STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155246	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHESTERTON MANOR	110 BEVERLY DR CHESTERTON, IN 46304

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 20, 21, 22, 23, and 24, 2023 Facility number: 000150 Provider number: 155246 AIM number: 100267000 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 3 Medicaid: 52 Other: 9 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/3/23.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective April 24, 2023, for the complaint survey completed March 24, 2023. Chesterton Manor would like to respectfully request a desk review/paper compliance of this plan of correction.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders and an assessment to self-administer their own medications for 3 residents randomly reviewed for self-administration of medication. (Residents 31, 55, and 57)	F 0554	F554 Resident Self-Administration of Medication- Clinically Appropriate It is the practice of this facility to ensure that residents are assessed and physician's orders obtained if determined to be	04/24/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
sherrie lamore	Administrator	04/14/2023

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	Findings include: 1. On 3/20/23 at 10:25 a.m., Resident 31 was observed in her room in bed. There were two tubes of Preparation H hemorrhoid cream on the resident's bedside stand. On 3/21 at 10:52 a.m. and 3/22/23 at 11:15 a.m., the tubes of Preparation H remained on the bedside stand. The record for Resident 31 was reviewed on 3/23/23 at 11:36 a.m. Diagnoses included, but were not limited to, type 2 diabetes and muscle weakness. The Quarterly Minimum Data Set (MDS) assessment, dated 3/10/23, indicated the resident was cognitively intact. The resident had no Care Plan related to self-administering medications. A Physician's Order, dated 3/16/23, indicated the resident was to receive Preparation H rectal ointment 0.25-14-74.9% (Phenylephrine-Mineral Oil-Petrolatum), insert 1 application as needed (prn) for hemorrhoids. There was no Physician's Order for the medication to be left at the bedside or for self-administration. The resident had no assessment related to self-administration of medications. Interview with the Director of Nursing on 3/23/23 at 2:20 p.m., indicated the Preparation H cream should not have been left at the bedside. 2. During a random observation on 3/20/23 at 9:00		appropriate to self-administer medications. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: A Medication Self-Administration Assessment was completed for Resident 31 to self-administer Preparation H rectal ointment. A Self-Administration of medications care plan was completed, and the order for Preparation H has been updated to specify medication may be left at bedside for self-administration. Oral medications were removed from the bedside of resident 55 by the Nurse Consultant with resident permission. A Medication Self-Administration Assessment was completed to self-administer Nystatin cream per physician's order. The Self-Administration of medication care plan was updated to include this medication and the order updated to specify medication may be left at bedside for self-administration. The discontinued Miconazole antifungal powder was removed from the bedside of resident 57. The resident has no identified skin issues that warrants physician notification to continue medication. How other residents having the potential to be affected by the	

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	a.m., Resident 55 was observed in bed. At that time, there was a bottle of nasal spray, eye drops, and a tube of Nystatin cream on the over bed table. The resident indicated the medications were hers and she was able to self-administer those medications to herself. On 3/20/23 at 1:34 p.m., the resident was interviewed. At that time, there was a plastic zip lock bag in her purse. Inside the bag was a green bottle of medication and multiple unidentified oral pills. On 3/21/23 at 9:02 a.m. and 3:30 p.m., the bag full of the unidentified medication remained inside the resident's purse. The record for Resident 55 was reviewed on 3/22/23 at 10:40 a.m. Diagnoses included, but were not limited to, kidney failure, kyphosis, conversion disorder with seizures, high blood pressure, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 3/9/23, indicated the resident was cognitively intact. A Care Plan, updated 12/14/22, indicated the resident had requested to self-administer medications at the bedside such as nasal spray and eye drops. The approaches were for the resident to only self-administer the nasal spray and eye drops. Physician's Orders, dated 3/15/23, indicated the resident may self-administer her eye drops and nasal spray. A Self-Administration of Medications Assessment had been completed in 12/2022 and		same deficient practice will be identified and what corrective action(s) will be taken: All residents with medications at bedside have the potential to be affected by the deficient practice. A facility wide audit was completed to ensure medications are not left at bedside that have not been assessed by the IDT for self-administration. A physician's order will be obtained, and a care plan developed for self-administration if applicable. For residents that currently self-administer medications, self-administration assessments and care plans will be reviewed to determine if self-administration remains appropriate. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The facility policy on resident self-administration of medication was reviewed by the IDT. An in-service was conducted with all facility nursing staff on the policy. A performance improvement tool has been developed to monitor that any resident with medication in their rooms has been determined clinically appropriate for self-administration of medication, physician orders are present and a care plan developed. How the corrective action(s) will be monitored to ensure the	

