from interruption of blood supply) and chronic obstructive pulmonary disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe.) A quarterly Minimum Data Set (MDS) assessment, dated 7/2/22, indicated the resident had a severe cognitive impairment, was total dependence of two persons for bed mobility and transfers, had upper and lower impairments on one side of his body, and became short of breath (SOB) while lying flat. A care plan, dated 10/7/20 and revised on 5/10/22, indicated the resident was at risk for complications related to COPD with SOB while lying flat and asthma. Interventions included but were not limited to, administer aerosol or bronchodilators medications per medical provider's orders and monitor/document any side effects and effectiveness. The medical record lacked documentation of a physician's order for a nebulizer treatment for Resident 37. During an observation with the Director of Nursing (DON), on 7/25/22 at 9:52 a.m., Resident 37 was observed lying in bed with the unbagged nebulizer mask observed sitting on top of the nebulizer machine on the nightstand table. The DON indicated the nebulizer mask should have been covered or bagged and Resident 37 should have a physician's order for nebulizer treatments with pre and post assessments completed for the		weeks, then 3 nurses per week for 4 weeks, then 1 nurse per week for 4 months during nebulizer administration to ensure pre and post assessments are completed ordered and that nebulizer equipment is cleaned and stored per policy. If any corrective action is needed DON/Designee will conduct immediate 1:1 education with nurse. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.	

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	nebulizer treatments. During an interview, on 7/25/22 at 2:14 p.m., Licensed Practical Nurse (LPN) 27 indicated Resident 37 had a prn (as needed) physician's order for the nebulizer treatment was added today. Nebulizer mask should be bagged after usage, and a pre/post assessment of the resident's respiratory, respirations, O2 SAT, and lung sounds in the assessments should be documented. On 7/25/22 at 2:47 p.m., the Regional Director of Clinical Operations (RDCO) indicated Resident 37 did not have an active physician's order for the ipratropium-albuterol solution nebulizer treatment as needed every 6 hours until today, 7/25/22. Resident 37 had a physician's nebulizer treatment order, dated 5/8/22, for 10 days and it was discontinued on 5/18/22. Resident 37 must have had extra nebulizer medications for the staff to utilize when Resident 37 received the nebulizer treatments. Resident 37 did not have pre/post assessments for the July treatments. Resident 37 should have had a physician's order to do the nebulizer treatments. Staff were aware of the resident's previous nebulizer order and were not aware the nebulizer treatment order was discontinued. 2. On 7/18/22 at 11:17 a.m., Resident 100's unbagged nebulizer mask was observed on the bed side table in a plastic tub container, next to a hairbrush and colored pencils. The nebulizer machine was observed on the floor next to the bed and bedside table. On 7/18/22 at 3:03 p.m., Resident 100's unbagged nebulizer mask was observed on the bed side table in a plastic tub container, next to a hairbrush			

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	and colored pencils. The nebulizer machine was observed on the floor next to the bed and the bedside table. On 7/19/22 at 9:23 a.m., Resident 100's unbagged nebulizer mask was observed on the bed side table in a plastic tub container, next to a hairbrush and colored pencils. The nebulizer machine was observed on the floor next to the bed and the bedside table. On 7/20/22 at 2:19 p.m., Resident 100's unbagged nebulizer mask was observed on the bed side table in a plastic tub container, next to a hairbrush and colored pencils. The nebulizer machine was observed on the floor next to the bed and the bedside table. On 7/21/22 at 11:47 a.m., Resident 100's unbagged nebulizer mask was observed on the bed side table in a plastic tub container, next to a hairbrush and colored pencils. The nebulizer machine was observed on the floor next to the bed and the bedside table. On 7/22/22 at 11:14 a.m., Resident 100's unbagged nebulizer mask was observed on the nightstand table. The nebulizer machine was observed on the floor next to the bed and the bedside table. On 7/25/22 at 9:41 a.m., Resident 100's unbagged nebulizer mask was observed on the nightstand table. The nebulizer machine was observed on the floor next to the bed and the bedside table. During an observation with the Director of Nursing (DON), on 7/25/22 at 9:54 a.m., the DON indicated Resident 100's nebulizer machine should not have been on the floor and the nebulizer mask should have been cleaned and then bagged after			

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	usage. During an interview, on 7/25/22 at 10:50 a.m., the Administrator (ADM) indicated all nebulizer masks should be cleaned and bagged between uses and changed weekly and the nebulizer machine should never be placed on the floor. Resident 100's record was reviewed, on 7/22/22 at 12:41 p.m., diagnosis included but were not limited to Chronic Obstructive Pulmonary Disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe). A quarterly Minimum Data Set (MDS) assessment, dated 7/1/22, indicated the resident was cognitively intact, required extensive assistance of two persons for bed mobility and transfers, received oxygen therapy, and became short of breath (SOB) while lying flat. A care plan, dated 10/28/21 and revised on 2/16/22, indicated the resident was at risk for complications related to COPD with SOB while lying flat and asthma. Interventions included but were not limited to administer medications per medical provider's orders, observe for side effects and effectiveness. A physician's order, dated 2/8/22, indicated Budesonide Suspension 0.5 mg (milligrams)/2 mL (milliliters) nebulization solution vial to inhale 1 vial orally via nebulizer two times a day for COPD. 3. During the initial pool observation, on 7/18/22 at 1:43 p.m., Resident 60's nebulizer (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs) mask was unbagged and sitting on top of the resident's personal refrigerator.			

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	During a random observation, on 7/19/22 at 1:24 p.m., the resident's nebulizer mask was unbagged and sitting on top of the resident's personal refrigerator. During a random observation, on 7/20/22 at 2:24 p.m., the resident's nebulizer mask was unbagged and sitting on top of the resident's personal refrigerator. During a random observation, on 7/21/22 at 2:18 p.m., the resident's nebulizer mask was unbagged and sitting on top of the resident's personal refrigerator. During a random observation, on 7/25/22 at 9:07 a.m., the resident's nebulizer mask was unbagged and sitting on top of the resident's personal refrigerator. At the same time, the resident was observed to have an oxygen concentrator (a device that concentrates the oxygen from a gas supply by selectively removing nitrogen to supply an oxygen-enriched product gas stream), set at 2 liters (L) being administered to the resident by nasal cannula (NC) (a device used to deliver supplemental oxygen or increased airflow to a patient or person in need of respiratory help). Resident 60's record reviewed on 7/21/22 at 11:17 a.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe) and asthma (a condition in which a person's airways become inflamed, narrow and swell, and produce extra mucus, which makes it difficult to breathe). A significant change Minimum Data Set (MDS) assessment, dated 6/18/22, indicated the resident			

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	had moderate cognitive deficit, had diagnoses which included, but were not limited to, COPD and asthma, and became short of breath (SOB) while lying flat. A care plan, dated 11/16/21 and revised on 2/25/22, indicated the resident was at risk for complications related to COPD with SOB while lying flat and asthma. Interventions included, but were not limited to administer medications per medical provider's orders, observe for side effects and effectiveness. A physician's order, dated 7/2/22, indicated Albuterol Sulfate nebulization solution (2.5 milligrams (MG)/3 milliliters (ML) 0.083%. Inhale 3 ml orally via nebulizer every 6 hours as needed for wheezing (a high-pitched whistling sound made while breathing). A physician's order, dated 7/2/22, indicated nebulizer pre-assessment and record findings using code. Pre-breath Sound Code: 1=clear, 2=diminished, 3=rhonchi (low-pitched wheezes or coarse crackles, are non-repetitive, nonmusical, low-pitched sounds frequently produced during early inspiration and expiration), 4=crackles(the clicking, rattling, or crackling noises that may be made by one or both lungs of a human with a respiratory disease during inhalation), 5=wheezing, 6=other and explain in progress note. Every 6 hours as needed for nebulizer usage. A physician's order, dated 7/2/22, indicated nebulizer post-assessment record findings using code and record number of minutes spent on assessment and treatment. Pre/Post breath sound code: 1=clear, 2=diminished, 3=rhonchi, 4=crackles, 5=wheezing, 6=other and explain in progress note. Every 6 hours as needed for			

