STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155042	A. BUILDING 00 B. WING	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW MANOR	3801 OLD BRUCEVILLE ROAD, BOX 136 VINCENNES, IN 47591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00424807. Complaint IN00424807 - Federal/State deficiencies related to the allegations are cited at F 690. Survey dates: January 16, 17, 18, 22, 23, 24, 25, and 26, 2024 Facility number: 000016 Provider number: 155042 AIM number: 100291500 Census Bed Type: SNF/NF: 77 Total: 77 Census Payor Type: Medicare: 5 Medicaid: 60 Other: 12 Total: 77 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 6, 2024.	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

Ashli | Wesley | 02/19/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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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 each resident was treated with respect and dignity for 1 of 6 residents observed for care, and 3 of 3 random	F 0550	**F550** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been**	02/23/2024

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	observations. A staff member was observed speaking to a resident in an undignified manner, a resident waited on a meal for over 22 minutes after other residents were served, a resident was observed wearing clothing belonging to a recently deceased resident, and staff opened a window during care against the resident's wishes. (Resident 30, Resident 55, Resident 127, Anonymous Resident) Findings include: 1. On 1/22/24 at 12:20 P.M., Resident 30 was observed sitting at a dining room table with three other residents. The other three residents were eating lunch with a tray in front of them. Resident 30 did not have a tray. At that time, Certified Nurse Aide (CNA) 7 indicated the kitchen had been notified "a while ago" that Resident 30's lunch tray had not been brought to the unit with the other trays. CNA 7 and Registered Nurse (RN) 9 indicated it "happened a lot". On 1/22/24 at 12:36 P.M., CNA 7 was observed to call the kitchen to check on Resident 30's lunch tray. Following the phone call, CNA 7 indicated the kitchen said they had forgotten, and would send it right away. On 1/22/24 at 12:42 P.M., Resident 30's lunch tray was brought to the unit. 2. On 1/18/24 at 5:43 A.M., CNA 15 was observed assisting Resident 55 to get out of bed, as well as incontinence care. CNA 15 wet a washcloth, and placed it in Resident 55's left hand that was positioned by his face with part of the washcloth covering his face. At that time, CNA 15 indicated to the resident to "get with it, get with the program" and instructed him to wash his face.		**Affected by The Deficient Practice:** Resident 30 now receives his lunch tray with the other residents. Resident 55 is treated with dignity and respect. Resident 127 no longer wears clothing with other resident names visible on them. Staff no longer open (or close) resident windows against resident wishes. **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 have the potential to be affected; no other residents were identified as affected by this alleged deficient practice. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** All Staff were in-serviced on Resident Rights. All staff will be in-serviced on Resident Rights annually and on an as needed basis. All new hires will be in-serviced during the orientation process on Resident Rights. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** The administrator/designee will interview select residents, observe meal service and observe for	

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	While waiting for the resident to finish, CNA 15 then indicated to him "c'mon man, wake up" before assisting him to get out of bed. 3. On 1/16/24 at 11:48 A.M., Resident 127 was observed sitting in the dining area in a wheelchair. Resident 127 was wearing socks with a different resident's name on them. At that time, CNA 33 indicated the name on the socks belonged to a resident that had passed away the day before. On 1/25/24 at 2:06 P.M., Housekeeper 41 indicated when family donated clothing after a resident passed away, staff would take a heat press to peel the name label off and relabel it. On 1/25/24 at 2:39 P.M., the Social Services Director (SSD) indicated when clothing was donated to the facility, staff should write over the old name with the name of the resident it was going to. 4. During an interview on 1/17/24 at 2:05 P.M., an anonymous resident indicated staff members would open the window in the resident's room without permission. On that day, the staff member forgot to close the window prior to exiting the room, and the window was still open after lunch. During an observation on 1/17/24 at 2:30 P.M., the resident's thermostat was set to 75 degrees Fahrenheit, and the temperature of the resident's room was 69.1 degrees Fahrenheit. The temperature outside at that time was 30 degrees Fahrenheit with a "feels like" temperature of 17 degrees. The information regarding the weather was obtained from the WeatherChannel.com at that time. During an interview on 1/25/24 at 10:40 A.M. Licensed Practical Nurse (LPN) 25 indicated staff		improperly labeled clothing 3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. **Date of Completion: 02-23-2024**	

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	should not open windows in a resident's room when they are hot. On 1/24/24 at 2:41 P.M., a current Resident Rights policy, dated 8/2009, was provided and indicated "Employees shall treat all residents with kindness, respect, and dignity" 3.1-3(t)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the			

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	resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on observation, interview, and record review, the facility failed to ensure notification to a resident's healthcare provider following a significant change for 1 of 2 residents reviewed for nutrition. The Registered Dietician (RD) was not notified following a significant weight loss, and the physician was not notified of a significant weight loss or medication recommendation. (Resident 54) Finding includes: On 1/22/24 at 10:02 A.M., Resident 54's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety and depression. The most recent Annual and State Optional MDS (Minimum Data Set) Assessment, dated 11/4/23,	F 0580	**F580** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** Resident 54 significant weight change was reported to RD & MD and intervention for weight loss put into place. **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 have the potential to be affected, no other residents	02/23/2024

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	indicated a severe cognitive impairment, no swallowing disorders, and no weight loss. Resident 54 required setup with supervision for eating. Current physician orders included, but were not limited to: Regular diet, dated 5/6/24. House shake two times a day for supplement with breakfast and supper, dated 8/6/21. A current potential for nutritional problems related to dementia care plan, initiated 5/10/21, included, but was not limited to, the following interventions: Monitor/record/report to MD as needed for signs and symptoms of emaciation ... significant weight loss: 3 pounds in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months, dated 11/16/21. RD to evaluate and make diet change recommendations as needed, dated 5/10/21. Weights as ordered and as needed, dated 11/16/21. Weights from October 2023 through current included the following: 1/7/2024 9:16 A.M. 146.9 Lbs Standing (8.24% loss in three months) 1/5/2024 1:39 P.M. 147.8 Lbs Standing 1/1/2024 7:49 A.M. 146.8 Lbs Standing 12/1/2023 7:57 A.M. 153.6 Lbs Standing 11/1/2023 9:54 A.M. 157.1 Lbs Standing 10/2/2023 3:39 P.M. 160.1 Lbs Standing		were affected by this alleged deficient practice. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** Nursing staff will be in-serviced on the requirement of notification of change in condition. Audit tool will be implemented to ensure change of condition notifications guidelines are being followed. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** The ADON/designee will audit random resident charts with change of conditions to ensure the nursing staff have followed change of condition guidelines. Audit will be 3 times per week times 4 weeks, 2 times per week times 4 weeks, weekly times 2 months, once a month times 2 months. Any negative findings will be reported to Administrator/DON and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. **Date of Completion: 02/23/24**	

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	An RD dietary note, dated 1/10/24, indicated the following: "Res. [resident] is on a Reg. [regular] diet with 25-50% po [by mouth] intake ... Wt [weight] -146.9# [pounds], bmi [body mass index] -27.8 Wt. [weight] is an 11.9% loss x 180 days and a 4.4% loss x 30 days ... Rec [recommendation] -Remeron [may be used as an appetite stimulant] 7.5mg [milligram] dly [daily]. Will cont. [continue] to f/u [follow up] prn [as needed]" Resident 54's clinical record lacked RD and physician notification of a significant weight loss after the weight obtained on 1/7/24. Resident 54's clinical record lacked physician notification for the RD's recommendation of Remeron 7.5mg daily. On 1/22/24 at 12:33 P.M., Resident 54 was observed sitting in the dining area in front of a lunch tray that was 1/4 eaten. At that time, Resident 54 indicated she was finished with her food, and it was "so-so". On 1/23/24 at 10:30 A.M., Certified Nurse Aide (CNA) 33 was observed to weight Resident 54. Weight at that time was 143.7 pounds (3.2 pounds less that previous weight on 1/7/24). The weight obtained was not put into the clinical record, and no one was notified of the new weight. On 1/24/24 at 2:06 P.M., the Assistant Director of Nursing (ADON) indicated the RD came to the facility 1-2 times per week, and typically reviewed the residents with weekly weights or other concerns related to nutrition. She indicated she would communicate any new concerns such as weight loss to the RD through a phone call or email as they came up. She indicated she would			

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	notify the RD and physician of a significant weight loss either that same day or the next business day. On 1/24/24 at 2:21 P.M. the RD indicated she came to the facility twice a week or would review clinical records remotely. She indicated if a resident had a significant weight loss, she would either obtain that information from the MDS or from staff. If a significant weight loss is identified by the floor staff, they should have let the Director of Nursing (DON) know, and then the DON would let her know, then call the physician. She indicated at that time that Resident 54's weight that was obtained on 1/23/24 should have been charted and communicated to the DON, RD, and physician. On 1/16/24 at 10:30 A.M., a current Acute Condition Changes policy, dated 8/2009, was provided and indicated "The nursing staff will contact the Physician based on the urgency of the situation ... The staff will notify the Medical Director for additional guidance and consultation if a timely response is not received" On 1/24/24 at 2:41 P.M., a current non-dated Significant Change of Condition: Physician Notification policy was provided and indicated "The attending physician will be notified of a change in a Resident's condition by a licensed (all licensed nursing personnel) staff member as warranted ... Physician notification is to include but is not limited to: ... 7% weight loss or gain in 3 months ... The nurse will make an entry into the nurses notes regarding condition and that the physician has been notified" 3.1-5(a)(2)			

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F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other			

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	appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, interview, and record review, the facility failed to ensure care was provided in accordance with the written plan of care for 5 of 5 residents reviewed. Care plan interventions and orders were not followed or implemented for the following: fluid restriction, skin assessment, prescribed antibiotics, hand splints, and performance of household chores. (Resident 7, Resident 45, Resident 58, Resident 60, Resident 127) Findings include: 1. On 1/18/24 at 12:37 P.M., clinical records were reviewed for Resident 58. Diagnosis included, but were not limited to, chronic kidney disease, dependence on renal dialysis, Type II diabetes mellitus with retinopathy, and cerebral palsy. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 1/10/24, indicated Resident 58 was cognitively intact, required assistance of 2 for bed mobility, transfers, and toilet use, supervision and set up with eating. There were no skin issues or pressure ulcers. Current physician orders included, but were not limited to: CCHO (controlled carbohydrate diet), NAS (no added salt) diet regular texture, Thin-Regular	F 0656	**F656** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** Resident 58 educated on the importance on following fluid restriction. Head to toe skin assessment completed. Weekly skin assessments in place and documented on TAR. MD notified of resident 60's missed antibiotic. Staff educated on administering antibiotics on receipt of order. Resident 7 orders and care plans now reflect discontinuance of splints. Resident 45 now redirected as care planned. Resident 127 care planned updated to reflect personal activity of choice which included folding laundry and household chores. **How Other Residents Having the Potential to Be Affected by The Same Deficient Practice Will Be Identified and What Corrective Action(s) Will Be**	02/23/2024

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	consistency, 1500 cc (cubic centimeters)/24 hr(hour) Fluid restriction, dated 12/30/23 Duplicated order on the physicians order form for increased amount of fluids each shift. 1500 cc fluid restriction every shift (sic) , dated 12/30/23 Weekly Skin Assessment, every evening shift every Friday, dated 12/29/23 A care plan dated 11/3/21, titled "Skin breakdown: potential for" included, but was not limited to, the following intervention, "...Weekly skin assessments". A care plan dated 11/3/21, titled "The resident is at risk for nutritional problems r/t (related to) therapeutic diet d/t (due to) fluid restriction" included, but was not limited to, the following intervention, "...Provide and serve diet as ordered..." A care plan dated 7/12/23, titled "Resident has renal failure" included, but was not limited to, the following intervention, "Fluids as ordered, restrict or give as ordered..." The January 2024 TAR (Treatment Administration Record) was reviewed and lacked Weekly Skin Assessment documentation. The most recent Skin Assessment in the clinical record was 12/7/2023. Review of the TAR for 1500 cc Fluid Restriction every shift for January 2024 included, but was not limited to, the following 24 hour periods of greater than 1500 cc: 1/3/24 Day 420, Evening 1800, Night 200, total intake of 2420 ml		**Taken:** All residents have the potential to be affected; no other residents were affected by this alleged deficient practice. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** Staff in-serviced on fluid restrictions, skin assessments, antibiotic orders, following care plans. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** The DON/ADON/designee will ensure all in-servicing is completed. DON/ADON/designee will monitor progress of completion and compliance 3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. **Date of Completion: 02/23/24**	

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	1/5/24 Day 420, Evening 1800, Night 120, total intake of 2340 ml 1/14/24 Day 460, Evening 1000, Night 120, total intake of 1580 ml 1/17/24 Day 460, Evening 1000, Night 120, total intake of 1580 ml 1/22/24 Day 480, Evening 1000, Night 120, total intake of 1600 ml During an interview on 1/22/24 at 9:40 A.M., LPN (Licensed Practical Nurse) 16 indicated Resident 58 did not have an open area on his bottom. During an interview on 1/24/24 at 11:16 A.M., RN (Registered Nurse) 18 indicated Skin Assessments were in the computer, and there was a wound book. Resident 58 had no wounds. During an interview on 1/25/24 at 10:17 A.M., the ADON (Assistant Director of Nursing) indicated she assisted Resident 58 with care last week, and he had no open areas or skin areas. There was no documentation in the TAR due to the order not being marked to trigger the nurses to do weekly skin assessments. During an interview on 1/25/24 at 10:30 A.M., LPN 14 indicated the staff kept track of Resident 58's fluid restriction by keeping track of the fluids he drank from the cup in his room, which had measurements on it and the fluids at meals which were premeasured. CNAs (Certified Nurse Aides) reported his intake to the nurses and it was recorded in the TAR. 2. On 1/23/24 at 9:19 A.M., Resident 60's clinical record was reviewed. Diagnoses included, but were not limited to, neurogenic bladder, diabetes mellitus, and pneumonia. The most recent Annual MDS, dated 11/4/23, indicated Resident 60 had moderate cognitive			