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	3/2023 for the resident to self-administer the nasal spray and eye drops. There was no self-administration assessment or order for the resident to administer any oral medications or creams. Interview with the Director of Nursing on 3/23/23 at 1:30 p.m., indicated the Nurse Consultant had gone into the room and removed the bag of pills from the resident. The resident was to self-administer only her nasal spray and eye drops, not the oral medications. 3. On 3/20/23 at 11:10 a.m., Resident 57 was sitting in a wheelchair in her room. There was a bottle of miconazole (antifungal) powder on top of the dresser and the night stand. On 3/21/23 at 9:00 a.m., the two bottles of miconazole were still observed on the dresser and the night stand. The resident indicated the powder was applied to her daily. Record review for Resident 57 was completed on 3/21/23 at 1:01 p.m. Diagnoses included, but were not limited to, hypertension and depression. The 5 Day Minimum Data Set (MDS) assessment, dated 2/2/23, indicated the resident was cognitively intact. A Physician's Order, dated 1/27/23 and discontinued on 2/6/23, was for miconazole nitrate powder. The powder was to be applied to the groin and buttock topically every shift for excoriation. There was no documentation to indicate a self-medication administration assessment had been completed for the medication or an active		deficient practice will not recur: A Quality Assurance tool has been developed and implemented that randomly audits (5) five residents' rooms to be observed for medication at bedside, a self-administration of medication assessment is completed, and a physician's order and care plan are present if deemed appropriate. This tool will be completed by the Director of Nursing and/or her designee weekly times three, then monthly times three and then quarterly times three. The outcomes will be reviewed through the facility Quality Assurance Program. Additional action will be taken by the Quality Assurance Committee if warranted. By what date the systemic changes for the deficiency will be completed: April 24, 2023	

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	Physician's Order for the medication. Interview with the Director of Nursing on 3/21/23 at 2:33 p.m., indicated the medication was discontinued in February and should not have been in the resident's room. The resident did not have a self-medication administration assessment completed for the medication. A facility policy titled, "Self-Administration of Medications" and received as current from the Administrator on 3/24/23, indicated, "...1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident..." "...9. Staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for self-administration, for return to the family or responsible party...." 3.1-11(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to provide ADL (activities of daily living) assistance to dependant residents related to completing scheduled showers and shaving male residents for 3 of 7 residents reviewed for ADL care. (Residents 55, 45, and 15) Findings include:	F 0677	F677 ADL Care Provided for Dependent Residents It is the practice of this facility to ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good grooming, and personal hygiene. What corrective action(s) will be	04/24/2023

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	1. During an interview with Resident 55 on 3/20/23 at 1:32 p.m., she indicated she did not always get a shower twice a week. She could not remember the last time her hair had been washed. At that time, her hair was visibly greasy with dandruff flakes noted. During another interview with the resident on 3/21/23 at 9:02 a.m., she indicated her hair still had not been washed, nor had she had a shower. The record for Resident 55 was reviewed on 3/22/23 at 10:40 a.m. Diagnoses included, but were not limited to, kidney failure, kyphosis, conversion disorder with seizures, high blood pressure, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 3/9/23, indicated the resident was cognitively intact. The resident needed extensive assist with a 2 person physical assist with personal hygiene. The resident needed help with bathing with a 2 person physical assist. A Care Plan, revised on 12/14/22, indicated the resident had an ADL self-care deficit. The approaches were to provide the resident with a sponge bath when a full bath or shower couldn't be tolerated. The resident was scheduled every Tuesday and Friday evenings for showers and/or bed baths. The resident received a shower on 1/31/23 and 3/9/23. A bed bath was given to the resident on 2/2, 2/8, 2/14, 2/28, and 3/21/23. The resident refused the shower on 2/3 and 3/7/23. A Social Service Note, dated 2/22/23 at 2:58 p.m., indicated the writer met with the resident		accomplished for those residents found to have been affected by the deficient practice: Resident 55 was out of the facility from 3/25/23 until 3/31/23 and was offered and accepted a shower and shampoo on return. Her task sheet was reviewed to include offering a shower/bed bath twice weekly. Resident 45 has been offered and received shower and shaves. His task sheet was reviewed to include offering a shower/bed bath twice weekly and assistance with shaving daily per his preference. Resident 15 has been discharged per choice to an independent living facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents who are unable to carry out activities of daily living have the potential to be affected by the deficient practice. A facility wide audit was conducted to ensure all residents bathing preferences are reflected on their care plan and task sheet. All dependent residents were observed for proper hygiene and appropriate care was provided as necessary. The bathing report in the EMR was ran to ensure showers/baths were offered twice weekly or per resident preference. What measures will be put into place and what systemic changes	