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	155484	A. BUILDING 00 B. WING	07/26/2022

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	nebulizer usage. A review of the July 2022 medication administration record (MAR) and treatment administration record (TAR) indicated the resident had received an administration of the nebulizer solution on 7/5/22. The records lacked documentation of the pre and post respiratory assessment being completed as ordered. During an interview, on 7/25/22 at 1:58 p.m., the Regional Director of Clinical Operations (RDCO) indicated the facility had a policy which indicated all nebulizer masks should be cleaned and bagged in between uses. The staff should always follow physician's orders and the facility policy related to nebulizer procedures. On 7/25/22 at 11:14 a.m.., the Director of Nursing (DON) provided a document, dated 8/25/17, titled, "Nebulizer Treatments," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...II. Preparation for treatment. a. Obtain ordered medication and supplies...c. Review order per standard nursing procedure for medication administration...e. Collect data for respirations, pulse, and breath sounds pre-treatment...III. Administering Treatment...e. Treatment may take up to five (5) minutes to administer...iii. Repeat collection of data for respirations, pulse, and lung sounds post treatment...." On 7/25/22 at 2:02 p.m., the DON provided a document, dated 5/2/14 and revised 12/3/21, titled, "Continuous Aerosol Therapy," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...V. Clinical Consideration: ...c. Aerosol tubing and mask should be placed in patient set-up bag when			

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	not in use. d. Provide respiratory assessment before and after treatment...." 3.1-47(a)(6)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to ensure a resident received dialysis services as indicated by physician orders and failed to ensure ongoing communication with the dialysis facility for 1 of 1 resident reviewed for dialysis care. (Resident 9) Findings include: Resident 9's clinical records were reviewed on July 20, 2022 at 11:55 a.m. Diagnoses included but were not limited to end-stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or process of removing toxins from the blood). A physician open ended order, start date May 06, 2022, indicated Resident 9 was to received dialysis three times a week. The most current quarterly Minimum Data Set Assessment, dated April 08, 2022, indicated Resident 9 was cognitively intact and understood communication with clear comprehension.	F 0698	Facility respectfully requests a desk review for paper compliance. F698 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident 9 has not missed any HD session since 7/6/22. Pre and Post Dialysis assessment have been completed with each session since 8/1/22. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: Any resident who receives HD has the potential to be affected. No resident was found to be affected. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Re-education was provided to all licensed staff regarding completion of pre and	08/25/2022

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	Progress notes, dated July 14, 2022 through July 20, 2022, lacked documentation of dialysis care. The clinical record lacked documentation of pre-dialysis and post-dialysis communication information. On July 19, 2022 at 11:15 a.m. Resident 9 was interviewed. During the interview, Resident 9 indicated recently on 2 separate days she did not go to dialysis due to transportation not being available. On July 20, 2022 at 1:45 p.m. the central supply/transportation staff was interviewed. During the interview, the staff indicated Resident 9 had missed dialysis 2 times last week, because we did not have transportation. "If they can't get transportation, [resident] does not go." On July 20, 2022 at 2:40 p.m. transportation documentation was reviewed. The documentation indicated on Wednesday July 13, 2022, "the driver had called in and the agents did not have the time to rework the trip to secure another driver." On Friday July 15, 2022, "vehicle issues were reported." Interview and documentation indicated Resident 9 had gone from Wednesday July 13, 2022 through Monday July 18, 2022, having received no dialysis treatment. On July 21, 2022 at 9:45 a.m. the Dialysis Communication Book was reviewed. One, un-dated, Communication Form was present in the book. Interview, at the time of the dialysis communication review, the Director of Nursing indicated she would look for additional		post dialysis assessments and placing them in dialysis communication binder and completed 8/10/22. All dialysis residents are set up for transportation for routines runs with Trans car. All licensed nurse have been educated that any resident whom does not attend dialysis sessions due to transportation issues will be sent to ER for evaluation and completion of HD if determined medically necessary by Hospital. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DON/ Designee will audit all dialysis resident charts 3 days per week for 4 weeks, then 3 residents per week for 4 weeks, then 1 resident per week for 4 months to ensure pre and post assessments are complete and in communication binder. DON/Designee will audit all residents who missed hemodialysis to determine if emergency services were required and resident sent to ER. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.	

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	documentation. On July 26, 2022 at 11:15 a.m., the Administrator indicated no additional documentation was available. Upon entrance; on July 18, 2022; the Administrator provided the facility's current Hemodialysis Care and Monitoring Policy dated November 01, 2013 and revised on March 23, 2018. A review of the policy indicated, "...Definitions... Hemodialysis: the use of a dialysis filtering machine that connects to the resident by way of a vascular access device that removes the blood from the resident, filters the blood through an artificial kidney filtration process to remove toxic waste...and returns the newly filtered blood back to the resident by way of the vascular device...It is the policy of this facility to provide resident centered care that meets the...physical...concerns of the residents...The facility remains responsible for the overall quality of care the resident receives... Pre-Dialysis a. Evaluation completed within four (4) hours of transportation to dialysis to include but not limited to: i. Accurate weight ii. Blood Pressure, Pulse, Respirations, and Temperature b. Medications administered or medication(s) withheld prior to dialysis... d. Send copy of nursing evaluation with resident to dialysis center i. Include MAR [Medication Administration Record} ii. Emergency contact and facility contact information Post-Dialysis a. Nurse to review notes from dialysis center			

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	i. Review resident tolerance to treatment ii. Review medications that may have been given during dialysis iii. Review if blood transfusion was given 1. Check labs for hemoglobin/hematocrit values iv. Post dialysis notes will be uploaded into EHR [electronic health record] or placed on hard medical record... A 24 hours per day communication method is established to communicate resident clinical status between the dialysis center and the facility...." 3.1-37(a)			
F 0725 SS=F Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.			

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	§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, record review, and interview, the facility failed to ensure adequate staffing on the dementia care unit to complete daily scheduled activities with the potential to affect 20 of 20 residents who resided on the dementia care unit, and to ensure adequate staffing on the main area of the building to provide necessary daily care to the residents with the potential to affect 86 of 86 residents who resided in all other areas of the building (Residents 46, 92, 37, 25, 11, and 9). Findings include: 1. During multiple observations of the dementia care unit, activities were not provided as scheduled by the Certified Nursing Assistants (CNAs). During an interview, on 7/26/22 at 10:35 a.m., the Activity Director indicated all of the activity staff worked in the main part of the building. No activity staff was assigned to the dementia care unit. There had not been an activity aide employed back there for a long time to her knowledge. The Resident Services Director and CNAs were assigned to ensure activities were provided as scheduled on the dementia care unit. Cross reference F744. 2. During a family interview, on 7/18/22 at 10:50 a.m., a family member indicated Residents 46 and 92 were her parents. There was not enough staff, especially at mealtimes.	F 0725	Facility respectfully requests a desk review for paper compliance. **F 725 Sufficient Nursing Staff** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** No residents were identified as being harmed by the alleged deficient practice. **II. The facility will identify other residents that may potentially be affected by the practice.** All residents have the potential to be affected by this alleged practice **III. The facility will put into place the following systemic changes to ensure that the practice does not recur.** /p> **IV. The facility will monitor the corrective action by implementing the following measures.** The staffing schedule will be reviewed daily with the Executive Director, DON, Human Resource manager, and staffing coordinator to confirm appropriate staffing levels and identify the distribution of staff based on residents' needs. This remains an ongoing facility practice Monday through Friday	08/25/2022