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	impairment. Resident 60's physician's orders included, but were not limited to, "Cefdinir Oral Capsule 300 MG [milligrams], Give 1 capsule by mouth two times a day for UTI [urinary tract infection]/pneumonia for 5 days. Start Date 10/29/2023..." A review of the Medication Administration Record (MAR) indicated the facility failed to give the medication on 10/29/23 because it was "pending arrival from pharmacy," and was only given 4 of the 5 scheduled days. A current indwelling suprapubic catheter care plan, dated 11/22/22, included, but was not limited to, an intervention to administer medications as ordered, dated 12/14/22. During an interview on 1/25/24 at 11:13 A.M., the DON indicated that staff should have pulled the medication from the EDK (emergency drug kit) on 10/29/23, and the medication should have been given all 5 days. 3. On 1/22/24 at 1:38 P.M., Resident 7 was observed during a smoke break without splints on his hands. On 1/23/24 at 2:23 P.M., Resident 7 was observed in the common area watching TV without splints on his hands. On 1/19/24 at 10:19 A.M., Resident 7's clinical record was reviewed. Diagnoses included, but were not limited to, traumatic brain injury and hemiplegia affecting right dominant side. The most recent Annual MDS Assessment, dated 11/22/23, indicated Resident 7 was cognitively intact, had impairment of both upper and both			

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	lower extremities, and totally dependant on 2 staff for toileting, transfers, and bed mobility. Current Physician Orders included, but were not limited to, the following: Resident to have on bilateral resting hand splints in the afternoon for 2-4 hours , dated 7/20/23 Observe for increased weakness and development of contractures and/or worsening of contractures on right side of body, dated 8/24/22 A current Restorative Program care plan, revised 2/19/19, included, but was not limited to the following interventions: Resident to have bilateral resting hand splints on in the afternoon for 2-4 hours or as tolerated, initiated 7/20/23 During an interview on 1/23/24 at 2:23 P.M., LPN 22 indicated putting the splints on Resident 7 was the nurse's responsibility and they should be put on after lunch and off two to four hours after. At that time, LPN 22 observed the splints were not on Resident 7 and she not able to find them. 4. On 1/16/24 at 10:30 A.M., Resident 45 was observed attempting to push the door on A Hall (locked unit) open as a visitor came in. Staff was observed to witness the behavior, instructed to visitor to pull the door shut, and did not intervene or redirect the resident as she then walked back and forth from A Hall to B Hall through the nurses station that connected them. On 1/22/24 at 9:43 A.M., Resident 45's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety, and depression. The most recent quarterly and state optional MDS (minimum data set) Assessment, dated 11/3/23, indicated a severe cognitive			

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	impairment, wandering, and required setup with supervision for bed mobility, transfers, and eating. A current care plan for pushing at others to get past to go on another unit, initiated 10/10/22, included, but was not limited to, the following interventions: Offer a snack of resident choice, dated 10/26/22. Take on a walk to calm the behavior down, dated 10/26/22. On 1/23/24 at 10:08 A.M., an elopement binder at the nurses station was reviewed and identified Resident 54 was an elopement risk. 5. On 1/16/24 at 11:15 A.M., Certified Nurse Aide (CNA) 33 was observed assisting Resident 127 to sit in the dining area of A Hall. CNA 33 then gestured to the laundry basket sitting on the table in front of Resident 127 and asked if she could match the socks and fold the laundry. Resident 127 then began folding the items in the basket. On 1/16/24 at 11:46 A.M., Resident 127 was observed sitting in the same place, still folding the laundry from the laundry basket. CNA 33 brought another basket to the table, and encouraged Resident 127 to fold the laundry that was in it. On 1/22/24 at 10:09 A.M., Resident 127's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety, and depression. The most recent quarterly and state optional MDS Assessment, dated 11/10/23, indicated a severe cognitive impairment, and a requirement of setup with supervision for all activities of daily living. Resident 127's clinical record lacked an order to			

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	perform household chores. Resident 127's clinical record lacked a care plan to perform household chores. On 1/24/24 at 2:41 P.M., a current non-dated Care Plan policy was provided and indicated "An interdisciplinary Care Plan provides guidance to all staff caring for the Resident and communicates changes in care to all direct care staff" On 1/24/24 at 2:50 P.M., the Administrator indicated it was the policy of the facility to have an order and/or a care plan before having residents do household chores. 3.1-35(a)			
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable			

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	for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview, and record review, the facility failed to develop a care plan for 2 of 5 residents reviewed for development of care plans and failed to provide care plan conferences with residents and residents' representatives for 5 of 5 residents reviewed for care plan conferences. A resident lacked a care plan for dialysis and dementia. A resident lacked a care plan for smoking. (Resident 17, Resident 24, Resident 31, Resident 57, Resident 58) Findings include: 1. On 1/22/24 at 10:20 A.M., the clinical record for Resident 24 was reviewed. Resident 24 was admitted on 1/4/23. Diagnoses included, but were not limited to, hypertension, neurogenic bladder, paraplegia, anxiety, depression, and bipolar disease. The most current Quarterly MDS (Minimum Data Set) Assessment, dated 12/14/23, indicated Resident 24 was cognitively intact and required substantial assistance for bed mobility and was totally dependent on staff for transfers, toilet use and bathing. The last care plan conference in the clinical record was 4/18/23. During an interview on 1/22/24 at 12:20 P.M.,	F 0657	**F657** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** Resident 24 and 31's care conference notes are now up to date; documentation now reflects date and time care conference invitations completed with responses. Resident 58 now has care plan for Dementia, Dialysis and Dialysis interventions. Resident 17's care conference was held, and sister attended via phone. Resident 57 now has a care plan for smoking. **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 have the potential to be affected; no other residents were identified as affected by this alleged deficient practice. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to**	02/23/2024

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	Social Services indicated the last care plan conference was 11/21/23. He provided the invitation for 11/21/23 but no notes for an actual meeting on that date. During an interview on 1/24/24 at 10:17 A.M., Social Services indicated a care plan conference was scheduled for 1/25/24 at 10:30 A.M. The emergency contact didn't want to come. It was not documented when he contacted him. Resident 31 was his own person. 2. On 1/18/24 at 10:14 A.M., the clinical record for Resident 31 was reviewed. Resident 31 was admitted on 11/29/21. Diagnoses included, but was not limited to, acute and chronic respiratory failure with hypoxia, pressure ulcer of sacral region, stage 4, paraplegia, demyelinating disease of central nervous system, neuromuscular dysfunction of the bladder, depression, colostomy status and panic disorder. The most current Quarterly MDS Assessment, dated 11/24/23, indicated Resident 24 was cognitively intact, required extensive assistance of two for bed mobility and toilet use, was totally dependent on two staff for transfers and required supervision for eating. The last care plan conference in the clinical record was 7/28/23. During an interview on 1/22/24 at 12:20 P.M., Social Services indicated the last care plan conference was 11/21/23. On 1/23/24 at 10:50 A.M., Social Services provided an invitation to the meeting dated 11/21/23, but no note from the care plan conference was provided.		**Ensure That the Deficient Practice Does Not Recur:** Care conference notes reviewed to ensure all are up to date and appropriate invites are documented with responses. Residents reviewed for Dementia, Dialysis, and smoking care plans as indicated. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** Social Services/designee will audit care plans, and care conference documentation to ensure compliance. Above will be done 3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. **Date of Completion: 02/23/2024**	

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During an interview on 1/24/24 at 10:17 A.M., Social Services indicated Resident 24 was now scheduled for 1/25/24 at 11:00 A.M., gave invite yesterday and asked about spouse and she said no he couldn't attend because he was working. Resident 24 was her own person.

3. On 1/18/24 at 12:37 P.M., the clinical record for Resident 58 was reviewed. Resident 58 was admitted on 10/28/21. Diagnoses included, but were not limited to, cerebral palsy, Type II diabetes mellitus with retinopathy, chronic kidney disease, dependence on renal dialysis and vascular dementia with other behavioral disturbance.

The most current Quarterly MDS Assessment, dated 1/10/24, indicated Resident 58 was cognitively intact, required extensive assistance of two for bed mobility, transfers and toilet use, supervision and set up for eating and was on dialysis.

A care plan dated 7/12/23 titled " Resident has renal failure" lacked an intervention for dialysis. The clinical record lacked a care plan for dialysis.

The clinical record lacked a care plan for dementia.

The last care plan conference in the clinical record was 3/21/23.

During an interview on 1/24/24 at 10:17 A.M., Social Services indicated Resident 58 was scheduled on 1/29/24. He talked to the brother yesterday by phone to schedule.

During an interview on 1/25/24 at 11:23 A.M., the Administrator indicated if a resident was on

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	dialysis they should have a care plan for dialysis or dialysis should be listed in interventions under kidney failure. If a resident has a diagnosis of dementia, they should have a care plan for dementia. 4. On 1/19/24 at 8:12 A.M., Resident 17's clinical record was reviewed. Diagnoses included, but were not limited to, multiple sclerosis, Post Traumatic Stress Disorder (PTSD), and depression. The most recent Quarterly MDS Assessment, dated 11/23/23, indicated Resident 17 was cognitively intact and an extensive assist of 2 staff for bed mobility, transfers, and toileting. During an interview on 1/24/24 at 10:17 A.M., the SSD indicated Resident 17's last care plan conference was on 9/26/23 and he did not have one scheduled at this time. He indicated he sent an email to Resident 17's sister on 1/23/24 at 7:47 A.M., to set up a care plan conference but had not received a response back. At that time, the SSD indicated the care plan conferences should be done quarterly but if needed he would do sooner. He kept his schedule in a handwritten planner. He will schedule a meeting and send invite to resident and/or representative 7 days prior to conference. 5. On 1/23/24 at 9:00 A.M., Resident 57's clinical record was reviewed, Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. The most recent Quarterly MDS Assessment, dated 10/17/23, indicated Resident 57 was cognitively intact and supervision of staff for bed mobility, toileting, and transfers. On 1/16/24 at 10:30 A.M., a list of smokers in the			

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	facility was provided by the Administrator and indicated Resident 57 was a smoker. Resident 57's last care plan conference was 10/20/23. Resident 57's clinical record lacked a care plan for smoking. During an interview on 1/23/24 at 2:54 P.M., RN (Registered Nurse) 54 indicated Resident 57 should have a care plan to smoke. During an interview on 1/24/24 at 10:17 A.M., the SSD indicated the care plans were reviewed at each care plan conference and smokers should have a care plan. On 1/16/24 at 10:30 A.M., a current Care Plan Policy, dated 1/2011, was provided by the Administrator and indicated " ... Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident ... The Care Planning/Interdisciplinary Team is responsible for the periodic review and updating of care plans ... The resident and/or responsible party will be invited to participate in the quarterly review of the residents overall plan of care. Record of this invitation will be maintained in the resident's clinical record ... " 3.1-35(a)			
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive			

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	care plan, must- (i) Meet professional standards of quality. Based on observation, interview and record review, the facility failed to ensure a new diagnosis of schizophrenia was reviewed for appropriateness for 1 of 5 residents reviewed for unnecessary medications. (Resident 63) Finding includes: On 1/22/24 at 9:54 A.M., Resident 63's clinical record was reviewed. Admission date was 5/11/23. Diagnosis included, but was not limited to, schizophrenia. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 11/30/23, indicated a severe cognitive impairment, and a diagnosis of schizophrenia. Current physician orders included, but were not limited to: Risperidone extended release subcutaneous suspension prefilled syringe 125 mg (milligram)/0.35 ml (milliliter) one time a day every 28 days related to schizoaffective disorder, dated 10/29/23. An admission record, dated 5/11/23, did not indicate schizophrenia or schizoaffective disorder under diagnosis information. An admission record, dated 7/19/23, indicated schizoaffective disorder with an onset date of 8/3/23. A PASRR (preadmission screening and resident review), dated 3/13/23, indicated major depression, bipolar disorder, depression, and intermittent explosive disorder as mental health diagnoses. Schizophrenia or schizoaffective disorder were not	F 0658	**F658** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** **Resident 63 diagnosis and medications reviewed for appropriateness. Resident still has diagnosis of schizoaffective disorder per psychic MD, however risperidone has been discontinued.** **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 have the potential to be affected; no other residents were identified as affected by this alleged deficient practice. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** **DON/designee will review admissions diagnosis and medications for appropriateness.** **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** DON/designee will review admissions, and this will be done	02/23/2024

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	listed on the form. A PASRR, dated 7/14/23, indicated schizoaffective disorder as a mental health diagnoses. On 1/26/24 at 3:40 P.M., a hospital discharge summary form was provided, dated 7/19/23. The form indicated schizoaffective disorder as a discharge diagnoses. At that time, the ADON indicated that was the first time the diagnoses was mentioned in Resident 63's clinical record. On 1/24/24 at 2:12 P.M., the Assistant Director of Nursing (ADON) indicated the MDS Coordinators would review new diagnosis as they were put into the chart, and notify the physician, ADON, or Director of Nursing (DON) if any new diagnosis was inappropriate or needed review. On 1/25/24 at 11:13 A.M., the MDS Coordinator indicated when a resident received a new diagnosis, they would look to see if it fit within the resident's documentation in their clinical record, and would question with psychiatric services if the resident did not have that mental health diagnosis prior. On 1/24/24 at 2:41 P.M., a current non-dated Use of Antipsychotic Medications policy was provided, and indicated "Antipsychotic medications may only be used when a comprehensive assessment of a Resident's medical, psychiatric, and behavioral condition proves evidence that an enabling condition is present" 3.1-35(g)(1)		3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. **Date of Completion: 02/23/24**	
F 0678 SS=D	483.24(a)(3) Cardio-Pulmonary Resuscitation (CPR)			