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	yesterday in the resident's room. The resident indicated to the writer she had not been receiving her showers. The writer stated she would make sure the resident received a shower that was scheduled that day on the evening shift. Interview with the Director of Nursing on 3/23/23 at 12:10 p.m., indicated the resident did not receive a shower or bed bath at least 2 times a week. 2. During an interview with Resident 45 on 3/20/23 at 9:49 a.m., he indicated he had not been getting a bed bath twice a week "like he was supposed to be getting." The resident was observed with a moderate amount of facial hair on his face and neck. The resident stated, "I like to be clean shaven." During random observations on 3/21/23 at 9:30 a.m., and 1:15 p.m., on 3/22/23 at 10:14 a.m., and 11:40 a.m., the resident was observed with a moderate amount of facial hair on his face and neck. The record for Resident 45 was reviewed on 3/22/23 at 2:00 p.m. Diagnoses included, but were not limited to, Parkinson's disease, heart failure, and high blood pressure. The Significant Change Minimum Data Set (MDS) assessment, dated 3/3/23, indicated the resident was cognitively intact. The resident needed extensive assist with a 2 person physical assist for personal hygiene and bathing. A Care Plan, revised on 6/6/22, indicated the resident had an ADL self-care deficit. The resident was to receive a shower/bed bath on Monday and Thursday evenings. The resident		will be made to ensure that the deficient practice does not recur: The facility policy on ADL assistance was reviewed by the IDT. An in-service was conducted with all facility nursing staff on the policy. A performance improvement tool has been developed to monitor ADL care has been provided for dependent residents per their task sheet and care plan, offering showers/bed baths twice weekly per resident preference and shaving males residents. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A Quality Assurance tool has been developed and implemented that randomly audits (5) five residents to assure shower/bathing has been provided per their preference, that documentation is present in the EMR, and residents are free from facial hair per their preference. This tool will be completed by the Director of Nursing and/or designee weekly times three, then monthly times three, and then quarterly times three. The outcomes will be reviewed through the facility Quality Assurance Program. Additional action will be taken by the Quality Assurance Committee if warranted. By what date the systemic changes for the deficiency will be completed:	

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	received a bed bath on 1/30, 2/6, 2/8, 2/13, 2/23 and 3/16/23. He received a shower on 3/13/23. The resident was admitted to the hospital on 2/13/23 and returned on 2/22/23. There was no documentation the resident had been shaved. Interview with the Director of Nursing on 3/23/23 at 1:30 p.m., indicated the resident was to receive at least 2 baths a week and to be shaved as needed.3. On 3/20/23 at 10:05 a.m., Resident 15 was observed sitting in her bed. The resident indicated she never received showers "as she was supposed to." She had only had a few showers in the past month. Record review for Resident 15 was completed on 3/21/23 at 1:30 p.m. Diagnoses included, but were not limited to, anxiety, depression, and psychotic disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 2/10/23, indicated the resident was cognitively intact. The resident required an extensive 2 person assist for hygiene, and a total 2 person assist for bathing. The bathing Task indicated the resident received a shower on 2/28/23 and 3/17/23. She received a bed bath on 3/21/23. Interview with the Director of Nursing on 3/24/23 at 10:25 a.m., indicated the CNAs were not documenting when they gave the resident a shower. When the residents refused bathing, the CNAs should mark the refusal on the bathing Task and inform the nurse. She could not provide any documentation the resident had received any more bathing for the past month. 3.1-38(a)(2)(A)		April 24, 2023	

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	3.1-38(a)(3)(D)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure skin excoriation and bruising was assessed, monitored, and treated for 2 of 7 residents reviewed for skin conditions non-pressure related. (Residents 55 and 32) Findings include: 1. During an interview on 3/20/23 at 1:29 p.m., Resident 55 indicated she had extreme itchiness behind her thighs. She did not feel like she got "washed up" like she should have been. The record for Resident 55 was reviewed on 3/22/23 at 10:40 a.m. Diagnoses included, but were not limited to, kidney failure, kyphosis, conversion disorder with seizures, high blood pressure, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 3/9/23, indicated the resident was cognitively intact. The resident needed extensive assist with a 2 person physical assist with personal hygiene. The resident needed help with bathing with a 2 person physical assist.	F 0684	F684 Quality of Care It is the practice of this facility to ensure skin impairments are assessed, monitored and treated in accordance with professional standards of practice. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident 55 areas of excoriation to buttocks and left thigh were assessed by a licensed nurse on 3/21/23 and a wound evaluation assessment form was entered in the EMR for weekly monitoring of identified areas until resolved. A treatment to the areas was already in place. Resident 32 area of discoloration on right forearm was assessed on 3/23/23 by wound nurse and a wound evaluation assessment form was entered in the EMR for weekly monitoring of area until resolved.	04/24/2023

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	A Care Plan, revised on 2/1/23, indicated the resident had potential for impairment to her skin. The approaches were to keep her skin clean and dry and to use lotion on her dry skin. Monitor and document location and size of skin injury and report abnormalities. A Care Plan, revised on 12/14/22, indicated the resident complained of itching at times. The approaches were to observe for skin breakdown and provide medication as ordered and note effectiveness. Physician's Orders, dated 11/31/22, indicated the resident was to receive Hydrocortisone Cream 1%. Apply to back topically every 12 hours as needed for skin care. The cream was discontinued on 3/12/23. Physician's Orders, dated 11/2/22, indicated Calamine Lotion was to be applied to the resident's trunk, arms, and legs topically as needed for itching. The lotion was discontinued on 3/12/23. The Medication Administration Record (MAR) for 2/2023 and 3/2023 indicated both creams had not been applied to the resident. A Weekly Skin Review, dated 3/14/23, indicated the resident had no skin issues. A Skin Observation in the point of care responses, dated 3/19/23 at 2:29 p.m., indicated the resident had red areas. There was no documentation in the nursing progress notes regarding the location and size of the red areas.		How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with skin impairments have the potential to be affected by the deficient practice. A facility wide observation was conducted to identify residents with any further skin issues. Any areas observed have been documented on a wound evaluation assessment form in the EMR with weekly monitoring per facility policy and treatments are in place per physicians' order if indicated. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The facility policy on skin and wound management was reviewed by the IDT. An in-service was conducted with all facility nursing staff on the policy and protocol for newly identified skin areas. A performance improvement tool has been developed to assure documentation and monitoring has been completed on any newly identified wounds per the weekly skin assessment or clinical dashboard. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A Quality Assurance tool has been developed and implemented	