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	During an interview, on 7/18/22 at 2:30 p.m., Resident 37 indicated the facility was always short on staff and his wife had to go out in the hall to find assistance. During an interview, on 7/18/22 at 2:51 p.m., Resident 25 indicated there was not enough staff for his hallway. There was usually only one CNA scheduled. During an interview, on 7/19/22 at 9:43 a.m., Resident 11 indicated there was not enough staff at the facility. During an interview, on 7/19/22 at 11:37 a.m., Resident 9 indicated she needed two staff members for transfer assistance, and this was not always available. During the resident council meeting, on 7/21/22 at 10:33 a.m., 13 residents attended and indicated there was not enough staff available to meet their needs. Residents who required a Hoyer (mechanical) lift especially had to wait a long time for assistance because the lift required two staff members to operate it. The staff often had to cover another hall, and residents had to wait on staff to return to get what they needed. The facility assessment, dated November 2021 through October 2022, indicated a staffing plan of 6 Licensed Practical Nurses (LPNs) or Registered Nurses (RNs) on first shift, 6 LPNs or RNs on second shift, and 3 LPNs or RNs on third shift for a total of 15 per day. Direct care staff was 14 CNAs first shift, 14 CNAs second shift, and 6 CNAs third shift for a total of 34 per day. The plan did not address Qualified Medication Aides (QMAs).		and the weekend scheduled is reviewed in the Friday staffing meeting. The ED/Designee is responsible for compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	A review of daily census, allotted hours, and the daily staffing schedules, dated 7/11/22 to 7/25/22 indicated: a. 7/11/22, facility census of 107, warranted 26 CNAs and 16 nurses. The daily schedule indicated 2 QMAs 22.5 CNAs and 14 nurses worked. b. 7/12/22, facility census of 107, warranted 26 CNAs and 16 nurses. The daily schedule indicated 1 QMA, 29 CNAs and 14.5 nurses worked. c. 7/13/22, facility census of 107, warranted 26 CNAs and 16 nurses. The daily schedule indicated 2 QMAs, 25 CNAs, and 13.5 nurses worked. d. 7/14/22, facility census of 107, warranted 26 CNAs and 16 nurses. The daily schedule indicated 2 QMAs, 20 CNAs, and 12.5 nurses worked. e. 7/15/22, facility census of 105, warranted 26 CNAs and 16 nurses. The daily schedule indicated 2 QMAs, 24 CNAs, and 14.5 nurses worked. f. 7/16/22, facility census of 106, warranted 26 CNAs and 13 nurses. The daily schedule indicated 4 QMAs, 27.5 CNAs, and 7.5 nurses worked. g. 7/17/22, facility census of 106, warranted 26 CNAs and 13 nurses. The daily schedule indicated 4 QMAs, 27 CNAs, and 8 nurses worked. h. 7/18/22, facility census of 106, warranted 26			

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	CNAs and 16 nurses. The daily schedule indicated 4 QMAs, 23.5 CNAs, and 13.5 nurses worked. j. 7/19/22, facility census of 102, warranted 25 CNAs and 16 nurses. The daily schedule indicated 2 QMAs, 22 CNAs, and 13 nurses worked. k. 7/20/22, facility census of 101, warranted 25 CNAs and 15 nurses. The daily schedule indicated 2 QMAs, 28 CNAs, and 16.5 nurses worked. l. 7/21/22, facility census of 102, warranted 25 CNAs and 16 nurses. The daily schedule indicated 2 QMAs, 24.5 CNAs, and 14.5 nurses worked. m. 7/22/22, facility census of 102, warranted 25 CNAs and 16 nurses. The daily schedule indicated 2 QMAs, 26 CNAs, and 13 nurses worked. n. 7/23/22, facility census of 102, warranted 25 CNAs and 12 nurses. The daily schedule indicated 4 QMAs, 22 CNAs, and 9.5 nurses worked. p. 7/24/22, facility census of 102, warranted 25 CNAs and 12 nurses. The daily schedule indicated 4.5 QMAs, 22 CNAs, and 10 nurses worked. q. 7/25/22, facility census of 107, warranted 26 CNA's and 16 nurses. The daily schedule indicated 3 QMAs, 24 CNAs, and 11.5 nurses worked. During an interview, on 7/26/22 at 10:08 a.m., the			

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	Scheduler indicated the number of staff scheduled was determined by census. Nurses and CNA hours were counted separately, and QMA hours were part of the CNA hour total, even though QMAs passed medications. Acuity and resident behaviors were not considered when staff numbers were determined. She was not aware there was a facility assessment or that it provided guidance as to how much staff was required to meet the residents' needs. She thought she was normally able to meet what was required based on census, but there were call ins at times, and they were difficult to fill. The wound nurses, two unit managers, and a hospitality aide also counted into the hours she was allotted to schedule Monday through Friday. If a name was circled on the daily schedule the staff member called in for their shift. If there was a slash mark and name written on either side, that person worked half a shift. During an interview, on 7/26/22, at 10:20 a.m., the Scheduler indicated she scheduled based on census per patient day (PPD) (number of hours of direct care staff per resident) from a PPD spread sheet she was provided. She cross referenced the daily census columns titled weekday hours per day or weekend hours per day as indicated and divided that number by 7.5 hours for CNAs and 8 hours for nurses. The result after dividing was the total number of CNAs or nurses she was allowed to schedule for that day. During an interview, on 7/26/22 at 10:45 a.m., the Scheduler reviewed the facility assessment staffing information, and indicated she was never instructed to use those numbers to guide scheduling staff. During an interview, on 7/26/22 at 11:00 a.m., LPN 20 indicated the unit she was working had one			

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	CNA assigned, and another CNA splitting her hall and a second hall. Sometimes there were two full CNAs scheduled on the unit, but not always. There were three residents who were in bed for breakfast who required assistance to eat, and it was difficult to provide this with the staff available. They were not able to get them up and to the dining room for breakfast, so they had to be assisted in their rooms. During an interview, on 7/26/22 at 11:02 a.m., CNA 21 indicated she was assigned to the unit with LPN 20. There were three residents who required Hoyer lift transfers, which took two staff members to complete. Sometimes they were unable to get the residents who required Hoyer lift transfers out of bed because there was not enough staff. When the residents were not out of bed, they had to be assisted to eat meals in their room which was also difficult to get done with the number of staff available. During an interview, on 7/26/22 at 11:06 a.m., CNA 22 indicated she was the only CNA assigned to her unit. There were 3 or 4 residents on the unit who required a Hoyer lift transfer, but she was not normally able to get them up because she was the only CNA assigned to the unit. There was not enough staff to get everything done. During an interview, on 7/26/22 at 11:18 a.m., the Executive Director (ED) indicated she was not sure where the staffing numbers in the facility assessment came from, but they staffed according to the PPD calculation, which would not have equated what was indicated in the facility assessment. She was unaware of the specific staffing numbers in the assessment. During an interview, on 7/26/22 at 11:46 a.m., the			

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	ED reviewed the allotted hours sheet provided by the Scheduler and indicated it was not current. The numbers on the sheet did not reflect the current budgeted PPD. The Scheduler should have been aware of what the current numbers were, they have regular meetings to go over. Acuity was not considered in staffing. On 7/26/22 at 11:42 a.m., the ED provided a document titled, "Nurse Staffing Information," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. The facility will provide sufficient number of staff to care for the resident population. Daily nurse staffing requirements will vary based upon resident census, acuity and safety needs...." 3.1-17(a)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, record review, and interview, the facility failed to ensure adequate staffing on the dementia care unit to complete daily scheduled activities with the potential to affect 20 of 20 residents who resided on the dementia care unit, and to ensure adequate staffing on the main area of the building to provide necessary daily care to the residents with the potential to affect 86 of 86 residents who	F 0744	Facility respectfully requests a desk review for paper compliance. **F 744 Sufficient Nursing Staff** **I. The corrective actions to be accomplished for those residents found to have been affected by the practice.** No residents were identified as	08/25/2022

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	155484	A. BUILDING 00 B. WING	07/26/2022