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	155042	A. BUILDING 00 B. WING	01/26/2024

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Bldg. 00	§483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. Based on interview and record review, the facility failed to provide emergency basic life support immediately when needed, including CPR (cardiopulmonary resuscitation) for 1 of 1 resident reviewed for CPR. Staff did not immediately provide services to a resident that required emergency care and CPR. (Resident 178) Finding includes: On 1/24/24 at 10:48 A.M., Resident 178's clinical record was reviewed. Diagnosis included, but was not limited to, dementia and traumatic brain injury. The most recent Significant Change MDS (Minimum Data Set) Assessment, dated 11/10/23, indicated a severe cognitive impairment, no falls, and no swallowing disorders. Physician orders included, but were not limited to, the following: CPR - Full Code, dated 12/8/22. A full code care plan was in place, dated 12/9/22. Progress notes included, but were not limited to, the following: 10/17/23 0 at 9:30 A.M."Resident was sent to [hospital] ER via [hospital EMS] at 9:00 am for eval [evaluation]. During breakfast resident was seating next to this nurse eating breakfast, this nurse looked away to feed another resident and	F 0678	**F678** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** Staff member that removed resident from dining room to initiate CPR was re-educated to perform life saving measures immediately. **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 have the potential to be affected; no other residents were affected by this alleged deficient practice. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** All pertinent staff will be in-serviced to perform live saving measures immediately. All pertinent staff will be in-serviced upon hire, annually and on an as needed basis. **How The Corrective Action(s) Will Be Monitored to Ensure**	02/23/2024

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	when this nurse looked back at resident his lips where purple and he wasn't responding. This nurse immediately took resident down to residents' room and possibly code resident but by time we made it to resident's room resident started to vomit. Resident continued to vomit several times after that. At this time nurse decided to have resident evaluated at ER. NP [Nurse Practitioner], POA [power of attorney], all are aware" 10/17/23 at 11:14 A.M. Hospital called to report resident was being admitted for aspiration pneumonia. On 1/26/24 at 1:57 P.M., the distance from where Resident 178 was sitting in the dining room to his room (room 60) was observed to be 64 steps and traveled in 40 seconds at a walking speed. On 1/24/24 at 2:16 P.M., the ADON (Assistant Director of Nursing) indicated staff was expected to immediately intervene with a full code resident that was choking or nonresponsive in the dining room, and not to take them to their room first. On 1/26/24 at 10:47 A.M., LPN (Licensed Practical Nurse) 20 indicated as she was watching Resident 178 eat on 10/17/23, she was also assisting another resident to eat. At one point, she turned to Resident 178 and he was unresponsive with lips turning blue. She indicated she immediately took him to his room where he projectile vomited. He was then sent to the hospital. She indicated she was aware now that an immediate intervention should have been done, but was thinking of the resident's dignity and wanted to take him to his room. On 1/24/24 at 2:41 P.M., an undated code status policy was provided and indicated "The long-term		**the Deficient Practice Will Not Recur:** DON/ADON/Designee will ensure that in-servicing is completed. Any negative findings will be reported to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. **Date of Completion: 02/23/24**	

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	care facility requires all physicians to address code status for each Resident regarding the use of resuscitation. This enables nursing staff to readily and clearly ascertain how to treat the Resident in the even [sic] of an emergency ... If the Resident desires a NO CODE status, the chart will be marked accordingly per facility practice"			
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview, and record review, the facility failed to ensure an ongoing program to support residents in their choice of activities for 2 of 7 halls reviewed. A and B Halls lacked activities in accordance with the activity calendar. (Locked Dementia Unit A and B Hall) Finding includes: On 1/16/24 at 12:24 P.M., Licensed Practical Nurse (LPN) 22 indicated she wished activity staff would give Resident 45 more to do to keep her occupied. She indicated Resident 45 liked to walk, and someone took her for a walk twice a day, but she needed more to do. At that time, Resident 45 was observed sitting in the common area on B Hall, then wandering from B Hall to A Hall, and back again.	F 0679	**F679** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** Activities are now being performed by staff on A&B halls. Facility hiring for dedicated Activities Staff for A&B unit. **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 have the potential to be affected.	02/23/2024

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	On 1/17/24 at 11:06 A.M., no activities were observed on A or B Halls. At that time, an activities calendar posted in the hall indicated "Name 5" for the 11:00 A.M. activity. On 1/22/24 at 10:52 A.M., no activities were observed on A or B Halls. At that time, the activities calendar indicated "Nailed it" for the 10:00 A.M. activity, and "[name] sing along" for the 11:00 A.M. activity. On 1/22/24 at 1:02 P.M., no activities were observed on A or B Halls. At that time, the activities calendar indicated "Self-directed activities" for the 1:00 P.M. activity. On 1/23/24 at 9:24 A.M., no activities were observed on A or B Halls. At that time, the activities calendar did not indicate an activity until 10:00 A.M. On 1/23/24 at 11:13 A.M., no activities were observed on A or B Halls. At that time, the activities calendar indicated "UNO" for the activity at 11:00 A.M. On 1/23/24 at 1:57 P.M., Resident 45 was observed asking staff to take her walking, and was told there was no staff available. Activities 23 indicated to the resident they had already walked that morning, and would walk again the following morning. On 1/24/24 at 1:45 P.M., Resident 45 was observed lying in bed with her eyes open. She indicated she was not resting, there was just nothing to do. On 1/24/24 at 1:47 P.M., five residents were observed in the dining area of A Hall. No		**What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** Activities staff educated on the importance of following the activity calendar. A&B staff educated on doing activities with residents. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** Administrator/designee will monitor activities on A&B 3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. **Date of Completion: 02/23/24**	

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	activities were observed. On 1/25/24 at 2:10 P.M., Activities 23 was observed preparing the activities room by C/D Halls for an ice cream social. At that time, she indicated they had to change the activities schedule because it was to hard to do what was scheduled and pass the mail. She indicated they could not be all over the building at the same time. On 1/25/24 at 2:25 P.M., staff on A and B Halls were observed taking residents off of the unit to an activity that was scheduled at 2:00 P.M. On 1/26/24 at 10:26 A.M., Activities 57 was observed in the activities room (by C/D Hall) doing a ring toss activity with the residents. She indicated they had to change the time for the ring toss because she was currently assisting with two activities at the same time in two different areas (ring toss in the activities room and rosary in the dining room). On 1/24/24 at 2:00 P.M., an activities schedule was provided and indicated the following dates in January 2024 that one activities staff was scheduled (with an average census of 74 residents): 1/1/24 1/6/24 1/7/24 1/8/24 1/13/24 1/14/24 1/18/24 1/20/24 1/21/24 1/22/24 1/27/24			

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	On 1/23/24 at 1:41 P.M., Activities 23 and Activities 57 indicated there were currently 3 activities staff (2 of them were 4 days a week, and 1 was 5 days a week working every other weekend). They indicated on average, 3 staff were in the building 3 days a week, and the other days there were 2 activities staff. Activities 23 indicated there were not enough activities staff for the whole building, and the dementia unit did not have dedicated activities staff. They indicated there was not enough staff to do all of the activities scheduled, and would have to change activities due to not enough time or staff. At that time, Activities 23 indicated the activities calendar was used as a policy as to what activities were to be done in the facility. On 1/24/24 at 2:41 P.M., the Administrator indicated there was not a specific activities policy, but the activities staff were to follow their job description, which at that time was provided. The job description indicated "The Activity Director is responsible for planning, organizing and implementing an ongoing program of group and individual resident activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each Resident" 3.1-33(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is			

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	unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to ensure residents with limited mobility received appropriate services and assistance to prevent further decrease in range of motion for 2 of 2 residents reviewed for the restorative nursing program. (Resident 7, Resident 29) Findings include: 1. During an interview on 1/17/24 at 2:29 P.M., Resident 7 indicated he should be getting restorative therapy, but doesn't always get it. On 1/19/24 at 10:19 A.M., Resident 7's clinical record was reviewed. Diagnoses include, but were not limited to, traumatic brain injury and hemiplegia affecting right dominant side. The most recent Annual MDS Assessment, dated 11/22/23, indicated Resident 7 was cognitively intact, had impairment of both upper and both lower extremities, totally dependant on 2 staff for toileting, transfers, and bed mobility, and received restorative therapy. The following orders were included in the "Point	F 0688	**F688** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** Resident 7 & Resident 29 now receiving restorative per orders. Dedicated CNA for restorative care. **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 receive restorative care have the potential to be affected; no other residents were identified as affected by this alleged deficient practice. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** There is now a dedicated CNA for	02/23/2024

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	of Care" nursing tab of the resident's electronic clinical record, but not limited to: "NURSING REHAB: Passive ROM [range of motion]- Resident will allow staff to perform passive range of motion [PROM] to bilateral upper and lower extremities and neck X 10 reps (all planes) at least 6 days per week ", ordered 6/10/2022 A current Hemiplegia-Right Side of Body Care plan, dated 11/22/19, included, but was not limited to, the following intervention: Range of motion (active or passive) with am/pm (morning/afternoon) care daily, initiated 6/7/17 A current Traumatic Brain Injury Care Plan, dated 11/26/16, included, but was not limited to, the following intervention: Turn and reposition every 2 hours and as needed. Keep body in good alignment, initiated 11/26/16 On 1/22/24 at 1:44 A.M., a CNA (Certified Nurse Aide) assignment sheet for the F Hall was provided by LPN (Licensed Practical Nurse) 22 and indicated Resident 7 was on a restorative program. On 1/25/24 at 2:05 P.M., a list of residents receiving restorative therapy as of 1/18/24 was provided by MDS (Minimum Data Set) Coordinator 1 and indicated Resident 7 was to get PROM 6 days a week. On 1/25/24 at 11:42 A.M., an occupational therapy discharge summary, signed 5/24/22, was provided by Physical Therapist (PT) 16 and indicated "Restorative Nursing Program (RNP) to facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNPs has been		the restorative program. MDS Nurses to monitor the restorative program. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** MDS Nurses/designee to monitor residents on restorative program 3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. **Date of Completion: 02/23/24**	

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	completed with the Inter Disciplinary Team (IDT): ROM (Passive), wheelchair positioning" Restorative Therapy tasks for the following months were reviewed and indicated: November 2023- resident missed 3 days December 2023-resident missed 0 days January 2024-resident missed 3 days (as of 1/25/24) During an interview on 1/25/24 at 10:49 A.M., PT 16 indicated it had been a while (2022) since Resident 7 was seen for therapy, that he did have posture problems, and they tried to get him another wheelchair but it wasn't cost effective for the family. She indicated frequent repositioning was recommended for his posture but he did sometimes refuse. 2. During an interview on 1/17/24 at 2:19 P.M., Resident 29 indicated he had restorative therapy ordered but didn't feel like he did it. On 1/23/24 at 10:06 A.M., Resident 29's clinical record was reviewed. Diagnoses included, but were not limited to, stroke, dementia, and diabetes mellitus type II. The most recent Quarterly MDS Assessment, dated 11/25/23, indicated Resident 29's cognition was moderately impaired, receiving restorative therapy, and an extensive assist of 2 staff for bed mobility, transfers, and toileting. The following orders were included in the "Point of Care" nursing tab of the resident's electronic clinical record, but not limited to: "NURSING REHAB: AROM [active range of motion]- Resident will perform AROM to bilateral lower extremities (all planes to tolerance) X [times]			

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	20 reps [repetitions] at least 3 days per week ", ordered 10/25/23 "NURSING REHAB: AMBULATION Resident will be able to walk 40 feet with limited assist and rolling walker daily at least 3 days per week ", ordered 10/25/23 A current Nursing Restorative Program: Ambulation Care Plan, revised 1/25/23, included, but was not limited to, the following intervention: Assist resident to walk 40 feet, initiated 10/25/23 A current Nursing Restorative Program: AROM, dated 10/25/23, included but was not limited to, the following intervention: Give verbal, visual and tactile cues to do fine motor exercises: string beads, peg board, find objects in thera putty, stack cones, fold laundry etc for 15 minutes. Provide frequent reminders to stay on task, initiated 10/25/23 On 1/22/24 at 1:44 A.M., a CNA (Certified Nurse Aide) assignment sheet for the F Hall was provided by LPN 22 and indicated Resident 29 was on a restorative program. On 1/25/24 at 2:05 P.M., a list of residents receiving restorative therapy as of 1/18/24 was provided by MDS Coordinator 1 and indicated Resident 29 was to get AROM and walking 3 days a week. On 1/25/24 at 11:42 A.M., an occupational therapy discharge summary, signed 10/18/23, was provided by PT 16 and indicated "Discharge Recommendations: walk with walker and assist of CNA staff daily, participate in active movement exercises BLE [bilateral lower extremities], amb [ambulate] to commode with assist of staff ... RNP:			

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	BLE there ex [bilateral lower extremity therapy exercises], transfers and am b [sic] with ww [wheeled walker]." Restorative Therapy tasks for the following were reviewed and indicated: November 2023- resident missed 3 days December 2023-resident missed 2 days January 2024-resident missed 2 days (as of 1/25/24) During an interview on 1/23/24 at 1:24 P.M., LPN 20 indicated CNAs were responsible for getting restorative therapy completed as ordered for residents. At that time, she indicated there was not an aide specifically dedicated to do restorative therapy. During an interview on 1/23/24 at 2:08 P.M., CNA 24 indicated there was no one that she knew of on restorative therapy for the E/F Halls. She indicated if you see someone declining or more stiff, they would notify the nurse of the decline. During an interview on 1/25/24 at 10:49 A.M., PT 16 indicated when a resident finishes therapy, and the therapist feels they would benefit from a restorative program, then they would write a referral for restorative therapy and notify MDS Coordinator 2. She indicated she is in charge of overseeing the program to make sure it was being completed on residents. During an interview on 1/25/24 at 11:25 A.M., the Director of Nursing (DON) indicated there was a staff member specifically assigned to do restorative therapy for residents but he has been gone for about 2-3 months so the CNAs are responsible for doing it and monitoring was done by MDS Coordinator 2.			

