STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155831	A. BUILDING 00 B. WING	04/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRIARCLIFF HEALTH & REHABILITATION CENTER	5024 WESTERN AVENUE SOUTH BEND, IN 46619

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00366448, IN00371389, IN00372741 and IN00375599. Complaint IN00366448 - Unsubstantiated due to lack of evidence. Complaint IN00371389 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00372741 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00375599 - Substantiated. Federal/state deficiencies related to the allegations are cited at F657 and F758. Survey dates: March 29, 30, 31, & April 1, 4, 2022 Facility number: 013420 Provider number: 155831 AIM number: 201293620 Census Bed Type: SNF: 92 Total: 92 Census Payor Type: Medicare: 6 Medicaid: 68 Other: 18 Total: 92 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	**Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Annual Survey on April 4, 2022 . Please accept this plan of correction as the provider's credible allegation of compliance.** **The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.**	

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

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	Quality review completed on 4/12/22.			
F 0570 SS=D Bldg. 00	483.10(f)(10)(vi) Surety Bond-Security of Personal Funds §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. Based on interview and record review, the facility failed to ensure the Surety Bond amount was sufficient to cover the Resident's personal fund account on a daily basis. This deficient practice had the potential to effect 91 of 91 residents in the facility. Finding includes: During an interview, on 3/31/2022 at 9:31 A.M., the Business Office Manager indicated the Surety Bond amount was $75,000 and the resident funds was $113,947.90. During an interview, on 3/31/2022 at 10:35 A. M., the Business Office manager indicated the amount was not high enough and would not cover the resident fund and would have to be increased. On 4/4/2022 at 12:10 P.M., the Corporate Nurse provided the policy titled,"Surety Bond", dated April 2017, and indicated the policy was the one currently used by the facility. The policy indicated,"...Our facility has a current surety bond or provides self-insurance to assure the security of all resident's personal funds deposited with the facility. 1. The facility holds a surety bond to guarantee the protection of residents' funds managed by the facility on behalf of its residents.	F 0570	**F 570 – Surety Bond-Security of Personal Funds** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · A bond in the proper amount to ensure resident trust funds has been obtained. **2. 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 by this practice. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not reoccur.** · Resident Trust Fund balance will be checked weekly by BOM to ensure the bond in place	05/01/2022

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	... 3. The purpose of the surety bond is to guarantee that the facility will pay the resident of losses occurring from any failure by the facility to hold, safeguard, manage, and account for the resident's funds (i.e., losses occurring as a result of acts or errors of negligence, incompetence or dishonesty)...." 3.1-6(i)		is sufficient to cover the amount of funds being held. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** · ED and BOM will monitor the resident trust fund monthly during reconciliation to ensure appropriate bond coverage in in place. **5. By what date the systemic changes for each deficiency will be completed.** · May 1, 2022	
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			

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	consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, 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 notify the physician and responsible party of the residents change in skin condition and obtain a treatment for one of one record reviewed for skin integrity. (Resident 38)	F 0580	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • The Physician was notified of resident # 38's impaired skin integrity and treatment orders	05/01/2022

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	Finding Includes: A clinical record review was completed, on 3/31/22 at 1:40 P.M., and indicated Resident 38's diagnoses included, but were not limited to: delusional disorders, retention of urine, major depressive disorders, chronic embolism, and thrombosis of deep veins of right lower extremity, and dementia without behavioral disturbances. . The record indicated the resident was admitted on 12/28/2021. An Admission MDS (Minimum Data Set) assessment, dated 1/15/2022, indicated Resident 38's BIMS (Brief Interview for Mental Status) severely impaired cognition. And it indicated he needed extensive assist with activities of daily living. On 4/1/2022 at 8:35 A.M., the progress notes, care plan, orders, and skin assessments were reviewed for 3/31/2022 and no documentation about the wound was found from the previous day. During an interview on 4/01/2022 at 8:47 A.M., LPN (Licensed Practical Nurse) 18 indicated she got in report that morning he has a new skin tear to the elbow. During an interview on 4/1/2022 at 11:03 A.M., the Director of Nursing indicated she finds out about skin condition changes by reading the 24- hour report, a staff member puts a skin sheet in her box, or they call and notify her. During an interview on 4/1/2022 at 11:15 A.M., the Director of Nursing indicated that she should have been notified as well as the Physician and responsible party about a new pressure area.		were obtained. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility have the potential to be affected by alleged deficient practice • Full house skin sweep completed with any new or abnormal assessments reported to the Physician. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • All licensed staff will be in serviced on policy related to Notification of changes with emphasis on when to notify the physician and documentation of notification of the physician. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • DON/ Designee will “complete change of condition audit” to ensure that MD was notified for all change of conditions and that notification is documented. • Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts	