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	resided in all other areas of the building (Residents 46, 92, 37, 25, 11, and 9). Findings include: 1. During multiple observations of the dementia care unit, activities were not provided as scheduled by the Certified Nursing Assistants (CNAs). During an interview, on 7/26/22 at 10:35 a.m., the Activity Director indicated all of the activity staff worked in the main part of the building. No activity staff was assigned to the dementia care unit. There had not been an activity aide employed back there for a long time to her knowledge. The Resident Services Director and CNAs were assigned to ensure activities were provided as scheduled on the dementia care unit. Cross reference F744. 2. During a family interview, on 7/18/22 at 10:50 a.m., a family member indicated Residents 46 and 92 were her parents. There was not enough staff, especially at mealtimes. During an interview, on 7/18/22 at 2:30 p.m., Resident 37 indicated the facility was always short on staff and his wife had to go out in the hall to find assistance. During an interview, on 7/18/22 at 2:51 p.m., Resident 25 indicated there was not enough staff for his hallway. There was usually only one CNA scheduled. During an interview, on 7/19/22 at 9:43 a.m., Resident 11 indicated there was not enough staff at the facility.		being harmed by the alleged deficient practice. **II. The facility will identify other residents that may potentially be affected by the practice.** All residents have the potential to be affected by this alleged practice **III. The facility will put into place the following systemic changes to ensure that the practice does not recur.** /p> **IV. The facility will monitor the corrective action by implementing the following measures.** The staffing schedule will be reviewed daily with the Executive Director, DON, Human Resource manager, and staffing coordinator to confirm appropriate staffing levels and identify the distribution of staff based on residents' needs. This remains an ongoing facility practice Monday through Friday and the weekend scheduled is reviewed in the Friday staffing meeting. The ED/Designee is responsible for compliance. Audit findings will be presented to the QA Committee monthly meetings x 6 months. The results of these audits will be reviewed in the monthly QA Committee monthly	

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	During an interview, on 7/19/22 at 11:37 a.m., Resident 9 indicated she needed two staff members for transfer assistance, and this was not always available. During the resident council meeting, on 7/21/22 at 10:33 a.m., 13 residents attended and indicated there was not enough staff available to meet their needs. Residents who required a Hoyer (mechanical) lift especially had to wait a long time for assistance because the lift required two staff members to operate it. The staff often had to cover another hall, and residents had to wait on staff to return to get what they needed. The facility assessment, dated November 2021 through October 2022, indicated a staffing plan of 6 Licensed Practical Nurses (LPNs) or Registered Nurses (RNs) on first shift, 6 LPNs or RNs on second shift, and 3 LPNs or RNs on third shift for a total of 15 per day. Direct care staff was 14 CNAs first shift, 14 CNAs second shift, and 6 CNAs third shift for a total of 34 per day. The plan did not address Qualified Medication Aides (QMAs). A review of daily census, allotted hours, and the daily staffing schedules, dated 7/11/22 to 7/25/22 indicated: a. 7/11/22, facility census of 107, warranted 26 CNAs and 16 nurses. The daily schedule indicated 2 QMAs 22.5 CNAs and 14 nurses worked. b. 7/12/22, facility census of 107, warranted 26 CNAs and 16 nurses. The daily schedule indicated 1 QMA, 29 CNAs and 14.5 nurses worked.		meetings for 6 months or until 100% compliance is achieved x 3 consecutive month. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	c. 7/13/22, facility census of 107, warranted 26 CNAs and 16 nurses. The daily schedule indicated 2 QMAs, 25 CNAs, and 13.5 nurses worked. d. 7/14/22, facility census of 107, warranted 26 CNAs and 16 nurses. The daily schedule indicated 2 QMAs, 20 CNAs, and 12.5 nurses worked. e. 7/15/22, facility census of 105, warranted 26 CNAs and 16 nurses. The daily schedule indicated 2 QMAs, 24 CNAs, and 14.5 nurses worked. f. 7/16/22, facility census of 106, warranted 26 CNAs and 13 nurses. The daily schedule indicated 4 QMAs, 27.5 CNAs, and 7.5 nurses worked. g. 7/17/22, facility census of 106, warranted 26 CNAs and 13 nurses. The daily schedule indicated 4 QMAs, 27 CNAs, and 8 nurses worked. h. 7/18/22, facility census of 106, warranted 26 CNAs and 16 nurses. The daily schedule indicated 4 QMAs, 23.5 CNAs, and 13.5 nurses worked. j. 7/19/22, facility census of 102, warranted 25 CNAs and 16 nurses. The daily schedule indicated 2 QMAs, 22 CNAs, and 13 nurses worked. k. 7/20/22, facility census of 101, warranted 25 CNAs and 15 nurses. The daily schedule indicated 2 QMAs, 28 CNAs, and 16.5 nurses worked.			

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	l. 7/21/22, facility census of 102, warranted 25 CNAs and 16 nurses. The daily schedule indicated 2 QMAs, 24.5 CNAs, and 14.5 nurses worked. m. 7/22/22, facility census of 102, warranted 25 CNAs and 16 nurses. The daily schedule indicated 2 QMAs, 26 CNAs, and 13 nurses worked. n. 7/23/22, facility census of 102, warranted 25 CNAs and 12 nurses. The daily schedule indicated 4 QMAs, 22 CNAs, and 9.5 nurses worked. p. 7/24/22, facility census of 102, warranted 25 CNAs and 12 nurses. The daily schedule indicated 4.5 QMAs, 22 CNAs, and 10 nurses worked. q. 7/25/22, facility census of 107, warranted 26 CNA's and 16 nurses. The daily schedule indicated 3 QMAs, 24 CNAs, and 11.5 nurses worked. During an interview, on 7/26/22 at 10:08 a.m., the Scheduler indicated the number of staff scheduled was determined by census. Nurses and CNA hours were counted separately, and QMA hours were part of the CNA hour total, even though QMAs passed medications. Acuity and resident behaviors were not considered when staff numbers were determined. She was not aware there was a facility assessment or that it provided guidance as to how much staff was required to meet the residents' needs. She thought she was normally able to meet what was required based on census, but there were call ins at times, and they were difficult to fill. The wound nurses, two unit			

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	managers, and a hospitality aide also counted into the hours she was allotted to schedule Monday through Friday. If a name was circled on the daily schedule the staff member called in for their shift. If there was a slash mark and name written on either side, that person worked half a shift. During an interview, on 7/26/22, at 10:20 a.m., the Scheduler indicated she scheduled based on census per patient day (PPD) (number of hours of direct care staff per resident) from a PPD spread sheet she was provided. She cross referenced the daily census columns titled weekday hours per day or weekend hours per day as indicated and divided that number by 7.5 hours for CNAs and 8 hours for nurses. The result after dividing was the total number of CNAs or nurses she was allowed to schedule for that day. During an interview, on 7/26/22 at 10:45 a.m., the Scheduler reviewed the facility assessment staffing information, and indicated she was never instructed to use those numbers to guide scheduling staff. During an interview, on 7/26/22 at 11:00 a.m., LPN 20 indicated the unit she was working had one CNA assigned, and another CNA splitting her hall and a second hall. Sometimes there were two full CNAs scheduled on the unit, but not always. There were three residents who were in bed for breakfast who required assistance to eat, and it was difficult to provide this with the staff available. They were not able to get them up and to the dining room for breakfast, so they had to be assisted in their rooms. During an interview, on 7/26/22 at 11:02 a.m., CNA 21 indicated she was assigned to the unit with LPN 20. There were three residents who required			