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	During an interview on 1/25/24 at 2:01 P.M., MDS Coordinator 1 indicated the facility had an aide recently quit that was dedicated to the restorative program and they had not replaced him. At that time, she indicated it was difficult for staff to get restorative therapy duties completed due to being pulled in other directions. She indicated they check the charts once every other week or as needed to make sure therapy was completed on the restorative residents. During an interview on 1/26/24 at 11:19 A.M., CNA 6 indicated Resident 7 gets his range of motion with arms and legs in the mornings when the staff get him up and Resident 29 was self sufficient and would walk with assistance when he wanted to. On 1/25/24 at 2:45 P.M., a current non dated Restorative Nursing Policy and Procedure was provided by the Administrator and indicated " ... It is the policy of this facility to provide restorative nursing interventions that promote the resident's ability to adapt to living as independently and safely as possible. This concept actively focuses on achieving and maintaining, optimal physical, mental and psychosocial functioning ... " 3.1-42(a)(2)			
F 0689 SS=E 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			

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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents for 4 of 5 residents reviewed for accidents. A resident was found smoking several times in his room/bathroom and was still allowed to carry his smoking supplies on his person. Residents' care plan interventions were not followed and alarms were not working. (Resident 57, Resident 25, Resident 127, Resident 178) Findings include: 1. On 1/16/24 at 11:34 A.M., ashes were observed in the shared bathroom sink and a cigarette butt floated up into the sink from the drain when the water was turned on. On 1/17/24 at 11:00 A.M., Resident 57 was observed smoking a yellow colored vape in his room, a camouflage colored vape was plugged into the wall charging, and a black colored vape was laying next to it on the night stand. On 1/22/24 from 1:38 P.M.- 2:05 P.M., during a smoke break observation in an unventilated barn, the following was observed: At 1:40 P.M., Resident 57 reached into his coat pocket, pulled out a pack of cigarettes and lighter, and put them back into his coat after lighting the cigarette. At 1:44 P.M., two anonymous residents indicated they didn't get to smoke over the previous weekend and sometimes after maintenance leaves for the day because staff can't or don't want to	F 0689	**F689** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** Residents & staff educated on smoking policy. Staff educated on collecting smoking materials, smoking assessments, and safe smokers. Resident 57 no longer has his vape in room or smoking materials kept on person. Smoking assessment updated to reflect does not keep smoking materials. Resident 25 deceased. Resident 127 now has fall interventions in place as per orders and care plan. Resident 178 deceased. **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 have the potential to be affected. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** Staff & residents educated on smoking policies. Staff educated on fall interventions. Smoking	02/23/2024

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	take them out even though it's their right to smoke. An anonymous resident indicated they don't smoke in their room but some residents do because of this. At 1:49 P.M., Resident 57 reached into his coat pocket, pulled out a pack of cigarettes and lighter, and put them back after lighting the cigarette. At 1:53 P.M., Resident 57 left smoking area without staff taking smoking supplies on his way out. On 1/23/24 at 9:00 A.M., Resident 57's clinical record was reviewed, Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. The most recent Quarterly MDS Assessment, dated 10/17/23, indicated Resident 57 was cognitively intact and supervision of staff for bed mobility, toileting, and transfers. On 1/16/24 at 10:30 A.M., a list of smokers in the facility was provided by the Administrator and indicated Resident 57 was a smoker. The clinical record lacked a care plan for smoking. Smoking Assessments on Resident 57 were completed on the following dates: 3/28/23-indicated resident may smoke independently (i.e. safe smoker) in designated areas, resident wishes to keep smoking materials on his person 7/8/23-indicated resident must be supervised at all times when smoking and does not indicate whether resident may keep supplies on his person		assessment reviewed and updated as needed. Fall interventions reviewed to ensure appropriate measures in place. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** DON/ADON/designee will monitor progress to ensure compliance and appropriate measures in place 3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. **Date of Completion: 02/23/2024**	

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	10/10/23-indicated resident must be supervised at all times when smoking, resident wishes to keep smoking materials on his person (for safe smokers only), and resident had been informed of smoking evaluation results, policies, and procedures On 1/26/24 at 9:00 A.M., Resident 57's January 2023 through January 2024 log of behaviors regarding smoking in his room was provided and indicated: 1/1/23 resident was smoking in his room and staff educated resident on not smoking in room, offered reassurance, and validated feelings, which was effective. 12/12/23 resident was smoking in his room, staff got Social Services Director (SSD) assistance, and educated resident on not smoking in room, which was effective. 12/18/23 resident was smoking in his room, staff got SSD assistance, and educated resident on not smoking in room, which was effective. During an interview on 1/23/24 at 2:24 P.M., Resident 57 indicated they should not smoke or vape in their room but he had smoked in his room about 1-2 times per week in the morning because he wanted to smoke earlier then the first smoke break at 9:30 A.M. At that time, he indicated staff knew he smoked and vaped in his room. He indicated he kept his cigarettes and lighter in his room with him in his coat pocket or dresser "so he has them". During an interview on 1/23/24 at 2:54 P.M., Registered Nurse (RN) 54 indicated residents that smoke should have a care plan indicating that and SSD made the care plans. At that time she indicated that Administration decides smoke break times for the residents, they have recently changed, and some resident's were complaining.			

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	She was unsure if there was anyone termed a "safe smoker" on the G/H/I unit and not sure who determined that. She indicated smoking supplies, including vapes, should be locked up in the medication storage room and she didn't know anyone who would be allowed to keep their smoking supplies on their person. During an interview on 1/24/24 at 10:17 A.M., the SSD indicated the term "safe smoker" comes from the resident's smoking assessment done on admission, quarterly, and as needed and resident's also sign a "confirmation of understanding the smoking rules of this facility" on admission and as needed. At that time, he indicated the resident's short and long term memory has to be intact and be able to make decisions, should be alert and oriented and practice safe smoking techniques, have adequate hearing, vision and communication, and fine motor skills to hold and light own cigarette, and be able to communicate the risk of smoking. The nursing staff and SSD would review and decide if resident is termed a "safe smoker". At that time, he indicated that they consider vaping and smoking rules the same and if a resident is a "safe smoker" then they are permitted to keep their smoking supplies on their person but not smoke in the building. He indicated Resident 57 had been caught smoking in the building before and when this happened, the nursing staff alerted the SSD and/or DON and they educated and reminded Resident 57 about the smoking rules. Nursing staff should monitor for smoking behaviors and complete an entry in the behavior book kept at the nurse's station. It is not documented as part of the resident's clinical record. He indicated on the first offense of finding resident's smoking in their room, staff will talk to them and most likely take away their smoking supplies and lock them up at the nurse's station			

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	for safety. During an interview on 1/24/24 at 11:39 A.M., the Administrator indicated staff were supposed to go by the smoking assessments to determine if a resident was a "safe smoker" and won't smoke in their room but it was a struggle at this facility. During an interview on 1/25/24 at 11:25 A.M., the Director of Nursing (DON) indicated Resident 57 had been caught multiple times smoking/vaping in his room. At that time, she indicated that he should not have smoking supplies on his person. 2. On 1/22/24 at 9:38 A.M., Resident 25's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, epilepsy, anxiety, depression, psychotic disorder, and schizophrenia. The most recent Annual and State Optional MDS (Minimum Data Set) Assessment, dated 11/14/23, indicated a severe cognitive impairment, and one fall with no injury. Resident 25 required limited assist of one staff with bed mobility and transfers, extensive assist of one staff with toileting, and setup with supervision with eating. A current falls care plan, initiated 2/2/23, included, but was not limited to, the following interventions: Keep resident in high traffic area when up, dated 3/17/23. Pressure pad alarm to chair, dated 12/13/23. Put alarm box out of site, dated 12/28/23. A falls risk assessment, dated 6/23/23, indicated Resident 25 was a high risk for falls. Progress notes included, but were not limited to,			

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	the following: 9/25/23 at 5:00 P.M. "Resident readmitted to facility from [hospital psychiatric stay]. Follow all physician orders from transfer and ancillary orders ..." 9/29/23 at 5:07 P.M. "Resident sitting in dining room. Alert with forgetfulness ... Calls for assist before getting up with walker due to dizziness ..." 10/7/23 at 8:16 A.M. "resident was up in dining room for breakfast complained of dizziness routine Tylenol [pain reliever and fever reducer] and Neurontin [anticonvulsant and nerve pain medication with main side effect of dizziness] given appetite good went back to room after toileting n [sic] room at this time no distress noted no complaints" Fall 1 10/8/23 at 12:02 P.M. "resident was coming out of bathroom in room had gripper socks on walker by bathroom door [sic] told cna that resident went down to knees due to dizziness resident [sic], resident assessed head to toe no injuries neurological checks started able to move all extremities complained of dizziness, resident did not eat breakfast this morning did take medication ... intervention toilet resident before lunch" 10/8/23 at 1:12 P.M. "resident complained of dizziness comes an [sic] goes pain scale a 2 does not want anything at this time" 10/9/23 at 10:18 A.M. "IDT [Interdisciplinary Team] met this day during clinical and discussed incident to where resident had taken himself to the bathroom, lost balance/become dizzy and went to knees. This incident happened before lunch. Staff intervened with toileting resident before meals.			

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	Will c/t [continue] with current intervention ..." Fall 2 12/3/23 at 11:00 A.M. "this nurse entered residents room found resident on floor by window no [sic] knees had shoes on and matt [sic] beside bed resident stated was looking for nephews outside resident has psychotic disturbances head to toe complete sight bruising left forearm old bruisingright [sic] hip neurological checks started ... matt [sic] removed for intervention" 12/4/23 at 10:08 A.M. " IDT met this day during clinical and discussed residents recent incident that occurred on 12/3 and plan of care related to falls. On 12/3 resident had been in bed, got up and tripped over bedside matt [sic] and fell. Removed bedside matt [sic] and adjusted plan of care d/t [due to] bedside matt [sic] being a contributing factor in this incident ..." Fall 3 12/12/23 at 6:11 P.M. "Resident has been confused with unstable gait. Resident was ambulating in hallway without walker or assistance. Small laceration above left eye, order obtained for triple antibiotic ointment for a week to area ... Neuro checks initiated. Pressure alarm placed as intervention to increase safety of resident. No neuro deficits noted ..." 12/12/23 at 7:26 P.M. "Resident sleeping soundly in bed. Fall follow up cont [continues] ... Gait unsteady ..." 12/13/23 at 10:32 A.M. "IDT met this day during clinical and discussed residents incident that occurred on 12/12. Resident had gotten up from bed and fell. Staff placed pressure pad alarm on bed to alert staff when attempting to get out of			

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	bed. Pressure pad alarm is an appropriate intervention at this time ..." Fall 4 12/13/23 at 6:17 A.M. "Resident's bed alarm was sounding and staff went to answer it when the resident was found laying on his right side on the floor in between his bed and the wall. A laceration noted on his right head. Pressure was applied. [doctor] was notified and new order noted to send to ER [emergency room] for eval [evaluation] and treat [treatment]. EMT's [emergency medical technician] loa [leave of absence] with resident per stretcher at 5:20 A.M. Report given to ER nurse" 12/13/23 at 9:39 A.M. "resident returned from [hospital ER] residents abrasion not cleaned had blood on face and neck resident toileted and cleaned abrasion area no complaints at this time resident eating some breakfast continue with neuro checks head to toe complete has small abrasion to left knee and right elbow small skin tear will continue to monitor" Fall 5 12/28/23 at 4:23 P.M. "Heard noise et upom [sic] looking in hall pt [patient] on floor laying on rt [right] side. Area noted on rt side of forehead above rt eye. sm [small] laceration noted approx [approximately] 0.2 x0.1 in [inch] middle of abrasion 2x3 x 0.5. Cleansed with NS [normal saline]. Ice applied. Neuro checks ... New order to send to er to eval et treat ..." 12/28/23 at 4:26 P.M. "Resident put on 15 min checks and alarms out of residents sight. Forehead cleansed with ns and ice packs applied" 12/28/23 at 5:30 P.M. " Resident returned to			

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	facility via facility transport. Nurse from ER reported a CT of head was done and is negative no new orders received at this time" 12/29/23 at 12:06 P.M. "IDT met this day and discussed residents fall from 12/28 and plan of care related to falls. Resident had turned pressure pad alarm off and was running down hallway and fell. Staff placed resident on 15 minute safety checks. Will c/t with 15 minute checks through the 1st of year to monitor resident for safety ..." Fall 6 1/22/24 1:19 P.M. "Resident was in diniong [sic] room got up from table started went in circle [sic] started to stumble knocked food off table then fell on floor did not hit head able to move all extremities resident was toileted ... intervention to find out if resident finished then walk back to chair after meals" 1/23/24 at 8:49 A.M. IDT Note "Reviewed resident's incident that occurred on 1/22. Resident had been at dining room table and got up from table, lost balance, stumbled and fell. Resident has a decrease in safety awareness and requires hands on assistance with transfers at times. Staff to ask and anticipate when resident finished with meal and assist resident away from table when finished ..." On 1/22/24 at 10:58 A.M., Resident 25 was observed sitting in a recliner in the dining area on an alarm. The alarm box was observed on and sitting on the floor under the recliner. On 1/22/24 at 12:41 P.M., Resident 25 was observed sitting at a table in the dining room. The resident stood up and immediately fell to the floor, knocking his food tray off the table on the way			

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	down. There were two staff members in the dining room at the time of the fall. Both nurse and CNA (Certified Nurse Aide) were with other residents assisting them to eat, and unable to reach Resident 25 in time. An alarm was not sounding. On 1/23/24 at 9:35 A.M., Resident 25 was observed lying in bed on an alarm pad. At that time, Registered Nurse (RN) 2 checked the alarm box and it was observed to be off. At that time, RN 2 indicated the alarm should have been turned on. On 1/23/24 at 10:36 A.M., Resident 25 was observed sitting in a recliner in the dining area with no pad alarm. On 1/26/24 at 10:59 A.M., Resident 25 was observed sitting in a recliner with a pad alarm in the dining area with a walker beside him. The alarm box was observed on and sitting in a cup that was affixed to the walker. The alarm box was within sight and reach of the resident. 3. On 1/22/24 at 10:09 A.M., Resident 127's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety and depression. The most recent Quarterly and State Optional MDS Assessment, dated 11/10/23, indicated a severe cognitive impairment, and required setup with supervision for all activities of daily living. A current falls care plan, initiated 1/11/24, included, but were not limited to, the following interventions: Bed/chair alarm at all times, dated 1/11/24. A falls risk assessment, dated 1/11/24, indicated Resident 127 was a moderate risk for falls.			