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	On 4/1/2022 at 10:20 A.M., the Director of Nursing provided a policy titled, "Building a Productive Workforce Together", Policy: Notification of Changes, dated July 1,2021, and indicated the policy was the one currently used by the facility. The policy indicated "...The facility shall promptly notify the resident and/or the resident representative and his or her physician or delegate of changes in the resident's condition or status in order to obtain orders for appropriate treatment and monitoring and promote the resident's rights to make choices about treatment and care preferences. 3. Document the notification and record any new orders in the resident's medical record. 6. Update the resident's care plan, transcribe, and implement the provider's orders...." 3.1-5(a)(2)		until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property			

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	from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview and record review, the facility failed to ensure a clean environment was maintained related to bugs in a ceiling light cover in one resident room, bugs in 4 light covers in 1 of 4 halls and a dirty ice machine in the main dining room observed for environment. (Room 301 and 300 hall) Finding includes: During an environmental tour, on 4/4/2022 at 11:30 A.M., with the Administrator, the director of maintenance and housekeeping staff, the following were observed: Dead bugs in the over head light covering in Room 301 and in 4 of 4 light coverings on the 300 hall. In the main dining room an ice machine with a filter covered in dust on the	F 0584	**F 584 – Safe/Clean/Comfortable/Homelike Environment** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · The dead bugs found in the light coverings in room 301 have been removed. · The dead bugs found in the light covering on hall 300 have been removed. · The filters on the ice machine in the main dining hall have been cleaned and are free of	05/01/2022

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	front of the machine and a build up a white substance along the rim on the top of the machine. During an interview, on 4/4/2022 at 11:48 A.M., maintenance staff indicated the bugs should not be in lights and the ice machine was dirty. On 4/42022 at 1:55 P.M., the Director of Maintenance provided a print out from TELS, undated, and indicated this is what the facility uses for the ice machine and indicated he had no policy on cleaning the lights. The print out, "Ice Machines" indicated"... Check air-filter (if present). 1. Check that air filter is correctly installed. 2 Replace filter as needed. Clean Coils. 1. Shut off unit. 2. Remove panel cover to expose condenser. 3. Use brush to remove lint and dirt buildup on condenser coil. 4. Use air compressor to blow residual dirt/dust buildup. 5. Vacuum condenser area to remove all dirt/dust. ...Clean Exterior. 1. Clean and wipe down exterior...." 3.1-19(f)		dust. The machine has been cleaned and is free of calcium buildup. **2. 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 in the facility have the potential to be affected by dead bugs in the light fixtures. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** · A facility wide audit has been conducted to ensure that the light fixtures are free of dead bugs. · A preventative maintenance task to investigate the potential presence of and elimination of dead bugs has been added to master PM schedule. · A preventative maintenance task to investigate the potential presence of calcium buildup and elimination of said buildup has been added to master PM schedule . **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.**	