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	Hoyer lift transfers, which took two staff members to complete. Sometimes they were unable to get the residents who required Hoyer lift transfers out of bed because there was not enough staff. When the residents were not out of bed, they had to be assisted to eat meals in their room which was also difficult to get done with the number of staff available. During an interview, on 7/26/22 at 11:06 a.m., CNA 22 indicated she was the only CNA assigned to her unit. There were 3 or 4 residents on the unit who required a Hoyer lift transfer, but she was not normally able to get them up because she was the only CNA assigned to the unit. There was not enough staff to get everything done. During an interview, on 7/26/22 at 11:18 a.m., the Executive Director (ED) indicated she was not sure where the staffing numbers in the facility assessment came from, but they staffed according to the PPD calculation, which would not have equated what was indicated in the facility assessment. She was unaware of the specific staffing numbers in the assessment. During an interview, on 7/26/22 at 11:46 a.m., the ED reviewed the allotted hours sheet provided by the Scheduler and indicated it was not current. The numbers on the sheet did not reflect the current budgeted PPD. The Scheduler should have been aware of what the current numbers were, they have regular meetings to go over. Acuity was not considered in staffing. On 7/26/22 at 11:42 a.m., the ED provided a document titled, "Nurse Staffing Information," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: It is the policy of this facility to provide			

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	resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. The facility will provide sufficient number of staff to care for the resident population. Daily nurse staffing requirements will vary based upon resident census, acuity and safety needs...." 3.1-17(a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive			

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	psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to ensure pharmacy recommendations were signed by the physician and included documented clinical rationale for the declination of the recommendations for 3 of 5 residents reviewed for unnecessary medications (Residents 88, 11, and 94). Findings include: 1. Resident 88's record reviewed on 7/20/22 at 10:16 a.m. The profile indicated the resident's diagnoses included, but were not limited to bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and major depressive disorder (a disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life).	F 0758	Facility respectfully request a desk for paper compliance. F758 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The MRR for residents 88 was reviewed with Medical Director no new orders at this time. Resident 11's MRR was reviewed with the Medical Director over the phone and no changes were made to medication. Resident 94 has a current AIMS assessment. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions	08/25/2022

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	An annual Minimum Data Set (MDS) assessment, dated 5/1/22, indicated the resident had no cognitive deficit, and received medications which included, but were not limited to antipsychotics (a type of psychiatric medication which are available on prescription to treat psychosis [a disconnection from reality]) on a routine basis. A gradual dose reduction (GDR) of the medication had been attempted on 2/24/22, and had been declared clinically contraindicated by the physician. A care plan, dated 10/7/20, indicated the resident received psychotropic medication (medication to treat psychiatric disorders) and was at risk for drug related side effects. A care plan, dated 10/7/20, and revised on 2/9/22, indicated the resident was at risk for complications due to the diagnoses bipolar disorder and major depressive disorder. Interventions included, but were not limited to, consult with pharmacy for medication review as needed, physician to consider dosage reduction when clinically appropriate, monitor for changes that may suggest dose may need reduction, discontinuation or increasing, and communicate changes and any pharmacy/interdisciplinary team recommendations to resident's physician. Review of the July 2022 medication administration record (MAR), indicated a physician's order, dated 6/8/21, for paliperidone extended release (ER) (antipsychotic medication) tablet 9 milligrams (mg). Staff were to administer 1 tablet by mouth one time a day for Bipolar disorder. A pharmacy recommendation, dated 8/25/21, indicated a recommendation for consideration for		taken: All residents have the potential to be affected. The current MRR's have been reviewed and signed by the Medical Director and all orders completed. All residents whom are prescribed an antipsychotic have been audited to ensure and AIMS evaluation has been completed and scheduled every 6 months. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The DON/Designee provided 1:1 education with Medical Director in regards to completing rationale and wet signing every MRR on 8/15/22. The RDCO provided education to DON to ensure Aims is completed upon admission for all resident whom are prescribed and antipsychotic and then every 6 months thereafter. DON/Designee will re-educate all licensed nurses on completing AIMS evaluation. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DON/Designee will audit 5 residents per week for four weeks, 3 residents per week for 4 weeks then 1 resident per week for 4 months to ensure AIMS is completed upon admission and every 6 months for those residents taking antipsychotics. The DON/Designee will audit 10 MRR per month for 6 months to ensure rationale is given for all	

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	a GDR of palperidone 9 mg daily for bipolar disorder. The psychologist declined the recommendation and documented the resident had a failed reduction attempt in the past. The psychologist had signed the recommendation form. The form lacked documentation by the resident's physician. During an interview, on 7/21/22 at 10:44 a.m., the Social Services Director (SSD) indicated all pharmacy recommendations should be reviewed and signed by the physician. During an interview, on 7/21/22 at 2:35 p.m., the psychologist indicated he had addressed the pharmacy recommendation and assumed that the facility would have presented it to the physician for signature. As a psychologist, he was not a medical doctor, and could not sign the order. 2. Resident 11's record was reviewed on 7/21/22 at 1:46 p.m., diagnoses included but were not limited to, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety (intense, excessive, and persistent worry and fear about everyday situations). A quarterly Minimum Data Set (MDS) assessment, dated 4/18/22 indicated the resident was cognitively intact, received medications which included, but were not limited to antidepressants and antianxiety medications on a routine basis. A care plan, dated 10/7/20 and revised on 1/5/22, indicated the resident received an antianxiety medication (medication to treat anxiety) and was at risk for drug related side effects. Interventions included, but were not limited to consult with pharmacy for medication review as needed, physician to consider dosage reduction when		declinations and MRR has MD signature. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation	

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	clinically appropriate, monitor for changes that may suggest dose may need reduction, discontinuation or increasing, and communicate changes and any pharmacy/interdisciplinary team recommendations to resident's physician. Review of the July 2022 Medication Administration Record (MAR), indicated a physician's order, dated 12/13/21, for lorazepam tablet 1 mg two times a day for anxiety. A pharmacy recommendation, dated 10/20/21, indicated a recommendation for consideration for a GDR (gradual dose reduction) of lorazepam 1 mg two times a day for anxiety. The physician declined the recommendation and indicated a GDR was contraindicated as continued use is in accordance with current relevant standards of practice AND the following clinical rationale (write below). The physician signed the recommendation, on 10/24/21, but did not provide a clinical rationale for the declination. During an interview, on 7/21/22 at 10:40 a.m., the Social Services Director (SSD) indicated the physician should have written a clinical rationale for a declination of the pharmacy recommendation for the lorazepam medication. 3. Resident 94's record was review on 7/20/22 at 11:21 a.m. Diagnosis included, but was not limited to, unspecified dementia with behavioral disturbance (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems). A quarterly Minimum Data Set (MDS) assessment, dated 6/27/22, indicated the resident had a moderate cognitive deficit, received medication which included, but was not limited to,			

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	antipsychotic (a type of psychiatric medication which were available by prescription to treat psychosis (a disconnection from reality) on a routine basis. A care plan, dated 12/31/20 and revised on 2/23/22, indicated the resident received a psychotropic medication (medication to treat a psychiatric disorder) and was at risk for drug related side effects. Interventions included, gut were not limited to, completed AIMS (abnormal involuntary movements) on admission, quarterly and prn (as needed) and consult with pharmacy/medical provider to consider dosage reduction when clinically appropriate. An Abnormal Involuntary Movement Scale (AIMS) assessment was completed for Resident 94 on 12/23/21 and 4/4/22. Review of the July 2022 Medication Administration Record (MAR) indicated a physician's order, dated 4/4/22, for Risperdal (risperidone) tablet (psychotropic medication) 0.25 milligrams (mg). Staff were to administer 0.25 mg by mouth two times a day for psychosis. A pharmacy recommendation, dated 10/20/21, indicated the resident received risperidone a medication which may cause involuntary movements including tardive dyskinesia (TD), but an AIMS assessment was not documented in the resident record within the previous 6 months with a recommendation to monitor involuntary movement by performing an AIMS test now and then at least every six months thereafter. The physician signed the pharmacy recommendation on 12/23/21 and an AIMS was completed for Resident 94 on 12/23/22 at 3:44 p.m.			