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	Progress notes included, but were not limited to, the following: Fall 1 1/11/24 at 3:05 A.M. "cna was doing rounds entered residents room and found resident sitting on the floor next to bed ... skin tear noted to left thumb ... bed alarm put in place as immediate intervention ..." 1/11/24 at 11:38 A.M. "IDT met this day during clinical and reviewed residents incident that occurred earlier this morning and plan of care r/t [related to] falls. Resident has been confused and has required more assist with care since returning to facility from recent hospital stay at [inpatient psychiatric hospital]. Staff has made more frequent safety checks on resident. After incident, a pressure pad alarm was applied to residents bed and chair d/t [due to] a decrease in safety awareness ..." Fall 2 1/22/24 at 8:27 A.M. "cna walking by residents room noted resident sitting on edge of bed when entering room resident slid off bed, resident was wet toileted ... intervention to toilet resident at 6 am" 1/23/24 at 8:40 A.M. IDT Note "Reviewed resident's incident that occurred on 1/22. Resident has been disoriented since upon return from [inpatient psychiatric hospital]. Resident has pressure pad alarm in place d/t decreased safety awareness and unsteady gait. Alarm in place and functioning at time of incident. Resident was sitting on side of bed and had been incontinent of urine and was attempting to get up OOB [out of bed] when slid off bed. Resident needs assist with toileting and/or incontinent care. Staff to offer,			

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	encourage and assist with toileting q [every] AM around am [sic] ..." On 1/22/24 at 1:02 P.M., Resident 127 was observed sitting int he dining area in a chair with no alarm on. She was observed getting up and down in different chairs as well as moving those chairs around the dining area. The nurse and aide were both assisting other residents down the hall with no other nursing staff near the resident. On 1/23/24 at 9:24 A.M., Resident 127 was observed sitting in the dining area in a wheelchair with no alarm. She had one sock on and was holding the other one in her hand. On 1/23/24 at 11:13 A.M., Resident 127 was observed sitting in the dining area. At that time, CNA 91 indicated they were unsure if Resident 127 was supposed to have an alarm on in the wheelchair or not, and was only aware of the one required in the bed. RN 2 was then overheard telling CNA 91 that Resident 127 required a pad alarm in the wheelchair. On 1/24/24 at 1:48 P.M., Resident 127 was observed sitting in the dining area with fuzzy socks on without grippers on the bottom. 4. On 1/24/24 at 10:48 A.M., Resident 178's clinical record was reviewed. Diagnosis included, but was not limited to, dementia and traumatic brain injury. The most recent significant change MDS (minimum data set) Assessment, dated 11/10/23, indicated a severe cognitive impairment and no falls. Physician orders included, but were not limited to, the following: Change batteries in alarm every 30 days, dated			

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	6/12/23. Dycem (non-slip matting) to chair, dated 2/1/23. A falls care plan, dated 12/16/22, included, but was not limited to, the following intervention: Pull alarm when up in chair, dated 3/1/23. Keep in high traffic area when up, dated 8/31/23. Progress notes included, but were not limited to, the following: 10/23/23 at 1:00 A.M. Resident was out in the hall crawling. Placed in high back wheel chair and taken by the nurses station. Fall 1 10/31/23 at 1:00 A.M. Resident was found on floor pad by low bed with hive type areas on buttocks. Moaned when put back to bed and range of motion done to left arm, but unable to tell if pain in elbow or shoulder. Will report to day nurse and follow up. Fall 2 11/6/23 at 1:37 P.M. "Nurse noted resident to be in room on floor. Was previously in geri chair in room. Nurse assessed resident, resident c/o [complained of] severe back pain, nurse notified NP, order received to send to ER for eval r/t [related to] back pain. [hospital EMS] contacted. First responders showed up, assessed resident, resident not wanting to go in for eval, first responders said no need to go ... Staff re-educated on not leaving resident in room in chair d/t [due to] safety purposes. Resident to be in high traffic area when up. Resident family aware" 11/7/23 at 9:44 A.M. "IDT [interdisciplinary team] met this day and discussed residents recent			

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	incident that occurred in room. Resident was in room in geri chair unattended and had fallen. Staff re-educated on not leaving resident unattended in room while in chair. Resident family and NP aware" On 1/24/24 at 2:41 P.M., a current non-dated Fallen Resident policy was provided and indicated "Upon observing a fall, or finding a Resident who has fallen, the Resident will be assessed for injuries and emergency care provided. To assess a Resident (noted to have fallen) for injuries and provide treatment, as indicated" The policy did not include information about following or updating care plans as needed. On 1/24/24 at 2:41 P.M., the Administrator provided a current Smoking Policy, dated 8/2018, and indicated " ... The facility's leadership will establish and enforce a specific smoking policy for residents and visitors, outlining the parameters under which residents, visitors, and employees may be permitted to smoke on the facility's property ... Residents, employees and/or visitors may smoke only in those areas which have been approved and identified as a designated smoking area (this includes e-cigarettes) ... each resident will be supervised ... unless deemed a "safe smoker" per the safe smoking evaluation form ... Residents who choose to utilize devices such as the electronic cigarette or e-cigarette are subject to this same policy ... Residents who have been assessed as "safe smokers" will be permitted to keep their smoking materials (lighter, cigarettes, etc) in their rooms and/or on their person. Any "safe smoker" who fails to follow the smoking policy ... will be re-assessed by the Inter Disciplinary Team (IDT) and may be			

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	re-categorized as a supervised smoker ... Any "safe smoker" who is observed or has been determined to be utilizing ignition materials in an unsafe manner will immediately be re-categorized as a supervised smoker, and will no longer be permitted to carry or keep their smoking materials on their person or in their room, and could potentially receive a discharge from the Facility as well ... A resident's failure to comply with the facility's Smoking Policy may result in progressive action(s) up to and including discharge. Progressive actions may include, but are not limited to: installing a wireless cigarette smoke detector in the resident's room/bathroom. Random searches of the resident's room/person. Performing searches of person and property upon return from LOAs [leave of absences]. Room change to ease monitoring. One-on-one supervision. Monitored/supervised visits, if it is suspected visitors are supplying smoking materials ...Smoking by any person, including, without limitation, residents, employees or visitors, in non-designated areas of the building or on facility property, is strictly prohibited ... " 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must			

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	ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure residents incontinent of urine received incontinence services and assistance. Residents were observed saturated with urine at the end of night shift for 2 of 5 residents reviewed for incontinence care. (Resident B, Resident E) Findings include: 1. On 1/18/24 at 5:22 A.M., Certified Nurse Aide (CNA) 15 was observed assisting Resident B out of bed and with toileting. Resident B walked into the bathroom and CNA 15 removed the incontinence pad which was observed saturated with urine. CNA 15 then assisted the resident	F 0690	**F690** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** Nursing staff educated on timely toileting and incontinence care. Staff schedule reviewed to ensure appropriate number of staff scheduled to provide care to residents. **How Other Residents Having the Potential to Be Affected by The Same Deficient Practice Will Be Identified and What**	02/23/2024

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	with a clean and dry incontinence pad. At that time, CNA 15 indicated she had been the only CNA on two halls (20 residents) and had not had time to provide incontinence care to all residents by herself. On 1/25/24 at 10:21 A.M., Resident B's clinical record was reviewed. Diagnosis included, but were not limited to, bipolar disorder and dementia. The most recent Quarterly and State optional MDS (Minimum Data Set) Assessment, dated 11/12/23, indicated a severe cognitive impairment, and extensive assistance of one staff for toileting. Resident B was frequently incontinent of urine. A current bladder incontinence care plan, initiated 5/1/20, included but was not limited to, the following interventions: Assist resident with toileting as needed, dated 5/3/20. Check for incontinence and assist with toileting as needed, dated 5/3/20. 2. On 1/18/24 at 6:14 A.M., CNA 15 was observed providing incontinence care for Resident E. When Resident E's incontinence pad was removed, it was observed to be saturated with urine. On 1/25/24 at 10:12 A.M., Resident E's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety and depression. The most recent Quarterly and State Optional MDS Assessment, dated 11/16/23, indicated a severe cognitive impairment, frequently incontinent of bladder, and required extensive assistance of two staff with toileting, bed mobility,		**Corrective Action(s) Will Be Taken:** All residents have the potential to be affected. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** Nursing staff in-serviced on incontinence care and toileting. Nursing schedule reviewed and adjusted as needed to ensure appropriate number of staff scheduled to provide care to residents. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** DON/designee will audit incontinence care on all shifts and conduct resident and staff interviews to ensure resident needs are being met. Above will be done 3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. **Date of Completion: 02/23/2024**	

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	and transfers. A current bladder incontinence care plan, initiated 7/18/23, included but was not limited to, the following interventions: Assist resident with toileting as needed, dated 7/18/23. Check for incontinence and assist with toileting as needed, dated 7/18/23. A grievance form, dated 11/22/23, indicated a concern that staff was not answering call lights, and a resident was concerned related to a CNA indicating to her that she was passing trays and unable to change her. Anonymous staff interviews during the survey included the following: There was not enough time for one CNA to get everything done on their shift, so many times the residents were left soiled. Due to a lack of staff, residents were left in urine because the staff that were working did not have enough time to change them. On 1/25/24 at 10:58 A.M., a current non-dated Application of Incontinent Briefs policy was provided and indicated "Incontinent Residents must be assess [sic] frequently to ensure that they are not wet or soiled for prolonged periods of time" This citation relates to complaint IN00424807. 3.1-41(a)(2)			
F 0725 SS=E	483.35(a)(1)(2) Sufficient Nursing Staff			

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Bldg. 00	§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. §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, interview, and record review, the facility failed to ensure sufficient and competent nursing staff was provided for 1 of 3 units reviewed, 2 of 6 resident council meetings reviewed, and 2 of 2 resident grievances reviewed. Incontinence care was not completed, hospice orders were not in place, interventions were not followed resulting in falls, notification was not completed following significant changes, and the unit was observed to not be sufficiently staffed. (A/B Unit)	F 0725	**F725** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** Facility reviewing nursing schedules and attempting to hire nursing staff as indicated to provide appropriate number of staff on all units including dementia care unit in attempts to ensure all	02/23/2024

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	Findings include: 1. During the survey dates of 1/16/24 through 1/26/24, the following anonymous staff interviews were completed: a. Many days, there is a lot of charting to do after a shift due to lack of time to complete it during the shift. I have stayed 1 1/2 to 2 hours over just to chart. There is often only one nurse on A/B, and 2 aides which is not enough. We need one nurse and two aides per hall. b. There is not enough staff to properly care for the residents. Several times, what is on the staffing sheet and who is actually here working are very different. c. Not all of our tasks can get done due to not enough staff. Whether it's passing ice, making beds, or changing linens, something is not getting done. Toileting all of the residents is not possible. Many residents sit in urine because there is not enough staff to change everyone. d. Family members observe the lack of care due to lack of staffing, but the staff do try. e. The lack of staff is not safe for residents. With the alarms going off, staff cannot get to all of them. f. There is no time to do your job when you have alarms going off and have to choose who you let fall because there is not enough staff. Residents are not clean and dry at the beginning of the shift because there is not enough staff to change everyone. One nurse cannot help both halls during meals and at supper time, not all residents		residents needs are being appropriately meet and resident supervision provided as needed. **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 have the potential to be affected. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** Facility continues to educate and hire new staff. Nursing schedule reviewed and adjusted as needed to ensure resident's needs appropriately met. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** DON/ADON/designee will monitor progress to ensure compliance and appropriate measures are in place 3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan	

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	can be fed. Trays end up on the floor, and there's not enough staff to be able to encourage those residents that need encouragement to eat. You try to cover a lot of holes, and it's impossible. It causes a lot of stress. The staff member was tearful during the interview. g. There is not enough staff. Showers are not getting done because we cannot get to them. Residents are not being changed properly, and staff feel as if they cannot ask for more help because they are treated like it's their fault that they cannot get everything done. 2. On 1/18/24 at 5:21 A.M., the A/B (Locked Dementia) Unit was observed with one nurse and one aide. At 6:00 A.M., two nurses and one aide came in for the day shift. At that time, staff indicated another aide would be in at 8:00 A.M. 3. On 1/22/24 at 10:32 A.M., the A/B Unit was observed with 23 residents. There were two residents that required a full body lift for transfers, and 10 total residents that required assistance of two staff for activities of daily living. At that time, Certified Nurse Aide (CNA) 7 indicated there was currently one nurse and two aides for both halls combined, but would require one nurse and four aides to be fully staffed. 4. The following observations were made on the A/B Unit during the survey: a. On 1/22/24 at 12:41 P.M., there was one aide and one nurse observed on A Hall, both assisting residents to eat. At that time, Resident 25 was observed to stand up from the table and fall. Neither staff member was able to get to the resident in time to prevent the fall. At that time, the residents that were being assisted to eat had		adjusted accordingly. **Date of Completion: 02/23/24**	