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			· The Director of Maintenance/Designee will complete room rounds as well as hallway rounds observing for dead bugs in light fixtures or visible signs of calcium buildup on ice machine daily using daily audit checklist daily x 5 days, weekly x 4 weeks, Monthly x 2 months and quarterly thereafter until compliance is maintained for at least two consecutive quarters · Results of audit tool will be presented at the QAPI Committee Monthly for review for compliance and follow up. **5. By what date the systemic changes for each deficiency will be completed.** · May 1, 2022	
F 0637 SS=D Bldg. 00	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) Based on record review, observation and	F 0637	What corrective action(s) will be	05/01/2022

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	interview, the facility failed to ensure a significant change in condition MDS (Minimum Data Set) assessment was completed following the initiation of hospice care for 1 of 23 residents whose MDS's were reviewed. (Resident 31) Findings include: A clinical record review was completed on 3/31/2022 at 11:47 A.M. Resident 31's diagnoses included, but were not limited to: chronic obstructive pulmonary disease, anxiety, chronic pain and chronic respiratory failure. A current physician's order, dated 1/26/2022, indicated Resident 31 was admitted to [name of hospice] care on 1/26/2022. During an interview, on 3/31/2022 at 12:17 P.M., LPN (Licensed Practical Nurse) 15 indicated a significant change MDS assessment had not been completed and should have been when she was admitted into hospice care. LPN 15 indicated she uses the RAI (Resident Assessment Instrument) manual. 3.1-31(d)(1)		accomplished for those residents found to have been affected by the deficient practice? • This had been identified by facility prior to survey and Resident 31 had significant change MDS assessment completed on 3/24/2022 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility that have been added or removed from hospice have the potential to be affected by alleged deficient practice • Audit completed to ensure that all residents that meet the criteria for significant change related to hospice in the last year have had significant change assessment completed and no further residents identified What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • New MDS coordinator in place at facility. Education Provided to MDS/ IDT team on criteria for significant change assessments to be implemented. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • MDS/ Designee will Sign Change	

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			for Hospice Resident Audit to ensure that residents that meet criteria for significant change have an MDS initiated. • Audit will be completed weekly x 4 weeks, monthly x 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0640 SS=D Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's			

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	assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.			
	Based on record review and interview, the facility failed to transmit a timely MDS (Minimum Data Set) assessment for 1 of 1 resident reviewed for resident assessments. (Resident 1) Finding includes:	F 0640	**F 640- Transmitting Resident Assessments** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	05/01/2022

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	A record review on 4/4/2022 at 8:44 A.M., indicated Resident 1 had a Quarterly MDS assessment completed on 11/3/2021. A discharge with return not anticipated was completed on 12/28/21. The assessment was not transmitted to CMS' QIES Assessment Submission and Processing system. During an interview on 4/4/2022 at 10:39 A.M., LPN (Licensed Practical Nurse) 15 indicated the MDS data should have been transmitted. According to the RAI manual (Resident Assessment Instrument) a discharge summary should be submitted within the Discharge Date plus 14 calendar days. On 4/4/2022 at 2:00 P.M., the DON provide the policy entitled, "Electronic Transmission of the MDS". The policy indicated, "...All MDS assessments and discharge and reentry records are completed and electronically encoded into our facility's MDS information system and transmitted ...in accordance with current OBRA (Omnibus Budget Reconciliation Act) regulations governing the transmission of MDS data ...."		**practice?** Resident 1 has had MDS transmitted **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** **All residents in the facility have the potential to be affected by alleged deficient practice** · Audit completed to ensure that all other MDS have been transmitted and no further assessments identified as missing transmission. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · New MDS coordinator in place at facility. Education Provided to MDS/ IDT team on criteria for submitting assessments timely . **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · MDS/ Designee will “complete MDS Transmission audit” to ensure that residents have had MDS transmitted per CMS/RAI standard. · Audit will be completed, weekly x 4 weeks, monthly x 6 and then quarterly to encompass	

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			all shifts until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. - !--[if !supportAnnotations]-->	
F 0656 SS=D Bldg. 00	483.21(b)(1) 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			