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	155484	A. BUILDING 00 B. WING	07/26/2022

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	During an interview, on 7/21/22 at 10:47 a.m., the Social Services Director (SSD) indicated the physician should have signed the pharmacy recommendations and the AIMS test should have been completed in a timely manner, not addressed by the physician and the resident's AIMS assessment completed two months later. On 7/21/22 at 3:30 p.m., the Director of Nursing (DON) provided and identified a document as a current facility policy titled, "Policies and Standard Procedures Subject: Medication Regimen Review," dated 9/23/19. The policy indicated, "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...The monthly medication review will be performed by a licensed pharmacist according to Federal and State regulations meeting current standards of practice...The pharmacist will report any irregularities to the attending physician, the facility's medical director and director of nursing, and these reports must be acted upon in a timely manner that meets the needs of the residents...4. Attending Physician Responsibilities: ...a. The resident's attending physician must document in the medical record that the identified irregularity has been reviewed, and what, if any action has been taken to address it...b. If there is to be no change in the medication, the attending physician must document his/her rationale in the resident's medical record...c. The irregularity report is considered part of the medical record and the physician may document their rationale upon it...d. If the attending physician fails to address the irregularity in a timely manner the director of nursing will escalate the concern to the medical director...."			

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	3.1-48(b)(2)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure opened Emergency Drug Kits (EDK) had been closed and resealed for 5 of 5 EDKs observed in 1 of 3 medication storage rooms reviewed for medication storage. Findings include:	F 0761	Facility respectfully request a desk review for compliance. Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The EDK's were immediately secured and zip tied in medication rooms. The facility	08/25/2022

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	During an observation, on July 19, 2022 at 1:55 p.m. of the medication storage room for the 200A hall, 5 opened and unsealed EDK boxes were observed. An interview, at the time of the observation, with the Director of Nursing indicated the boxes were opened and not resealed. No other staff/nurses were observed in the medication storage room nor came in during the observation. The boxes had been left unattended. On July 21, 2022 at 11:40 a.m., the Clinical Nurse Consultant provided the current copy of the facility's Emergency Kits Policy effective date of September 2018 with a revised date of August 2020. A review of the policy indicated, "Emergency pharmacy service is available 24 hours a day. Emergency needs for medication are met by using the facility's approved emergency medication supply...The provider pharmacy supplies emergency medication including emergency drugs, antibiotics, controlled substances, and products for infusion in limited quantities in portable, sealed containers in compliance with applicable state regulations...When removing medication from the emergency kit: Open the kit by breaking the green seal...Close and re-seal the emergency kit with red zip tie...." 3.1-25(m)		called Pharmacy and had the EDKs restocked. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: No residents were affected by the practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Education was provided to all licensed staff on 8/9/22 utilizing the medication Storage policy. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DON/Designee will conduct an audit of all EDKs 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then 1 time per for 4 months to ensure EDK boxes are secured after use with zip ties and pharmacy notified for refill. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.			

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	§483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State			

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	plan. Based on observation, interview, and record review, the facility failed to ensure residents received routine dental services for 2 of 3 residents reviewed for dental services (Residents 55 and 14). Findings include: 1. On 7/19/22 at 11:07 a.m., Resident 55 was observed to be missing several teeth. At the same time, Resident 55 indicated she had not seen a dentist. Resident 55's record was reviewed on 7/25/22 at 11:55 a.m. A quarterly Minimum Data Set (MDS) assessment, dated 6/7/22, indicated the resident was cognitively intact. Census information indicated the resident was admitted to the facility on 9/11/20. A general healthcare services consent form, signed on 2/15/20, indicated the resident consented to dental services. The resident's clinical record lacked documentation the resident had seen a dentist since her admission to the facility. A care plan, initiated 10/7/20, indicated the resident had oral and dental health problems related to broken and missing teeth due to poor oral hygiene. Interventions included, but were not limited to coordinate arrangements for dental care and transportation as needed. During an interview, on 7/26/22 at 9:14 a.m., the Director of Nursing (DON) reviewed the dental consent form, and indicated it was signed in 2020. The resident probably should have seen a dentist	F 0791	Facility respectfully request a desk review for paper compliance. F791- Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident 55 was scheduled for a dental exam via Health Drive with next visit to facility as current medical condition does not allow resident to be seen in a dental office Resident 44 was scheduled for a dental exam on 8/23/22. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected. Upon admission to facility SSD will review ancillary services with resident and if resident desires or needs dental services the residents will sign the form for ancillary services and dental exam will be made. Any current resident who requires dental services will be placed on list to be seen by the dentist on next facility visit. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Re-education was provided to SSD to review ancillary services with all residents upon admission and obtain consent for treatment of Dental services with	08/25/2022

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	by now. They did not currently have a dental service who would come into the facility. The resident was able to go out to see the dentist, but required a bariatric (large) stretcher and ambulance transportation which was difficult to accommodate. 2. Resident 14's clinical records were reviewed on July 21, 2022 at 10:30 a.m. The most current annual Minimum Data Set (MDS) assessment, dated August 11, 2021, indicated Resident 14 was without natural teeth. The most recent quarterly Minimum Data Set assessment, dated April 20, 2022, indicated Resident 14 cognition was at the low end of intact, having scored an 11 out of 15. Their speech was unclear. They had difficulty communicating some words or finishing thoughts, but was able if prompted or given time. They usually understood others. They missed some part or intent of a message, but comprehended conversations. Resident 14 was without natural teeth. A Social Service note, dated June 06, 2022 at 11:04 a.m., indicated, "[Resident 14's name] is wanting to get her dentures replaced. [name] received her first pair of dentures in 2010 ... she reports she lost them during her MVA [multi-vehicle accident]. ... set up consultation on Monday June 20th at 2:30 p.m. Social services will fill out transport sheet." The clinical record lacked documentation of Resident 14 having gone to the dental appointment and/or any follow up from a dental appointment. On July 18, 2022 at 2:30 p.m.; Resident 14 was interviewed. During the interview, Resident 14 indicated she did not have teeth nor dentures. She was suppose to go to see a dentist, but had not		facility provider. All nursing staff will be re-educated by 8/25/22 on who to notify when a resident requires dental services. The IDT will discuss in daily clinical meeting any resident whom is in need of dental services and notify SSD to obtain an appointment. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DON/SSD/Designee will complete an audit with any new admission to ensure the resident has been offered dental services. The DON/Designee will audit all residents who are in need of dental services to ensure an appointment is obtained. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.	

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	gone. On July 21, 2022 at 10:30 a.m. the Social Service Director (SSD) was interviewed. During the interview, the SSD indicated on June 20, 2022, when transportation came Resident 14 did not want to go, because she did not have someone to go with her. No one and/or staff member had been scheduled to go with her. "Currently," the appointment had not been rescheduled. On July 26, 2022 at 9:20 a.m.; the Director of Nursing provided a current copy of the facility's Dental Services policy dated effective October 31, 2018 and Revised on April 25, 2018. A review of the policy indicated, "... Routine dental services for the purpose of this policy ... inspection of the oral cavity ... cleaning, fillings, minor partial, or full denture adjustments, smoothing of broken teeth, ... taking impressions for dentures and fitting dentures. ... Dental and Oral health can impact the physical as well as the mental/emotional and psychological health of a resident. Poor dentition and/or poor oral health may impact nutritional and weight loss status. ... The facility will assist the resident in obtaining routine Dental Services ... Making appointments, Arranging for transportation to and from the dental service location, Promptly, within three (3) days refer residents with lost or damaged dentures for dental services ...." 3.1-24(a)(1)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure a cook, with visible facial hair, wore a beard restraint while preparing food for a lunch meal for 1 of 2 kitchen observations, and failed to ensure staff performed hand hygiene during meal service on the Memory Care Unit for 1 of 2 dining observations. Findings include: 1. During the initial kitchen tour, on 7/18/22 at 10:03 a.m., Cook 24 was observed with a visible beard showing below his medical facemask. He was not wearing a beard restraint. He proceeded to removed a large pan of meatloaf from the oven and, while standing directly over the meatloaf, sliced the meatloaf as preparation for the lunch service. At the same time, the Cook indicated he usually was clean shaven, but had not shaved over the past weekend.	F 0812	Facility respectfully request a desk review for paper compliance. F812 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The cook was immediately re-educated on 7/18/22 by the Dietary Manger. The staff on the Dementia unit on 7/18/22 were immediately re-educated on handwashing policy. DON began handwashing competencies on 8/3/22 for all staff. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the	08/25/2022