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	to stop eating so that the staff on the floor could tend to the fallen resident. Following the incident, CNA 15 assisted Resident 25 to the shower room to get cleaned up, and RN 9 was in the nurses station notifying appropriate parties and charting on the incident. At that time, Resident 127 was observed getting up out of her chair, setting off a pad alarm. There was no nursing staff on the unit. b. On 1/25/24 at 2:28 P.M., the A Hall was observed with one aide on the unit and no nurses. CNA 59 was observed in the dining area redirecting two residents at the same time that were both on pad alarms and getting up to walk around. There was no other staff on the unit to assist other residents. c. On 1/26/24 at 11:10 A.M., Resident 28 and Resident 54's beds were observed not made. 5. On 1/17/24 at 2:00 P.M., the following Resident Council minutes were reviewed: a. Meeting held on 9/26/23: Resident indicated it took too long to answer the call light, and usually took between 30-45 minutes for staff to come. Resident questioned why staff did not answer the call light at night. b. Meeting held on 10/26/23: Resident indicated he was not receiving medications on time. 6. On 1/17/24 at 2:00 P.M., the following Grievances were reviewed: a. 11/22/23 Resident was concerned that a staff member was not answering the call light. "Resident stated that CNA told her that she was passing trays and was unable to change her"			

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	b. 11/30/24 Resident indicated it took a while to answer call lights, and sometimes staff would walk right past the room when the call light was on. 7. The lack of sufficient nursing staff resulted in lack of notification following a significant change of status. Cross reference F580. 8. The lack of sufficient nursing staff resulted in not implementing interventions as per care plans. Cross reference F656. 9. The lack of sufficient nursing staff resulted in lack of incontinence care for the dependent resident. Cross reference F690. 10. The lack of sufficient nursing staff resulted in accidents related to falls. Cross reference F689. 11. The lack of sufficient nursing staff resulted in lack of communication with hospice services. Cross reference F849. On 1/26/24 at 12:30 P.M., the Director of Nursing (DON) indicated the A/B Unit generally required one nurse and two aides on each hall depending on the acuity of residents. She indicated the facility was currently experiencing several call-ins and hiring staff had been difficult. She indicated second shift especially had diminished on the A/B Unit recently.			

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	A staffing policy was requested and not provided. 3.1-17(a)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, interview, and record review, the facility failed to ensure residents were free of significant medication errors for 1 of 1 insulin administration. The nurse failed to prime the insulin pen before administering insulin to a resident. (Resident 60) Finding includes: On 1/18/24 at 7:11 A.M., LPN (Licensed Practical Nurse) 20 was observed administering insulin to Resident 60. LPN 20 applied the needle, dialed the Lantus SoloStar Pen to 7 units without priming the pen, put on gloves and administered the insulin into Resident 60's abdomen. LPN 20 opened another Lantus SoloStar Pen to finish the dose of medication, applied a needle, dialed the pen to 31 units without priming the pen, put on gloves and administered the insulin into Resident 60's abdomen. On 1/23/24 at 9:19 A.M., Resident 60's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II. The most recent Annual MDS (Minimum Data Set) Assessment, dated 11/4/23, indicated Resident 60's cognition was moderately impaired and the resident received insulin. Current Physician's Orders included, but were not	F 0760	**F760** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** LPN 20 educated on priming insulin pen before administering insulin to resident. All nurses are educated on appropriate insulin administration including Lantus, SoloStar Pens. Resident 60 now receives insulin appropriately per guidelines. **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 have an order for insulin have the potential to be affected. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** Nurses will be in-serviced and educated on appropriate procedures for administering	02/23/2024

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	limited to, the following: Lantus SoloStar Insulin, inject 38 units subcutaneously once daily in the morning, ordered 1/2/24 On 1/25/24 at 1:52 P.M., the DON (Director of Nursing) provided the last in service regarding giving insulin through a pen and the attendance sheet, dated 5/26/23, and LPN 20 was in attendance. During an interview on 1/25/24 at 11:25 A.M., the DON indicated she would expect priming of an insulin pen before administering insulin dose to the resident. A current Lantus SoloStar pen package insert from the manufacturer, dated 8/2022, indicated " ... Dial a test dose of 2 Units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test dose ... " On 1/16/24 at 10:30 A.M., a current Medication Administration Policy, revised 1/1/13, was provided by the Administrator and indicated " ... Follow manufacturer medication administration guidelines ... " On 1/24/24 at 2:41 P.M., a current Insulin Administration Policy, revised September 2014, was provided by the Administrator and indicated " ... The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system(s) prior to their use ... "		insulin to include insulin pens. Audits will be completed to ensure on-going compliance. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** DON/ADON/designee will monitor progress to ensure compliance and appropriate measures in place 3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. **Date of Completion: 02/23/24**	

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	3.1-48(c)(2)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility 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 and interview the facility failed to ensure all the freezers in the kitchen had thermometers in them and temperature logs filled out for 1 of 1 kitchen observations. The ice cream freezer did not have a thermometer in it and the freezer in dry storage lacked a temperature log for January 2024. (Kitchen) Findings include: On 1/16/24 at 10:02 A.M., the following was observed in the kitchen:	F 0812	**F812** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** The Dietary Manager will ensure that all freezers, in the kitchen, will have thermometers in place and up to date temperature logs. No residents were found to have been affected by the deficient	02/23/2024

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	no thermometer in the ice cream freezer no temperature log for the freezer in dry storage for January 2024 During an interview on 1/25/24 at 2:07 P.M., Kitchen Staff 27 indicated all of the freezers and refrigerators in the kitchen should have a thermometer in them, and they should all have a temperature log to write temperatures on daily. On 1/25/24 at 2:58 P.M., a current Record of Refrigeration Temperatures policy, not dated, was provided by the Administrator and indicated " A daily record is to be kept of refrigerated items. The Dietary Manager is to assign an employee to daily record all refrigerator and freezer temperatures". 3.1-21(i)(2) 3.1-21(i)(3)		practice. **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 have the potential to be affected; no other residents were identified as affected by this alleged deficient practice. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** Dietary staff educated on ensuring thermometers are in place in freezers and temperatures checked and documented as required. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** The dietary manager/designee will audit freezers on her scheduled work days,3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted	

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			accordingly. **Date of Completion: 02/23/2024**	
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: §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.			

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	§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, 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 interview and record review, the facility failed to ensure a complete and accurate facility assessment for 1 of 1 reviewed based on the resident population and identification of resources needed to provide the necessary care and services required for their residents. Finding includes: On 1/17/24 at 10:00 A.M., the Administrator provided a facility assessment form dated 1/16/24. The form listed general staff as Licensed Nurses, direct care staff, and other, but lacked specific	F 0838	**F838** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** The facility is aware of the requirement to complete a Facility-Wide Assessment. A Facility-Wide Assessment document has been reviewed and updated and all management	02/23/2024

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	staff titles and lacked the staffing plan to ensure sufficient staff were in the building to meet the needs of the residents. The form lacked training topics and competencies specific to the facility, and only listed those trainings and competencies included in the facility assessment template. All physical environment and building/plant needs listed were those in the template, and not specific to the facility. On 1/23/24 at 2:23 P.M., the Administrator indicated the facility assessment was completed using a template, and only those areas with blanks were filled in. She indicated she was unsure how to completely and accurately complete the facility assessment. At that time, she indicated the facility did not have a policy related to the facility assessment, but followed the online template for filling it out.		personnel were in-serviced on the requirements and expectations of said requirement. No residents were found to have been affected by the deficient practice. **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 have the potential to be affected; no other residents were identified as affected by this alleged deficient practice. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** All management personnel were in-serviced on the requirements and expectations of completing a Facility Wide Assessment. The QAPI Committee will review and update the Facility-Wide Assessment as frequently as needed, but no less frequently than annually. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** Discussion related to the Facility-Wide Assessment will be added to the Morning Meeting agenda. The task associated with the completion of the Facility-Wide	

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			Assessment no less frequently than annually has been added to a MASTER facility calendar to ensure it will be completed in a timely manner. **Date of Completion: 02/23/2024**	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in			

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	compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on observation, interview, and record review, the facility failed to ensure complete and accurate documentation of resident records for 1	F 0842	**F842** **What Corrective Action(s) Will Be Accomplished for Those**	02/23/2024

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	of 2 residents reviewed for nutrition, and 1 of 2 residents reviewed for restorative nursing program. (Resident 54, Resident 7) Findings include: 1. On 1/22/24 at 10:02 A.M., Resident 54's clinical record was reviewed. Diagnosis included, but was not limited to, dementia. The most recent Annual and State Optional MDS (Minimum Data Set) Assessment, dated 11/4/23, indicated a severe cognitive impairment, and no weight loss. Current physician orders included, but were not limited to: Monthly weight every 1st of the month, dated 7/1/21. A current potential for nutritional problems related to dementia care plan, initiated 5/10/21, indicated, but was not limited to, the following interventions: Monitor/record/report to MD as needed for signs and symptoms of emaciation ... significant weight loss: 3 pounds in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months, dated 11/16/21. Weights as ordered and as needed, dated 11/16/21. Weights from October 2023 through current included the following: 1/7/2024 09:16 146.9 Lbs Standing (8.24% loss in three months) 1/5/2024 13:39 147.8 Lbs Standing 1/1/2024 07:49 146.8 Lbs Standing 12/1/2023 07:57 153.6 Lbs Standing 11/1/2023 09:54 157.1 Lbs Standing 10/2/2023 15:39 160.1 Lbs Standing		**Residents Found to Have Been Affected by The Deficient Practice:** Resident 54 clinical record updated to reflect current weight and MD and RD notifications as needed. Resident 7 orders updated to reflect discontinuation of splint usage. Dedicated restorative CNA now working with MDS to ensure restorative orders being followed. **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 have the potential to be affected. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** Staff educated on documenting, reporting, and following physician orders. Audits completed to ensure weights documented and reported and splints in place as per orders. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** DON/ADON/designee will monitor progress to ensure compliance and appropriate measures in place 3 times per week times 4 weeks, then 2 times per week times 4	

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	On 1/23/24 at 10:30 A.M., Certified Nurse Aide (CNA) 33 was observed to weight Resident 54. Weight at that time was 143.7 pounds (3.2 pounds less that previous weight on 1/7/24). The weight obtained was not put into the clinical record, and no one was notified of the new weight. On 1/24/24 at 2:21 P.M. the RD (Registered Dietician) indicated Resident 54's weight that was obtained on 1/23/24 should have been charted and communicated to the DON (Director of Nursing), RD, and physician. 2. On 1/22/24 at 1:38 P.M., Resident 7 was observed during a smoke break without splints on his hands. On 1/23/24 at 2:23 P.M., Resident 7 was observed in the common area watching TV without splints on his hands. On 1/19/24 at 10:19 A.M., Resident 7's clinical record was reviewed. Diagnoses include, but were not limited to, traumatic brain injury and hemiplegia affecting right dominant side. The most recent Annual MDS Assessment, dated 11/22/23, indicated Resident 7 was cognitively intact, had impairment of both upper and both lower extremities, and totally dependant on 2 staff for toileting, transfers, and bed mobility. Current Physician's Orders included, but were not limited to, the following: Resident to have on bilateral resting hand splints on in the afternoon for 2-4 hours , dated 7/20/23 Observe for increased weakness and development of contractures and/or worsening of contractures on right side of body, dated 8/24/22		weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. **Date of Completion: 02/23/24**	

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	A current Restorative Program care plan, revised 2/19/19, included, but was not limited to the following interventions: Resident to have bilateral resting hand splints on in the afternoon for 2-4 hours or as tolerated, initiated 7/20/23 The January 2024 MAR was reviewed and the following was found: 1/22/24 Resident 7 had the splints put on at 1:00 P.M. and taken off at 5:00 P.M. 1/23/24 Resident 7 did not have the splints put on at 1:00 P.M. but they were taken off at 5:00 P.M. During an interview on 1/23/24 at 2:23 P.M., anonymous staff indicated putting the splints on Resident 7 was the nurse's responsibility and they should be put on after lunch and off two to four hours after. At that time, anonymous staff observed the splints were not on Resident 7 and she not able to find them. During an interview on 1/26/24 at 11:33 P.M., anonymous staff indicated staff have been documenting that he wears them but he doesn't. At that time, they indicated if it wasn't done, it should not be documented in the clinical record and she wasn't sure why it was being documented inaccurately. On 1/24/24 at 2:41 P.M., a current non-dated Charting and Documentation policy was provided and indicated "Nursing notes on each Resident shall be written by licensed nurses or nurse aides and shall address the Resident's condition ... Sufficient progress information should be addressed in an effort to meet the Resident's needs"			

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	3.1-50(a)(2)			
F 0849 SS=D Bldg. 00	483.70(o)(1)-(4) Hospice Services §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of			

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	care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of			

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	the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following:			

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	(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping			

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	requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. Based on observation, interview, and record review, the facility failed to follow 2 of 2 hospice contracts to ensure communication from the Hospice providers were available for the facility staff. Hospice diet orders were not put into place when ordered, and hospice communication was not available for review on a unit with a Hospice resident. (Resident 28, Resident 178) Findings include: 1. On 1/22/24 at 9:49 A.M., Resident 28's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety, and depression. The most recent Significant Change MDS (Minimum Data Set) Assessment, dated 12/28/23, indicated a severe cognitive impairment, extensive assistance of two staff with bed mobility, transfers, and toileting, total dependence of one staff with eating, and hospice services while a resident. Current physician orders included, but were not limited to, the following: Admit to [Hospice B], dated 12/29/23	F 0849	**F849** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** Hospice diet and code status orders reviewed and confirmed. Hospice communication binder was located during the annual state survey in the social services office. SSD reported that Heart to Heart Hospice was behind on getting the communication binders to the facilities. Communication binder was immediately taken to the unit where resident 28 resides. **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 have the potential to be affected; no other residents were identified as affected by this alleged deficient practice. **What Measures Will Be Put into**	02/23/2024