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	Nurses' Notes, dated 3/21/23 at 6:54 p.m., indicated during a bed bath skin assessment, the nurse noted excoriation to both buttocks and the left posterior thigh. The NP (Nurse Practitioner) was made aware and new orders were received. Physician's Orders, dated 3/21/23, indicated the resident was to receive Hydrophilic Petrolatum External Ointment (a moisturizer for itchy skin). Apply to both buttocks/left thigh topically every day and night shift for wound care. Interview with the Director of Nursing on 3/23/23 at 1:30 p.m., indicated the CNAs should have reported the red areas to the nurse so the nurse could have assessed the resident's skin on 3/19/23 and something could have been ordered sooner. 2. On 3/20/23 at 11:20 a.m., Resident 32 was observed sitting in a wheelchair in her room. The resident had a large purple discoloration to her right forearm. On 3/23/23 at 9:30 a.m., Resident 32 was observed sitting in a wheelchair in the dining room. The dark purple discoloration was still observed to her right forearm. Record review for Resident 32 was completed on 3/21/23 at 2:00 p.m. Diagnoses included, but were not limited to, anemia, peripheral vascular disease, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 2/27/23, indicated the resident was cognitively intact. The resident required a limited 2 person assist with bed mobility, dressing, toilet use, and personal hygiene. The resident received an anticoagulant (blood thinning) medication.		that randomly audits (5) five residents to ensure a wound evaluation assessment has been completed for any newly identified skin issues according to the clinical dashboard and treatment orders have been obtained as indicated. This tool will be completed by the Director of Nursing and/or designee weekly times three, then monthly times three, and then quarterly times three. The outcomes will be reviewed through the facility Quality Assurance Program. Additional action will be taken by the Quality Assurance Committee if warranted. By what date the systemic changes for the deficiency will be completed: April 24, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155246	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CHESTERTON MANOR	110 BEVERLY DR CHESTERTON, IN 46304

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	A Care Plan, dated 9/21/21 and revised 6/6/22, indicated the resident was at risk for impaired skin integrity and or discolorations related to blood thinning agents. An intervention included to observe skin daily with care and notify the nurse of any skin discolorations. A Care Plan, dated 5/27/21 and revised 6/24/21, indicated the resident was at risk for increased bleeding related to anticoagulant use of Coumadin (blood thinning medication). An intervention included to observe for signs or symptoms of anticoagulant complications which included bruising. The March 2023 Physician's Order Summary indicated orders for the following: - Coumadin 3 mg (milligrams), give 1 tablet on Monday, Tuesday, Wednesday, Thursday, Friday, and Sunday related to peripheral vascular disease - Coumadin 1 mg, give 1 1/2 tablets on Saturday - Weekly body audit by licensed nurse on Tuesday evenings - Monitor for signs of bleeding every shift when receiving anticoagulant therapy The last skin assessment, dated 3/14/23, indicated the resident did not have any bruising. There was no documentation to indicate the discoloration had been assessed and was being monitored. Interview with the Director of Nursing on 3/23/23 at 12:21 p.m., indicated she could not provide any documentation the discoloration had been assessed and was being monitored.			

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	3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on record review and interview, the facility failed to ensure residents with impaired hearing received the necessary services related to ear wax removal for 1 of 2 residents reviewed for vision and hearing. (Resident 55) Finding includes: During an interview with Resident 55 on 3/20/23 at 1:32 p.m., she indicated she was having trouble hearing and her ears were clogged. The wax needed to be removed from her ears and she had requested to go to an urgent care. The resident indicated the staff were aware of the situation. The record for Resident 55 was reviewed on 3/22/23 at 10:40 a.m. Diagnoses included, but were not limited to, kidney failure, kyphosis, conversion disorder with seizures, high blood pressure, and major depressive disorder. The Quarterly Minimum Data Set (MDS)	F 0685	F 685 Treatment/Devices to Maintain Hearing/Vision It is the practice of this facility to ensure that residents with impaired hearing receive the necessary services to receive proper treatment. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #55 ears were flushed on 4/12/23 by the Medical Director. An order was received to instil Deprox drops. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents with impaired hearing have the potential to be affected	04/24/2023