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	During an interview, on 7/18/22 at 11:25 a.m., the Dietary Manager indicated the Cook 24 should have been wearing a beard restraint while preparing the resident's food. The Cook was usually clean shaven, but apparently had not shaved over the weekend prior to reporting for work. On 7/21/22 at 11:40 a.m., the Regional Director of Clinical Operations (RDCO) provided a document, dated 5/2014 with a revision dated of 9/2017, titled, "Staff Attire," and indicated it was the policy currently being used by the facility. The policy indicated, "...All employees wear approved attire for the performance of their duties...Procedures. 1. All staff members will have their hair off of the shoulders, confined in a hair net or cap, and facial hair properly restrained...."2. During a continuous dementia dining room observation, on 7/18/22, from 12:06 p.m. to 12:25 p.m., lunch service was observed. Certified Nursing Assistant (CNA) 12 placed a clothing protector on a resident, then went to a laundry cart to retrieve a second clothing protector and placed on the same resident's lap while touching her arm, then served a tray to another resident. CNA 12 retrieved a coffee cart, and served coffee to 4 of 17 residents in the dining room. During the coffee service CNA 12 fed Resident 68 a bite of food, then continued to serve coffee. CNA 12 touched her own face mask bare handed and touched a resident's walker. After the coffee service, CNA 12 washed her hands. She then went back to Resident 68, touched her bare handed, assisted her to sit back down, and handed her a cup to get a drink. CNA 12 then assisted Resident 87 to take a bite of food. CNA 12 continued to alternate between Resident 68 and 87, handing them cups and giving them bites of food. Resident 68 stood up several times		potential to be affected. No others were found to be affected by the deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Health Care Services Group or designee will re-educate the dietary staff on the following policy: Staff Attire. All staff will have been re-educated by 8/25/22 on handwashing and return demonstrations observed. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The Dietary Manager will conduct an audit 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then once a week for 4 months to ensure compliance with hair covering is achieved. The DON/Designee will conduct audits of 5 staff member per week for 4 weeks then 3 staff members for 4 weeks, then one staff member a week for 4 months to ensure compliance with handwashing is achieved. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.	

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	during the observation and CNA 12 assisted her to sit down bare handed, and also touched Resident 68's back. No additional hand hygiene was observed. During an interview, on 7/25/22 at 9:13 a.m., CNA 12 indicated hand hygiene should have been done between tray passes and anytime something is touched, such as residents or food. On 7/25/22 at 10:13 a.m., the Director of Nursing (DON) provided a document titled, "Standard Precautions," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...When to perform Hand Hygiene: A. Before eating/before feeding or assisting in dining room and tray pass. B. Before and after direct contact with a resident's intact skin...D. After contact with inanimate objects...in the immediate vicinity of the residents...." 3.1-21(i)(3)			
F 0838 SS=F Bldg. 00	483.70(e)(1)-(3) Facility Assessment §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:			

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	§483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources,			

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	such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. Based on record review and interview, the facility failed to ensure the facility assessment was utilized when making staffing determinations as indicated in the assessment with the potential to affect 106 of 106 residents who resided in the facility. Findings include: On 7/26/22 at 11:13 a.m., the facility assessment, dated November 2021 through October 2022, indicated a staffing plan of 6 Licensed Practical Nurses (LPNs) or Registered Nurses (RNs) on first shift, 6 LPNs or RNs on second shift, and 3 LPN's or RNs on third shift for a total of 15 per day. Direct care staff was 14 CNAs first shift, 14 CNAs second shift, and 6 CNAs third shift for a total of 34 per day. The plan did not address Qualified Medication Aides (QMAs). During an interview, on 7/26/22 at 10:45 a.m., the Scheduler indicated she was not aware there was a facility assessment that contained staffing information. She had never been instructed to staff according to the guidance in the facility assessment. During an interview, on 7/26/22 at 11:18 a.m., the Executive Director (ED) reviewed the facility assessment, and indicated she was not sure where the staffing numbers came from. The number of staff was determined based on per patient day (PPD) (amount of hours per resident per day)	F 0838	Facility respectfully request a desk review for paper compliance. F838 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice, No residents were identified as being affected by the facility practice. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by facility practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Education has been provided to Executive Director and Interdisciplinary team on the Facility Assessment Tool. The Executive Director reviewed the facility assessment and corrected it to meet the needs of the residents. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The ED/DON will review the Facility Assessment Tool monthly and update as needed based off	08/25/2022

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	155484	A. BUILDING 00 B. WING	07/26/2022

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	calculations. During an interview, on 7/26/22 at 11:46 a.m., the ED indicated there was no facility policy regarding the facility assessment. Cross reference F725.		resident population. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies,			

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	and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure a community point of care glucose monitor was sanitized between residents as indicated by manufacturer's recommendations for 1 of 1 resident observed for glucose monitoring in a sample of 6 community residents (Resident 9, 44, 13, 25, 77, and 351) and the facility failed to ensure soiled linen was was transported in a sanitary manner for 1 random observation (Resident 95). Findings include: 1. On July 21, 2022 at 11:20 a.m., LPN 6 was observed implementing point of care glucose monitoring. LPN 6 obtained supplies and a glucose monitor. She opened an alcohol wipe, wiped the monitor down, and proceeded to Resident 13's room. During an interview, at the time of the observation, LPN 6 indicated she was using a community monitor for the 200A hall and had been instructed by other nurses to utilize an alcohol wipe to cleanse the monitor. LPN 6 then entered the nurse station and obtained a container of sani-wipes from a back desk for use. During an interview on July 21, 2022 at 11:55 p.m., the Administrator indicated 6 residents on the 200A hall utilized the same glucose monitor, Residents 9, 44, 13, 25, 77, and 351. On July 21, 2022 at 1:30 p.m.; the residents' clinical records were reviewed. Resident 77 had a diagnosis of metabolic syndrome, which placed them at risk for diabetes.	F 0880	Facility Respectfully request desk review for paper compliance. Victoria Gunter, RN Division IP / Clinical Tara Evans RN, Regional Director of Clinical Operations David Mlodecki Regional Director of Operations Brenda Hatfield Executive Director Jennifer Greiner RN Director of Nursing Joseph Abdayem MD Medical Director 1. On July 21, 2022 at 11:20 a.m., LPN 6 was observed implementing point of care glucose monitoring. LPN 6 obtained supplies and a glucose monitor. She opened an alcohol wipe, wiped the monitor down, and proceeded to Resident 13's room. During an interview, at the time of the observation, LPN 6 indicated she was using a community monitor for the 200A hall and had been instructed by other nurses to utilize an alcohol wipe to cleanse the monitor. LPN 6 then entered the nurse station and obtained a container of sani-wipes from a back desk for use. During an interview on July 21, 2022 at 11:55 p.m., the	08/25/2022