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	Resident 28's clinical record lacked any hospice notes or assessments. Hospice communication could not be located on the unit. On 1/22/24 at 1:06 P.M., Hospice Aide 77 was observed preparing a shower for Resident 28. At that time, Resident 28 was observed sitting in a high back wheelchair in the common area. Hospice Aide 77 indicated the only information she filled out before leaving the facility was a shower sheet that was placed in the shower binder at the nurses station. She was unsure of what information the nurses left on their visits. At that time, Registered Nurse (RN) 9 indicated the hospice nurse came once a week for Resident 28, and was unsure where they leave their summary for the visits. She indicated there was no written form of communication for that hospice company on the unit, and the nurses did not leave any type of communication with them after their visits. 2. On 1/24/24 at 10:48 A.M., Resident 178's clinical record was reviewed. The resident passed away 12/17/23 at the facility. Diagnosis included, but was not limited to, dementia and traumatic brain injury. The most recent Significant Change MDS Assessment, dated 11/10/23, indicated a severe cognitive impairment, and hospice services while a resident. Physician orders included, but were not limited to, the following: A hospice certification and plan of care, dated 11/1/23, indicated resident was a DNR. An order from Hospice A, dated 11/6/23, indicated		**Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** Facility will get in contact with all Hospice Providers and request in-servicing with Hospice Employees and Staff to educate on the matter of "Hospice and the Facility shall communicate with one another regularly and as needed for each Hospice patient. Each party is responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day". **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** DON/ADON/designee will review each hospice facility chart to verify documentation. DON/ADON/designee will ensure that nursing staff are communicating with hospice staff and all Hospice patients' needs are met 24 hours per day. Above will be done 3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be	

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	to add comfort foods by mouth and honey thickened liquids. Additional orders from the primary medical record: CPR (Cardiopulmonary Resuscitation) - Full Code, from 12/8/22 through 12/4/23. DNR (Do Not Resuscitate), dated 12/4/23. Nothing by mouth diet, from 10/22/23 through 12/1/23. A proposed aide care plan report, dated 11/1/23, indicated resident had nectar/honey/pudding thickened liquids, and was a DNR. Resident 178's documentation survey report (summary of oral intake) from 10/2023 through 12/2023 indicated NPO and no amount eaten until 11/30/23. On 1/26/24 at 12:42 P.M., the ADON indicated hospice had not communicated admitting orders for Resident 178 when the resident was first admitted to hospice including diet orders for comfort foods. On 1/16/24 at 10:30 A.M., a current contract agreement for Hospice A was provided and indicated "The Plan of Care will be written in collaboration with the Hospice IDT, the Facility staff, the Hospice staff, Patient or the Hospice Patient's Representative and the physician, based on the he needs of the Hospice Patient. Any change in the POC [plan of care] will be discussed with the Hospice Patient or the Hospice Patient's representative, and the Facility representatives, and must be approved by Hospice before implementation ... Will collaborate with the Facility in developing ongoing Plan of Care and promptly		forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. **Date of Completion: 02/23/2024**	

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	communicating any revision orally or in writing to the Facility .... Will provide all documentation to show that services are furnished in accordance with this agreement" On 1/16/24 at 10:30 A.M., a current contract agreement for Hospice B was provided and indicated "Facility shall participate in any meetings, when requested by Hospice, for the coordination of services provided to Hospice Patients. Hospice and Facility shall communicate with one another regularly and as needed for each particular Hospice Patient. Each party if responsible for documenting such communications in its respective clinical records to ensure that the needs of Hospice Patients are met 24 hours per day" On 1/24/24 at 2:41 P.M., a current Hospice Program policy, dated 1/2014, was provided and indicated "When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the resident's current status"			
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			

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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)(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, 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			

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	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. §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 infection control practices were followed for 5 of 9 residents during observation of perineal care. Gloves were not changed between dirty and clean tasks during peri care, staff dropped gloves on the floor and picked them up and used them to perform peri care. Staff failed to sanitize hands between dirty and clean tasks and after completing peri care (Resident 16, Resident 66, Resident B, Resident 55, Resident E) Findings include: 1. On 1/18/24 at 5:22 A.M., Certified Nurse Aide (CNA) 15 was observed to provide incontinence care for Resident B. CNA 15 washed hands with a five second lather, put gloves on, then assisted the resident to the toilet. After pulling their pants and incontinence brief off, CNA 15 assisted	F 0880	**F880** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** Nursing staff educated on handwashing procedures, glove donning and doffing, appropriate disposal of soiled briefs, providing privacy during care, handling of clean linens. Nursing staff will demonstrate appropriate infection prevention and control practices as per regulations. **How Other Residents Having the Potential to Be Affected by The Same Deficient Practice Will Be Identified and What**	02/23/2024

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	Resident B to get dressed using the same gloves. CNA 15 then washed hands with a nine second lather. 2. On 1/18/24 at 5:34 A.M., CNA 15 was observed to provide incontinence care for Resident 55. CNA 15 washed hands with a nine second lather, obtained clothes from the closet, then obtained a pair of gloves from a box, dropping one on the floor. CNA 15 picked up the glove, put it on, wet a washcloth, and gave it to the resident to wash. CNA 15 then cleaned the resident's peri area, removed the gloves, and washed hands with a four second lather. CNA 15 left the room to gather supplies, and washed hands with a five second lather upon return to the room. After Resident 55 was dressed, CNA 15 put the soiled brief on the bedside table, and wheeled the resident to the common area. 3. On 1/18/24 at 6:14 A.M., CNA 15 was observed to provide incontinence care for Resident E. CNA obtained gloves from a box, dropped one, picked it up and put it on, then assisted to take off Resident E's soiled brief. CNA 15 then cleaned the resident's peri area, and put a clean dry brief on with the same gloves. Following the incontinence care, CNA 15 washed hands with a nine second lather. 4. During an observation on 1/18/24 at 5:29 A.M., CNA 26 performed perineal care on Resident 16 and failed to close the residents door or pull the privacy curtain. CNA 26 used her gloved hands to used the remote and raise the bed, pulled back the covers, removed the soiled brief, opened the clean brief and placed it under the resident with the same gloves. CNA 26 then removed Resident 16's gown and lowered the bed with the remote with the same soiled gloves.		**Corrective Action(s) Will Be Taken:** All residents have the potential to be affected. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** Infection Control and Prevention In-servicing will be done annually and on an as needed basis. All new hires will be in-serviced during the orientation process on Infection Control and Prevention. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** Infection Preventionist/designee will monitor progress to ensure compliance and appropriate measures in place 3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. **Date of Completion: 02/23/24**	

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	5. During an observation on 1/18/24 at 5:35 A.M., CNA 26 performed perineal care on Resident 66. CNA 26 donned gloves and grabbed a gown and washcloths out of the linen cart in the hallway and placed the clean linens against her shirt. CNA 26 then used her gloved hands to close the door, used the remote to raise the bed, removed the soiled brief, placed her left hand on the residents leg to help him roll, and then covered the resident with his blankets. CNA 26 then used the same gloved hands and used the remote to lower the bed and opened the residents door to leave the room. At that time, CNA 26 indicated she did not place a brief on Resident 66 because he wasn't very wet and sometimes they let him without a brief. On 1/26/24 at 11:05 A.M., the Infection Preventionist (IP) indicated if a glove were to fall to the floor, staff was expected to obtain a new one, hand washing should include lathering hands with soap for 20 seconds or more, and gloves should be changed and hands sanitized when switching from dirty to clean tasks. On 1/24/24 at 2:41 P.M., a current non-dated Hand Hygiene policy was provided and indicated "... you should continue to lather the soap over all surfaces of the hands and fingers for at least 15 seconds ... the entire hand washing process should take 40-60 seconds to complete" On 1/24/24 at 2:41 P.M., a current non-dated Non-Sterile Gloves policy was provided and indicated "Disposable gloves shall be replaced when contaminated, torn, punctured, or then their function as a barrier has been compromised" 3.1-18(b)			

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F 0921 SS=E Bldg. 00	3.1-18(l) 483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a sanitary environment for resident rooms and halls. The outside of the building had paint peeled off the frame and window frames. The water temperature on the dementia unit was hot. (A wing, B wing, C wing, D wing, E wing, I wing) Findings include: 1. On 1/16/24 from 10:39 A.M. until 11:54 A.M., the following water temperatures were observed: B Hall shower room 128.7 degrees Fahrenheit Bathroom between Room 17 and Room 18 124.0 degrees Fahrenheit Bathroom between Room 19 and Room 20 123.1 degrees Fahrenheit A Hall shower room 123.3 degrees Fahrenheit Bathroom between Room 22 and Room 23 124.3 degrees Fahrenheit 2. On 1/16/24 at 10:57 A.M., the bathroom between Room 19 and Room 20 was observed with five toothbrushes and two combs sitting behind the faucet on the sink. The resident in Room 19 indicated at that time that both her and the resident in Room 20 use that bathroom, and she did not know which toothbrush and comb was	F 0921	**F921** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** Room 19 & 20 toothbrushes & combs removed from behind bathroom faucet. Water temperatures have been adjusted. B Hall shower room wall being repaired to prevent substance leakage by baseboard. Call light has been replaced and no longer dragging the floor. B hall shower room wall have been painted and vents have been cleared of dust, door and door frame have been repaired and painted. A&B nurses station painted and repaired. B hall hallway floor tiles being repaired and/or replaced. Hallway walls are being repaired and painted. Common area walls being repaired and painted. B Hall couch removed and replaced. B Hall sliding door strip replaced and cleared of substance and debris. Common area A hall wall repaired and painted. A hall shower room baseboards cleaned, door frame repaired, walls painted. A hall	02/23/2024

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	hers. The same was observed during a walkthrough on 1/23/24 that began at 2:00 P.M. 3. On 1/16/24 at 10:39 A.M., the B Hall shower room was observed with a wall dented in with a brown substance coming out from the bottom of the baseboard by the toilet. The call light was brown and dragging the floor, and scuff marks on both sides of the wall. The vent on the right when entering the shower room as well as the ceiling vent were observed caked with dust. The shower room door and door frame were scuffed at the bottom, and the frame had missing paint and chipped wood. The same was observed during a walkthrough on 1/23/24 that began at 2:00 P.M. 4. On 1/16/24 at 10:42 A.M., the nurses station between A and B Hall was observed with scuffed walls, paint missing and chipped. The same was observed during a walkthrough on 1/23/24 that began at 2:00 P.M. 5. On 1/16/24 at 10:43 A.M., the B Hall hallway was observed with several chipped tiles throughout and part of the tile missing around a copper circle on the floor. The walls in the hall were scuffed. At the beginning of the hall, a dent with several cracks was observed measuring 6x2 inches. The same was observed during a walkthrough on 1/23/24 that began at 2:00 P.M. 6. On 1/16/24 at 10:44 A.M., the B Hall common area was observed with scuffed walls, and a		hallway tiles being repaired and/or replaced. A hall kitchen counters cleaned; door handle repaired. Room 13 baseboards cleaned, and bathroom door frame repaired, bathroom ceiling vent cleared of dust. Room 2's sink cleared of clog. Room 5 & 6 bathroom base of toilet cleaned, bathroom knob repaired. Bathroom between 23 & 24 substance between sink and tile removed, urinal & plunger removed and bagger per guidelines. Room 21 strip of floor replaced, and window curtains removed and cleaned. Outlet plate in room 5 replaced. Floor area in front of A&B halls repaired. Vent cover in dining room by C&D repaired. All listed outside windows, frames, wooden trim and air conditioner are in the process of being repaired or replaced. **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 have the potential to be affected; no other residents were identified as affected by this alleged deficient practice. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** All staff in-serviced on work order protocols. Maintenance &	

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	couch with a rip on each of the arms. The area in front of the sliding doors between the door and floor was a strip missing and filled with a brown substance and debris. The same was observed during a walkthrough on 1/23/24 that began at 2:00 P.M. 7. On 1/16/24 at 11:02 A.M., the common area on A Hall was observed with a fist sized hold in the wall under the banister. The banister was scuffed with paint missing and chipping. The same was observed during a walkthrough on 1/23/24 that began at 2:00 P.M. 8. On 1/16/24 at 11:05 A.M., the A Hall shower room was observed with a black and brown substance around the baseboards. A crack was observed around the inside of the door frame, and it was observed coming away from the wall at the bottom of the outside of the room. The wall was scuffed in front of the shower at eye level. The same was observed during a walkthrough on 1/23/24 that began at 2:00 P.M. 9. On 1/16/24 at 11:08 A.M., the A Hall hallway was observed with black and discolored parts throughout, as well as dents in the floor. The same was observed during a walkthrough on 1/23/24 that began at 2:00 P.M. 10. On 1/16/24 at 11:09 A.M., the A Hall kitchen area was observed with brown splatters under the counters, and a door handle was hanging off the door in the kitchen area by the television. The same was observed during a walkthrough on		housekeeping staff in-serviced on homelike environment and upkeep. Maintenance Director to make facility rounds to ensure ongoing compliance. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** Administrator/Maintenance Director/Designee will monitor all the capital projects such as floors, painting of facility, etc are done in a timely manner in conjunction with corporate. DON/ADON/IP/Designee will monitor that all infection control policies & procedures are being followed 3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. **Date of Completion: 02/23/24**	