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	assessment, dated 3/9/23, indicated the resident was cognitively intact and her hearing was adequate. There was no Care Plan indicating the resident had ear wax or trouble hearing. A Nurse's Note, dated 3/13/23 at 7:32 p.m., indicated "Resident told writer multiple times that she wanted to use the outpatient walk-in clinic for x-rays and to have the wax cleaned out of ears. Spoke with [name] at same place who stated she could come in for both, but they are unable to take appointments. Resident informed again that an appointment is necessary to schedule transportation. Resident will pick another location and if unable, facility will have Doctor [name] choose a location. Resident voiced understanding." There was no further documentation or assessment of the resident's ears. There were no Physician's Orders for ear drops or wax removal medication. Interview with the Director of Nursing on 3/23/23 at 1:30 p.m., indicated she had spoken to the nurse who worked on 3/13/23 and she was aware the resident was having trouble with her ears. She indicated the NP (Nurse Practitioner) offered drops for the resident, but she declined, and the NP had not been back to the facility to make him aware. An ENT (Ear, Nose, and Throat) consult was just made today, and the resident would go out and be seen by a Physician as soon as they got back with the next available appointment date. 3.1-39(a)(1)		by the deficient practice. Facility wide interviews of all residents were conducted with no additional issues identified. For those residents unable to be interviewed, families were interviewed regarding their knowledge of any hearing losses with no further issues identified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The facility policy on Caring of Hearing Impaired Resident was reviewed by the IDT. An in-service was conducted with all facility nursing staff regarding the policy. A performance improvement tool has been developed to monitor residents for hearing difficulties and making arrangements for hearing assistive services. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A Quality Assurance tool has been developed and implemented that randomly audits (5) residents for any hearing difficulties and the coding for B0200 on the MDS for changes. This tool will be completed by the Director of Nursing and/or designee weekly times three, then monthly times three, and then quarterly times three. The outcomes will be reviewed through the facility Quality Assurance Program.	

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			Additional action will be taken by the Quality Assurance Committee if warranted. By what date the systemic changes for the deficiency will be completed: April 24, 2023	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure acceptable parameters of nutrition were maintained related to documenting food consumption for a resident with a history of weight loss for 1 of 1 residents reviewed for nutrition. (Resident 59) Finding includes:	F 0692	F 692 Nutrition/Hydration Status Maintenance It is the practice of this facility to ensure that residents maintain acceptable parameters of nutrition related to documenting food consumption. What corrective action(s) will be	04/24/2023

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	The record for Resident 59 was reviewed on 3/21/23 at 2:19 p.m. Diagnoses included, but were not limited to, morbid obesity, dysphagia (difficulty swallowing), and dementia without behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 2/18/23, indicated the resident was cognitively intact and required extensive assistance with eating. The resident was coded as having a significant unplanned weight loss. A Care Plan, revised on 3/20/23, indicated the resident had a nutritional problem or potential nutritional problem related to morbid obesity and receiving a therapeutic diet. The resident had a significant weight loss in the past 30 days. Interventions included, but were not limited to, provide and serve diet as ordered. Monitor intake and record every meal. On 9/9/22, the resident weighed 416 pounds. On 3/9/23, the resident weighed 310 pounds, a 25% weight loss within the past 6 months. A Physician's Order, dated 2/14/23, indicated the resident was to receive a regular, no added salt diet. The meat was to be cut into small pieces. The food consumption sheets, dated 2/21-3/21/23, indicated there was no meal intake documented on the following dates and times: - No breakfast or lunch documented on 3/3 and 3/11/23. - No lunch documented on 3/20/23. - No lunch or dinner documented on 2/23/23. - No dinner documented on 2/24, 2/26, 2/27, 2/28, 3/2, 3/4, 3/6, 3/9, 3/14, 3/16, and 3/17/23. - No food consumption documented for all meals		accomplished for those residents found to have been affected by the deficient practice: Nursing will review meal intake documentation on resident 59 prior to the end of each shift to ensure completed. A care plan was held with residents' husband and IDT to discuss residents' meal preferences to improve meal intake. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents that have a significant weight loss have the potential to be affected by the deficient practice. A facility wide audit was completed to identify residents with unplanned weight loss and referrals made to dietician. Nursing staff to review meal intake documentation on all residents with significant weight loss prior to the end of each shift to ensure completion. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The facility policy on nutrition/hydration was reviewed by the IDT. An in-service was conducted with all facility nursing staff on this policy and monitoring for completion of meal intake documentation. A performance improvement tool has been	

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	on 3/1, 3/10, and 3/13/23. Interview with the Director of Nursing on 3/23/23 at 2:15 p.m., indicated the resident's food consumption should have been documented. 3.1-46(a)(1)		developed to monitor residents for unplanned and significant weight loss and that documentation is being completed for meal intake. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: **A** Quality Assurance tool has been developed and implemented that randomly audits (5) five residents for significant weight loss and that meal consumption has been documented in the EMR. This tool will be completed by the Director of Nursing and/or designee weekly times three, then monthly times three, then quarterly times three. The outcomes will be reviewed through the facility Quality Assurance Program. Additional action will be taken by the Quality Assurance Committee if warranted. By what date the systemic changes for the deficiency will be completed: April 24, 2023	
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,			