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	An open ended physician order, with start date of June 13, 2022, indicated their blood sugars were to be monitored each day before meals and at bedtime. Resident 25 had a diagnosis of diabetes. An open ended physician order, with start date of May 13, 2022, indicated their blood sugars were to be monitored twice daily. Resident 13 had a diagnosis of diabetes. An open ended physician order, with start date of June 27, 2022, indicated their blood sugars were to be monitored daily before meals. Resident 351 had a diagnosis of diabetes. An open ended physician order, with start date of July 01, 2022, indicated their blood sugars were to be monitored as needed. Resident 44 had a diagnosis of diabetes. An open ended physician order, with start date of June 10, 2022, indicated their blood sugars were to be monitored each night or as needed. Resident 9 had a diagnosis of diabetes. An open ended physician order, with start date of February 15, 2022, indicated their blood sugars were to be monitored once daily. On July 21, 2022 at 1:27 p.m.; the Director of Nursing provided the current copy of the facility's Cleaning & Disinfection of Glucose Meter. A review of the policy indicated, "...Each cart will have at least two (2) glucose meters that are shared by residents. One meter may be in use while the other meter is undergoing disinfection with the high-level antimicrobial wipe for wet-contact time per the manufactures		Administrator indicated 6 residents on the 200A hall utilized the same glucose monitor, Residents 9, 44, 13, 25, 77, and 351. On July 21, 2022 at 1:30 p.m.; the residents' clinical records were reviewed. Resident 77 had a diagnosis of metabolic syndrome, which placed them at risk for diabetes. An open ended physician order, with start date of June 13, 2022, indicated their blood sugars were to be monitored each day before meals and at bedtime. Resident 25 had a diagnosis of diabetes. An open ended physician order, with start date of May 13, 2022, indicated their blood sugars were to be monitored twice daily. Resident 13 had a diagnosis of diabetes. An open ended physician order, with start date of June 27, 2022, indicated their blood sugars were to be monitored daily before meals. Resident 351 had a diagnosis of diabetes. An open ended physician order, with start date of July 01, 2022, indicated their blood sugars were to be monitored as needed. Resident 44 had a diagnosis of diabetes. An open ended physician order, with start date of June 10, 2022, indicated their blood sugars were to be monitored each night or as needed. Resident 9 had a diagnosis of diabetes. An open ended physician order, with start date of February 15, 2022,	

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	recommendation. ... Shared glucometers must undergo cleaning and disinfection after each resident use ... Follow the manufacturer's recommendation for cleaning and disinfecting the device used. ... Disinfect the glucometer immediately before re-use with an EPA approved wipe..." On July 21, 2022 at 1:30 p.m. the product label of the sanitizing wipes was reviewed. The label indicated, "TO CLEAN, DISINFECT... thoroughly wet .. surface must remain visibly wet for a full four (4) minutes. Use additional wipes if needed to assure continuous four (4) minute wet contact time. Let air dry...."2. On 7/20/22 at 10:24 a.m., Housekeeper 23 was observed cleaning Resident 95's room. There was a pair of soiled pants laying in the hall, outside of the resident's room, on the floor, not bagged. Housekeeper 23 indicated the pants belonged to Resident 95, and she found them behind the chair when cleaning the room. She removed her gloves, picked up the pants bare handed, the soiled pants made contact with her uniform, carried them to the utility room, opened the door, and placed the pants inside the room. No hand hygiene was observed. During an interview, on 7/25/22 at 9:10 a.m., Certified Nursing Assistant (CNA) 16 indicated soiled linen should have been placed in a bag before it was taken out of the room. Hand hygiene should have been completed and linen placed in the soiled laundry area. On 7/25/22 at 11:14 a.m., the Director of Nursing (DON) provided a document titled, "Infection Control Practices for Laundry/Linen," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...III. Transportation of Linen: ...b. Soiled linen		indicated their blood sugars were to be monitored once daily. On July 21, 2022 at 1:27 p.m.; the Director of Nursing provided the current copy of the facility's Cleaning & Disinfection of Glucose Meter. A review of the policy indicated, "...Each cart will have at least two (2) glucose meters that are shared by residents. One meter may be in use while the other meter is undergoing disinfection with the high-level antimicrobial wipe for wet-contact time per the manufactures recommendation. ... Shared glucometers must undergo cleaning and disinfection after each resident use ... Follow the manufacturer's recommendation for cleaning and disinfecting the device used. ... Disinfect the glucometer immediately before re-use with an EPA approved wipe..." On July 21, 2022 at 1:30 p.m. the product label of the sanitizing wipes was reviewed. The label indicated, "TO CLEAN, DISINFECT... thoroughly wet .. surface must remain visibly wet for a full four (4) minutes. Use additional wipes if needed to assure continuous four (4) minute wet contact time. Let air dry...." 2. On 7/20/22 at 10:24 a.m., Housekeeper 23 was observed cleaning Resident 95's room. There was a pair of soiled pants laying in the hall, outside of the resident's room, on the floor, not	

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	shall be transported in covered carts or closed bags; if transporting in closed bags, the bags should not touch the floor during transport...." 3.1-18(b)		bagged. Housekeeper 23 indicated the pants belonged to Resident 95, and she found them behind the chair when cleaning the room. She removed her gloves, picked up the pants bare handed, the soiled pants made contact with her uniform, carried them to the utility room, opened the door, and placed the pants inside the room. No hand hygiene was observed. During an interview, on 7/25/22 at 9:10 a.m., Certified Nursing Assistant (CNA) 16 indicated soiled linen should have been placed in a bag before it was taken out of the room. Hand hygiene should have been completed and linen placed in the soiled laundry area. On 7/25/22 at 11:14 a.m., the Director of Nursing (DON) provided a document titled, "Infection Control Practices for Laundry/Linen," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...III. Transportation of Linen: ...b. Soiled linen shall be transported in covered carts or closed bags; if transporting in closed bags, the bags should not touch the floor during transport...." /p> Lack of staff execution and management validation through rounding to ensure there are two glucometer's for a hall and they	

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			are being cleaned and disinfected. A root cause analysis (RCA) was conducted with the company Division (Consultant) Infection Preventionist (IP), with input and review from the Medical Director, IP, Executive Director, Director of Nursing, and Regional Director of Clinical Operations to determine the root cause resulting in the facilities Infection Control citation. The facility leadership failed to ensure full implementation through clear education / direction and direct observation of staff for the following: 1. Proper transportation of soiled linen to prevent cross contamination 2. Proper cleaning and disinfecting of glucometer The solutions and systemic changes developed by the Division (Consultant IP), DON, and facility IP include: The DON or designee will complete the following: · Ensure staff involved are educated on proper transportation or soiled and clean linen to prevent cross contamination during the transportation of linen. Staff are also educated on laundry policies related to soiled or contaminated	

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			linen. Follow CDC and facility policy. Policy: Infection Control Practices for Laundry/Linen · Ensure staff involved are educated on infection control practices regarding glucometer use. Policy: Cleaning and Disinfecting Glucose Meter DON, IP or designee will enforce corrective measures and education if deficiencies are observed. 1. The IP nurse/DON/Designee will monitor each solution and systemic change identified in RCA and as noted above, daily or more often as necessary for 6 weeks and until compliance is maintained. Ensure soiled and clean linen on being properly transported to prevent cross contamination Ensure glucometer's are being cleaned and disinfected 2. The IP nurse/DON/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions identified as above. This will occur for 6 weeks and until compliance	

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			is maintained Ensure soiled and clean linen are being properly transported to prevent cross contamination Ensure glucometer's are being cleaned and disinfected **Quality Assurance and Performance Improvement (QAPI):** The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months. **Root Cause Analysis Worksheet for Planning a Performance Improvement Project** Date of meeting: 8/10 /2022 Southwood HealthCare Center F 880 ***Steps:*** **1. Identify the event to be investigated and gather preliminary information**. Events and issues can come from many sources (i.e. incident reports, risk management referrals, resident or family concerns, health department citations) F 880 facility failed to follow Centers for Disease Control (CDC) guidance during the COVID-19	

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			pandemic and ensure infection control practices were followed when: 1. Staff holding unbagged soiled linen against the clothing. 2. Staff failed to clean and disinfect glucometer after each resident **2. Charter Team Members involved in planning: (Appointed by Leadership due to personal knowledge of systems involved.) List names and title below** **3.Describe what happened** *Collect and organize the facts surrounding the event to understand what happened.* **4.Identify contributing factors** *The situations, circumstances or conditions that increased the likelihood if the events are identified.* **5. Identify root cause** *A thorough analysis of contributing factors leads to identification of the underlying process of system issues (root causes).* **6. Design and implement changes to eliminate the root causes** *The team determines how best to change processes and systems to reduce the likelihood of another similar event.* **7. Measure the success of changes** *Like all improvement projects, the success of improvement actions*	

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			is evaluated.	