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	1/23/24 that began at 2:00 P.M. 11. On 1/16/24 at 11:26 A.M., Room 13 was observed with scuffed baseboards and bathroom door frame. The bathroom ceiling vent was caked with dust. The same was observed during a walkthrough on 1/23/24 that began at 2:00 P.M. 12. On 1/16/24 at 11:31 A.M., Room 2's bathroom sink was observed to be clogged, and the water did not go down after two minutes. The same was observed during a walkthrough on 1/23/24 that began at 2:00 P.M. 13. On 1/16/24 at 11:32 A.M., the bathroom between Room 5 and Room 6 was observed with a brown and black substance around the base of the toilet, and the bathroom doorknob was not attached to the door, with a piece hanging off. The same was observed during a walkthrough on 1/23/24 that began at 2:00 P.M. 14. On 1/16/24 at 11:54 A.M., the bathroom between Room 23 and Room 24 was observed with a green substance between the sink and the tile on the wall behind it. A male urinal and a plunger were observed on the floor uncovered. The same was observed during a walkthrough on 1/23/24 that began at 2:00 P.M. 15. On 1/18/24 at 6:14 A.M., Room 21 was observed with a strip of the floor missing between the room and bathroom where there was a black substance and debris in the open area. The window curtain was observed with 7 brown			

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	smudges. The same was observed during a walkthrough on 1/23/24 that began at 2:00 P.M. 15. On 1/22/24 at 12:59 P.M., Room 5 was observed with an outlet plate cracked and missing the upper left part, exposing jagged edges by the air conditioning unit. The same was observed during a walkthrough on 1/23/24 that began at 2:00 P.M. 16. On 1/24/24 at 1:50 P.M., the area in front of A and B Halls was observed with a strip coming up from the floor and a black substance underneath it. All four sides of the "square" on the floor were observed with areas coming up from the floor. 17. On 1/25/24 at 2:12 P.M., the vent cover in the dining room between the A/B Halls and C/D Halls was observed coming away from the wall.18. During an observation on 1/26/24 at 12:20 P.M., the following was viewed on the outside of the building: a. A wing: 11 sets of 4 windows had paint peeled off on the bottom 3 sides of the frame that meets the roof had paint peeled off of the wood in multiple places 1 wooden trim above the door to enter that wing had wood trim and paint peeled off 7 sets of air conditioner units viewed that had paint peeled off and the trim around the top of the units was peeled off. b. B wing: 1 set of 2 windows with paint peeled off 11 sets of 4 windows had paint peeled off			

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	2 sides of the frame that meets the roof had paint peeled off in multiple spots 12 sets of air conditioner units viewed with peeled paint and 1 unit was dented in c. C wing: 8 sets of 4 windows had paint peeled off 1 wooden trim above the door to enter that wing had wood trim and paint peeled off d. D wing: 8 sets of 4 windows had paint peeled off the bottom of the window frame 3 sides of the frame that meets the roof had paint peeled off of the wood in multiple places 1 wooden trim above the door to enter that wing had wood trim and paint peeled off e. E wing: 1 wooden trim above the door to enter that wing had wood trim and paint peeled off f. I wing: 5 sets of 4 windows with paint peeled off On 1/16/24 at 11:44 A.M., the Maintenance Supervisor indicated there had been an issue with the regulator that was effecting water temperatures. For a while, they had been trying to get an "even medium" for the temperatures. He indicated it had been a few days since checking them last. On 1/26/24 at 3:05 P.M., the Maintenance Supervisor indicated there were three maintenance staff that covered the entire building, and were not enough hours in the day to provide daily maintenance, preventative maintenance, and issues as they arise. He indicated because of the positioning of the building on a hill, the ground			

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	was settling and disturbing the tile floors of A and B Halls, causing them to crack. He indicated several tiles had been replaced before, but it was a temporary solution. He indicated in order to effectively fix the problem, the floor would need to be leveled and new flooring installed. He indicated the outside needed work in multiple areas, but had not been completed due to the current budget. At that time, he indicated there was not a facility policy related to maintenance. On 1/24/24 at 2:41 P.M., a current non-dated Water Temperature policy was provided and indicated "For burn prevention, federal guidelines advise that you keep domestic water temperatures below 120 degrees Fahrenheit, although this temp can still cause burns if exposure reaches five minutes" 3.1-19(a) 3.1-19(f)			
F 0926 SS=D Bldg. 00	483.90(i)(5) Smoking Policies §483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents. Based on observation, interview and record review, the facility failed to ensure the smoking policy was followed for 1 of 1 residents reviewed for smoking. A resident has been caught smoking in his room and was still considered a "safe smoker" and allowed to keep his smoking supplies on his person. (Resident 57) Finding includes:	F 0926	**F926** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** Residents & staff educated on smoking policy. Staff educated on collecting smoking materials, smoking assessments, and safe	02/23/2024

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	On 1/16/24 at 11:34 A.M., ashes were observed in the shared bathroom sink and cigarette butt floated up into the sink when the water was turned on, On 1/17/24 at 11:00 A.M., Resident 57 was observed smoking a yellow colored vape in his room. On 1/23/24 at 9:00 A.M., Resident 57's clinical record was reviewed, Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. The most recent Quarterly MDS Assessment, dated 10/17/23, indicated Resident 57 was cognitively intact and supervision of staff for bed mobility, toileting, and transfers. On 1/16/24 at 10:30 A.M., a list of smokers in the facility was provided by the Administrator and indicated Resident 57 was a smoker. On 1/26/24 at 9:00 A.M., Resident 57's January 2023 through January 2024 log of behaviors regarding smoking in his room was provided and indicated: 1/1/23 resident was smoking in his room and staff educated resident on not smoking in room, offered reassurance, and validated feelings, which was effective. 12/12/23 resident was smoking in his room, staff got Social Services Director (SSD) assistance, and educated resident on not smoking in room, which was effective. 12/18/23 resident was smoking in his room, staff got SSD assistance, and educated resident on not smoking in room, which was effective. Smoking Assessments on Resident 57 were		smokers. Resident 57 no longer has his vape in room or smoking materials kept on person. Smoking assessment updated to reflect does not keep smoking materials. **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 have the potential to be affected. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** Staff & residents educated on smoking policies. Smoking assessment reviewed and updated as needed. **How The Corrective Action(s) Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** SSD/designee will monitor progress to ensure compliance and appropriate measures in place 3 times per week times 4 weeks, then 2 times per week times 4 weeks, then weekly times 2 months, then monthly times 2 months. Any negative findings will be forwarded to the Administrator and corrected immediately and will result in re-education and/or disciplinary action. A report of progress will be forwarded to the	

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	completed on the following dates: 3/28/23-indicated resident may smoke independently (i.e. safe smoker) in designated areas, resident wishes to keep smoking materials on his person, 7/8/23-indicated resident must be supervised at all times when smoking and does not indicate whether resident may keep 10/10/23-indicated resident must be supervised at all times when smoking, resident wishes to keep smoking materials on their person (for safe smokers only), and resident had been informed of smoking evaluation results, policies, and procedures During an interview on 1/23/24 at 2:24 P.M., Resident 57 indicated they should not smoke or vape in their room but he had smoked in his room about 1-2 times per week in the morning because he wanted to smoke earlier then the first smoke break at 9:30 A.M. At that time, he indicated staff knew he smoked and vaped in his room. During an interview on 1/24/24 at 10:17 A.M., the SSD indicated the term "safe smoker" comes from the resident's smoking assessment done on admission, quarterly, and as needed and resident's also sign a "confirmation of understanding the smoking rules of this facility" on admission and as needed. At that time, he indicated the resident's short and long term memory has to be intact and be able to make decisions, should be alert and oriented and practice safe smoking techniques, have adequate hearing, vision and communication, and fine motor skills to hold and light own cigarette, and be able to communicate the risk of smoking. The nursing staff and SSD would review and decide if resident is termed a "safe smoker". At that time, he indicated that they consider vaping and smoking rules the same and		QAPI committee monthly for a minimum of 6 months and the plan adjusted accordingly. **Date of Completion: 02/23/24**	

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	if a resident is a "safe smoker" then they are permitted to keep their smoking supplies on their person but not smoke in the building. He indicated Resident 57 had been caught smoking in the building before and when this happened, the nursing staff alerted the SSD and/or DON and they educated and reminded Resident 57 about the smoking rules. Nursing staff should monitor for smoking behaviors and complete an entry in the behavior book kept at the nurse's station. It is not documented as part of the resident's clinical record. He indicated on the first offense of finding resident's smoking in their room, staff will talk to them and most likely take away their smoking supplies and lock them up at the nurse's station for safety. During an interview on 1/22/23 at 10 A.M., anonymous staff indicated a while ago, a resident on the dementia unit (no longer here) was outside with the smokers. Without staff's knowledge, he obtained a lighter and brought it inside to his room where he willingly lit a chair on fire in the room he shared with a roommate who was also in the room. During an interview on 1/25/24 at 11:25 A.M., the Director of Nursing (DON) indicated Resident 57 has been caught multiple times smoking/vaping in his room. At that time, she indicated that he should not have smoking supplies on his person. On 1/24/24 at 2:41 P.M., the Administrator provided a current Smoking Policy, dated 8/2018, and indicated " ... The facility's leadership will establish and enforce a specific smoking policy for residents and visitors, outlining the parameters under which residents, visitors, and employees may be permitted to smoke on the facility's property ... Residents, employees and/or visitors			

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	may smoke only in those areas which have been approved and identified as a designated smoking area (this includes e-cigarettes) ... each resident will be supervised ... unless deemed a "safe smoker" per the safe smoking evaluation form ... Residents who choose to utilize devices such as the electronic cigarette or e-cigarette are subject to this same policy ... Residents who have been assessed as "safe smokers" will be permitted to keep their smoking materials (lighter, cigarettes, etc) in their rooms and/or on their person. Any "safe smoker" who fails to follow the smoking policy ... will be re-assessed by the Inter Disciplinary Team (IDT) and may be re-categorized as a supervised smoker ... Any "safe smoker" who is observed or has been determined to be utilizing ignition materials in an unsafe manner will immediately be re-categorized as a supervised smoker, and will no longer be permitted to carry or keep their smoking materials on their person or in their room, and could potentially receive a discharge from the Facility as well ... A resident's failure to comply with the facility's Smoking Policy may result in progressive action(s) up to and including discharge. Progressive actions may include, but are not limited to: installing a wireless cigarette smoke detector in the resident's room/bathroom. Random searches of the resident's room/person. Performing searches of person and property upon return from LOAs [leave of absences]. Room change to ease monitoring. One-on-one supervision. Monitored/supervised visits, if it is suspected visitors are supplying smoking materials ...Smoking by any person, including, without limitation, residents, employees or visitors, in non-designated areas of the building or on facility property, is strictly prohibited ... "			

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	155042	A. BUILDING 00 B. WING	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW MANOR	3801 OLD BRUCEVILLE ROAD, BOX 136 VINCENNES, IN 47591

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 9999 Bldg. 00	7-3 STAFF TRAINING AND DEVELOPMENT PROGRAMS (a) Each facility shall provide in service training and shall require all staff working with developmentally disabled residents to attend staff development programs concerning developmental disabilities. Written records of such training shall be kept in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide in service training to staff working with developmentally disabled residents concerning their developmental disabilities. Specific in services were not provided concerning the 6 residents diagnosed with intellectual developmental disabilities and/or mental health disorders. This state finding was not met: On 1/16/24 at 10:30 A.M., the Director of Nursing (DON) provided a sheet of paper that indicated the facility had 3 residents with a intellectual and/or developmental disability. On 1/25/24 at 2:38 P.M., the Social Services Director (SSD) indicated the facility had 6 residents with a intellectual and/or developmental disability. At that time he indicated the facility had a QIDP (qualified intellectual disability professional), but was unaware of any extra in services for staff that detailed care for developmentally disabled residents.	F 9999	**F9999** **What Corrective Action(s) Will Be Accomplished for Those Residents Found to Have Been Affected by The Deficient Practice:** Facility working with QIDP and Q-Source to implement staff training and in-servicing for residents with intellectual and/or developmental disabilities. Audit completed of employee records, physical examines obtained as needed and new hires will now receive physical examinations per guidelines. **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 have the potential to be affected; no other residents were affected by this alleged deficient practice. **What Measures Will Be Put into Place and What Systemic Changes Will Be Made to Ensure That the Deficient Practice Does Not Recur:** SSD/designee will monitor on-going staff education. HR Director/designee will ensure employee physical exams completed as per guidelines. **How The Corrective Action(s)**	02/23/2024

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	During an interview on 1/26/24 at 9:55 A.M., the Administrator was unaware that in services needed to be completed related to the residents with intellectual and/or developmental disabilities and that they did not have a policy related to the QIDP. 3.1-14(t) Personnel A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. This State Rule was not met as evidenced by: Based on interview and record review, the facility failed to require newly hired staff to have a physical exam done within one (1) month prior to employment for 5 of 5 employees reviewed. Five staff members' employee records reviewed for being hired in the last year lacked a physical exam. (LPN 4, CNA 6, CNA 8, RN 10, CNA 12) Findings include: On 1/26/24 at 10:15 A.M., review of LPN 4's employee record indicated a hire date of 11/23/23 and lacked a physical exam. On 1/26/24 at 10:15 A.M., review of CNA 6's employee record indicated a hire date of 8/27/23		**Will Be Monitored to Ensure the Deficient Practice Will Not Recur:** Staff in-servicing on intellectual/developmental disabilities has been added to the facility required in-servicing material. HR Director now aware of physical exams must be completed upon hire. Administrator/designee to monitor progress to ensure on-going compliance. **Date of Completion: 02/23/2024**	

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	and lacked a physical exam. On 1/26/24 at 10:15 A.M., review of CNA 8's employee record indicated a hire date of 7/2/23 and lacked a physical exam. On 1/26/24 at 10:15 A.M., review of RN 10's employee record indicated a hire date of 9/25/23 and lacked a physical exam. On 1/26/24 at 10:15 A.M., review of CNA 12's employee record indicated a hire date of 11/13/23 and lacked a physical exam. During an interview on 1/26/24 at 10:15 A.M., Human Resources indicated they haven't required newly hired staff to get a physical exam since COVID and haven't started them back up yet. They do 2 Step tuberculin tests for new employees.			