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	the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure oxygen was set at the correct flow rate and functioning for 3 of 3 residents reviewed for oxygen. (Residents 59, 58, and 15) Findings include: 1. On 3/20/23 at 3:23 p.m., Resident 59 was observed in her room in bed. The resident had oxygen by the way of a nasal cannula in use. The oxygen concentrator was set at 3 1/2 liters. On 3/21/23 at 9:14 a.m., 10:57 a.m., 1:18 p.m., and 3:15 p.m., the resident's oxygen concentrator was set at 3 1/2 liters. The record for Resident 59 was reviewed on 3/21/23 at 2:19 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD) and dementia without behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 2/18/23, indicated the resident was cognitively intact. The resident was coded as receiving oxygen therapy. A Care Plan, dated 3/16/23, indicated the resident had the diagnoses of COPD and obstructive sleep apnea. The resident had shortness of breath while lying flat. Interventions included, but were not limited to, oxygen therapy as ordered by the Physician. A Physician's Order, dated 9/29/22 and listed as current on the March 2023 Physician's Order Summary (POS), indicated the resident was to	F 0695	**F695** **It is the practice of this facility to assure that residents receive oxygen in accordance with the physician orders.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** Residents #58 and #59 are receiving oxygen in accordance with the physician's orders. Resident #15 no longer resides at facility. ***Other residents that have the potential to be affected have been identified by:*** All residents that require oxygen have the potential to be affected. See system changes below to prevent reoccurrence. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The nurses have been in-serviced related to ensuring that the oxygen flowing is in accordance with the physician's orders. Via routine nurse rounds, the nurses will be responsible for assuring that the flow rate is correct. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool	04/24/2023

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	receive continuous oxygen at 3 liters per nasal cannula. Interview with the Director of Nursing on 3/23/23 at 1:46 p.m., indicated the resident's oxygen concentrator should have been set at 3 liters. 2. During observations on 3/20/23 at 10:23 a.m. and 1:12 p.m., on 3/21/23 at 9:00 a.m. and 1:05 p.m., and on 3/22/23 at 10:12 a.m. and 1:15 p.m., Resident 58 was wearing oxygen per a nasal cannula. At those times, the rate was set at 4 liters per minute. The record for Resident 58 was reviewed on 3/21/23 at 1:50 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, and anxiety. The Annual Minimum Data Set (MDS) assessment, dated 3/8/23, indicated the resident was not cognitively intact. The resident used oxygen while at the facility. A Care Plan, revised on 3/13/23, indicated the resident had oxygen therapy. The approaches were for oxygen to be administered per orders. Physician's Orders, dated 4/11/22 and listed as current on the March 2023 Physician's Order Summary (POS), indicated the resident was to receive supplemental oxygen via nasal cannula at 2 liters per minute every day and night shift for shortness of breath. Interview with the Director of Nursing on 3/23/23 at 11:00 a.m., indicated the flow rate should have been set at 2 liters per minute.3. On 3/20/23 at 11:20 a.m., Resident 15 was observed lying in her bed. An oxygen concentrator was observed next to the bed and on. The resident's nasal cannula		has been initiated that randomly reviews 5 (if applicable) residents that utilize oxygen to assure that the oxygen flow is in accordance with the physician's order. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tools. ***The date the systemic changes will be completed:*** 4-24-23	

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	was not on the resident but was hanging off the bed. The resident indicated she was unsure where her oxygen was and was having difficulty breathing. RN 1 was notified and indicated the resident must have taken her oxygen off. She went into the resident's room and applied the resident's nasal cannula for her. On 3/21/23 at 2:00 p.m., the resident was observed sitting in a wheelchair in her room. The resident indicated the staff filled her portable oxygen tank up approximately 10 minutes prior. The oxygen tank was hanging on the resident's wheelchair with the nasal cannula attached to the resident's nose. The tank was set at 3 liters. The resident indicated there was no air coming out of the nasal cannula and she was having difficulty breathing. The Administrator was observed in the hallway. Interview with the Administrator indicated the resident should be on 2 liters and not 3 liters. She looked at the portable oxygen tank and indicated there was no airflow coming from the tank. She indicated she would take the oxygen tank to get it fixed and provided her with a new one. Record review for Resident 15 was completed on 3/21/23 at 1:30 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, anxiety, depression, and psychotic disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 2/10/23, indicated the resident was cognitively intact. The resident was on oxygen therapy. A Physician's Order, dated 11/4/22, indicated supplemental oxygen via nasal cannula at 2 L (liters) every shift.			

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	3.1-47(a)(6)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to manage medications appropriately related to not monitoring the side effects of opioid medication and administering blood pressure medication outside of the parameters for 2 of 5 residents reviewed for unnecessary medication. (Residents 59 and 23) Findings include: 1. The record for Resident 59 was reviewed on 3/21/23 at 2:19 p.m. Diagnoses included, but were	F 0757	F 757 Drug Regimen is Free from Unnecessary Drugs It is the practice of this facility to ensure that residents medications are managed appropriately by monitoring side effects and administering medications within parameters. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:	04/24/2023

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	not limited to, dementia without behavior disturbance and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 2/18/23, indicated the resident was cognitively intact and required extensive assistance with bed mobility, transfers, and toileting. The resident was always incontinent of bowel and bladder. The resident was assessed for pain and had received as needed (PRN) opioid pain medication during the assessment reference period. A Physician's Order, dated 1/25/23, indicated the resident was to receive Norco (an opioid pain medication) 5-325 milligrams (mg), 1 tablet every 6 hours PRN for pain. A Physician's Order, dated 2/27/23, indicated the resident was to receive Bisacodyl EC (a laxative) Tablet Delayed Release 5 milligrams (mg), 2 tablets daily for bowel management. The February 2023 Medication Administration Record (MAR), indicated the resident received the PRN Norco on 2/20 at 4:20 p.m., 2/21 at 7:40 a.m., 2/22 at 12:04 p.m., 2/23 at 5:13 a.m. and 9:39 p.m., 2/25 at 11:00 p.m., 2/26 at 11:14 p.m., and 2/28/23 at 9:42 p.m. The March 2023 MAR, indicated the resident had received the PRN Norco on 3/1 at 8:47 p.m. and 3/2 at 2:25 p.m. and 10:35 p.m. The bowel movement sheet, dated 2/21-3/22/23, indicated the resident had no bowel movements on 2/21, 2/22, 2/24, 2/26, 2/27, 2/28, 3/1, and 3/2/23. No documentation related to bowel movements was completed on 2/23 and 2/25/23.		Nursing is to review documentation on bowel movements for resident #59 prior to the end of each shift to ensure documentation was completed and no adverse effects are present. Licensed Nurse who administered medication outside of parameters for resident #23 was immediately educated to follow parameters as prescribed by medical provider. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents receiving opioids and anti-hypertensive medications with stated parameters have the potential to be affected by the deficient practice. A facility wide audit was conducted on all residents that receive opioid analgesics to assure bowel movements have been documented. A facility wide audit was conducted on all residents receiving blood pressure medications with stated parameters to assure parameters are being followed per order. No further issues were found. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: The facility policy on unnecessary drugs was reviewed by the IDT. An in-service was conducted with all	

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	Constipation was a side effect from receiving Norco. Interview with the Director of Nursing on 3/23/23 at 3:30 p.m., indicated the resident's bowel movements should have been documented and monitored since the resident was receiving PRN Norco. 2. Record review for Resident 23 was completed on 3/22/23 at 3:08 p.m. Diagnoses included, but were not limited to, hypertension, heart failure, and diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 2/8/23, indicated the resident was cognitively intact. A Care Plan, dated 11/16/21 and revised 6/7/22, indicated the resident had hypertension. An intervention included to administer antihypertensive medications as ordered. The March 2023 Physician's Order Summary indicated an order for carvedilol (blood pressure medication) 12.5 mg (milligrams); give 1 tablet twice a day every Tuesday, Thursday, Saturday, and Sunday related to hypertension. Hold if the SBP (systolic blood pressure, top number of blood pressure reading) was less than 130. Review of the March 2023 Medication Administration Record indicated the carvedilol was given when the blood pressure (BP) was out of the ordered parameters on the following dates and times: - 3/2/23 at 8:00 a.m., BP 128/72, carvedilol given - 3/2/23 at 5:00 p.m., BP 126/66, carvedilol given - 3/4/23 at 5:00 p.m., BP 126/72, carvedilol given - 3/19/23 at 8:00 a.m., BP 116/76, carvedilol given - 3/21/23 at 5:00 p.m., BP 124/72, carvedilol given		facility nursing staff regarding this policy. A performance improvement tool has been developed to monitor residents for constipation related to opioid use and parameters for anti-hypertensive medication are being followed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A Quality Assurance tool has been developed and implemented that randomly audits (5) residents for documentation of bowel movements related to opioid use and parameters for anti-hypertensive medication are being followed per order. This tool will be completed by the Director of Nursing and/or designee weekly times three, then monthly times three, and then quarterly times three. The outcomes will be reviewed through the facility Quality Assurance Program. Additional action will be taken by the Quality Assurance Committee if warranted By what date the systemic changes for the deficiency will be completed: April 24, 2023	

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	Interview with the Director of Nursing on 3/23/23 at 12:18 p.m., indicated the medication should not have been given on the above dates and times due to the blood pressure being out of the ordered parameter. 3.1-48(a)(6)			
F 0805 SS=D Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure food was prepared in a form to meet individual needs related to not following a recipe for pureed food. This had the potential to affect 3 residents who received a pureed diet. (Main Kitchen) Finding includes: On 3/22/23 at 9:02 a.m., Cook 1 was observed preparing pureed food. There was no recipe present. She indicated three residents received a puree diet but would prepare 5 servings. She added 5 Salisbury steaks to the puree blender and started blending. She then added water and two slices of bread and continued to puree. She then added more water and thickener to the blender and started blending. She then poured it out into a pan. The Salisbury steak was a smooth consistency. Interview with the Cook on how much she had to add to the Salisbury steak indicated she "eyeballed it". She further indicated they did not have any broth so she added water.	F 0805	F805 [D] Food in Form to Meet Individual Needs It is the practice of this facility that we ensure that food is prepared in a form to meet individual needs by following the recipe. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* An in-service was conducted with Cook 1 on meals being prepared according to the recipe or manufacturers guidelines. *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* All residents who are served meals at the facility have the potential to be affected by the alleged deficiency. Staff will follow	04/24/2023

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	Interview with the the Dietary Manager after the Salisbury steak was pureed indicated the Cook should have followed the recipe. They had broth and she should have added the broth instead of water and measured out the ingredients. The recipe for the pureed Salisbury steak called for broth or gravy and thickener if product needed thickening. The recipe did not include water or bread. 3.1-21(a)(3)		the recipe for food to be served by accurately measuring and using listed ingredients. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* The policy and procedure reviewed for serving of food was reviewed by the IDT. In-servicing was completed with all kitchen staff regarding food preparation. A performance improvement tool has been developed to audit that recipes have been followed. *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audit (5) meals to assure recipes have been followed properly. This Quality Assurance Audit Tool will be completed by the Food Service Supervisor/ Designee weekly for three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made:* 4/24/2023	
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control			

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	program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview, the facility failed to promote antibiotic stewardship related to unnecessary antibiotic use for 1 of 1 residents reviewed for antibiotic use. (Resident 4) Finding includes: On 3/20/23 at 2:35 p.m., Resident 4 was observed lying in bed. The resident indicated she had recently taken an antibiotic for a cough and was feeling better. Record review for Resident 4 was completed on 3/23/23 at 1:22 p.m. Diagnoses included, but were not limited to, asthma, anemia, heart failure, and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 3/7/23, indicated the resident was moderately impaired for daily decision making and she had received an antibiotic. A Physician's Order, dated 3/1/23 and discontinued on 3/8/23, indicated ciprofloxacin (antibiotic) 500 mg (milligrams); give 1 tablet twice a day for cough for 7 days. A fax to the Physician, dated 3/1/23, indicated the resident had a nonproductive cough and the facility wanted to have an order for cough syrup. The Physician responded with orders to start	F 0881	**F881** **It is the practice of this facility to the policy related to antibiotic stewardship is in place when there is ordering of antibiotics.** ***The corrective action taken for those residents found to be affected by the deficient practice include:*** Resident #4 is not currently on an antibiotic. ***Other residents that have the potential to be affected have been identified by:*** Residents going forward that have an antibiotic ordered will be reviewed to assure that they meet the criteria for infection. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The nurses have been in-serviced related to ensuring that if an antibiotic is ordered that criteria is met in accordance with antibiotic stewardship. The facility has also educated the prescribing physician.	04/24/2023

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	Tessalon (cough medicine) 100 mg three times a day for 7 days and ciprofloxacin 500 mg twice a day for 7 days. There was no documentation to indicate the resident had any other symptoms besides a cough before the antibiotic was administered. Interview with the Director of Nursing on 3/23/23 at 1:40 p.m., indicated the resident's symptoms did not meet the criteria of a true infection to warrant the use of an antibiotic. A facility policy titled, "Infection Control Prevention, Control and Antibiotic Stewardship", and received as current from the facility, indicated, "...6. Core Elements of Antibiotic Stewardship..." "...Action: Formal review procedure for the appropriateness of any antibiotics prescribed by the Infection Preventionist on a regular basis when antibiotic orders are prescribed...."		***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 (if applicable) residents that has an antibiotic order. The Director of Nursing, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations for additional interventions as needed based on review of the outcomes of the PI tools. ***The date the systemic changes will be completed:*** 4-24-23	
F 0921 SS=B Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to marred doors and door frames, chipped floor tile, and broken shower heads on 2 of 4 units and 1 of 2 shower rooms. (The 200 and 300 Units and the Women's Shower Room) Findings include: During the Environmental tour with the Director of	F 0921	F921 [E] Safe/Functional/Sanitary/ Comfortable Environment It is the practice of this facility that the facility is maintained in a sanitary and homelike environment based on developed policies and procedures. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*	04/24/2023

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	Maintenance on 3/24/23 at 2:06 p.m., the following was observed: 1. 200 Unit a. The floor tile located next to the heating unit in Room 202 was chipped and pieces were missing. Two residents resided in this room. b. The wall behind bed "B" in Room 203 was gouged and marred. Two residents resided in this room. c. The bathroom door frame and door was scratched and marred in Room 209. There was cracked and missing floor tile next to bed "A." One resident resided in this room. d. The Women's Shower Room had two broken shower heads and the water trickled from the shower head. Interview with the Director of Maintenance at that time, indicated staff had not brought the issue to his attention. 2. 300 Unit a. The inside of the bathroom door in Room 310 was scratched and marred. Two residents used the bathroom. Interview with the Director of Maintenance at the time, indicated all of the above were in need of repair. 3.1-19(f)		· Room 202 and 209 floor tiles were repaired by replacing with new tiles · Room 203 and 310 walls were repaired. · Room 209 bathroom door frame was repaired. · The shower heads in the women's shower room were replaced *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* · All residents have the potential to be affected by the alleged deficiency. · All rooms were audited to ensure all walls were free from gouges and a marred appearance, and that floor tiles were intact and repaired if indicated. Shower rooms were audited to ensure shower heads were functioning and without leaks. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* · 1:1 In-servicing occurred with maintenance director regarding needed repairs in the facility. · A performance improvement tool has been developed to audit marred doors and door frames, floor tiles and shower heads. *How the corrective actions will be*	

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			monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits (5) rooms to ensure the identified items are in good repair. This Quality Assurance Audit Tool will be completed by the Maintenance Director/ Designee Weekly three weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made:* 4/24/23	