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	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 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.			
	Based on observation, interview and record review, the facility failed to ensure comprehensive care plans for falls, and weight loss were in place for 2 out of 3 residents reviewed for care plans. (Resident 29 & 38) Findings include: 1. A clinical record review was completed, on 3/31/22 at 1:40 P.M., and indicated Resident 38's diagnoses included, but were not limited to: delusional disorders, retention of urine, major	F 0656	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • IDT team reviewed resident 38 and compressive care plan was reviewed including care plan for falls. • IDT team reviewed resident 29 and comprehensive care plan was reviewed including care plan for weight loss.	06/01/2022

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	depressive disorders, chronic embolism, and thrombosis of deep veins of right lower extremity, and dementia without behavioral disturbances. During an interview on 4/4/2022 at 9:02 A.M., the MDS Nurse indicated that everyone should have a fall care plan or an at risk for falls and he did not have one. 2. A record review of Resident 29 was completed on 3/31/2022 at 8:29 A.M., diagnosis included, but were not limited to: end stage renal disease, hypertension and atrial fibrillation. A 5-day Medicare MDS (Minimum Data Set) Assessment, dated 3/18/2022, indicated that Resident 29 had A BIMS (Brief Interview Mental Status) of no cognitive impairment. Resident 29 required supervision with set up for eating, had no dental issues and hade weight loss of 5 percent or more in the last month or loss of 10 percent or more in last 6 months. Resident 29 was out of the building for surgery from 2/24/2022-3/11/2022. Vital Sign records indicated a weight on 12/27/2021 of 199.2 pounds, on 2/4/2022 of 195.4 pounds, on 3/14/2022 of 183.4 pounds, and on 3/28/2022 of 177.0 pounds. A review of the weights indicated a loss of 22.3 pounds or 11.14 percent in three months and 18.4 pounds or 9.42 percent on one month. Physician Orders, indicated Resident 29 received a consistent carbohydrate diet with supplements of Nepro 237 ml twice a day and a health shake 4 ounces with meals. A Care Plan for significant weight loss or nutritional needs could not be located during		How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility have the potential to be affected by alleged deficient practice • Facility to complete audit of all resident's care plans conducted to ensure accuracy, facility will audit 10 Resident Care plans weekly x 4 and 5 residents Care plans weekly until 100% of Resident care plans reviewed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • IDT in-serviced on the MDS assessment process and their role including use of CARE PLAN Review sheet to ensure all areas are addressed • Audits Tool "Comprehensive Care Plan Audit Tool" will be completed for all new admissions to ensure completion within 21 days of the date of admission or 7 days after the ARD to ensure accuracy of assessments, Care plans, and Coding. • Audit Tool "Comprehensive Care Plan Audit Tool" will be completed as part of all resident Quarterly and annual assessments or upon change of condition to ensure accuracy of MDS and Care Plans within 7 days of the ARD.	

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	record review. During an interview on 3/31/2022 at 10:59 A.M., the DON indicated she would call the MDS Coordinator to print the care plan for weight loss and nutritional needs. A nutritional care plan was provided on 3/31/2022 at 11:36 A.M. The care plan was canceled on 3/9/2022. During an interview on 3/31/2022 at 11:42 A.M., the DON indicated the care plan provided was not an active care plan and the nutritional care plan had not been updated. On 4/4/2022 at 2:00 P.M., the DON provide the policy entitled, "Care Planning -Interdisciplinary Team". The policy indicated, " ...Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident. 1. A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS) ...." 3.1-35(a)		How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • MDS/ Designee will complete Comprehensive Care Plan Audit Tool will be completed for all new admissions to ensure completion within 21 days of the date of admission or 7 days after the ARD to ensure accuracy of assessments, Care plans, and Coding. • Audit Tool “Comprehensive Care Plan Audit Tool” will be completed as part of all resident Quarterly and annual assessments or upon change of condition to ensure accuracy of MDS and Care Plans within 7 days of the ARD. • Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans			

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	§483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on record review, observation and interview, the facility failed to revise/update resident care plans for fall interventions, hallucination interventions, refusal of insulin, and the development of a new pressure ulcer for 3 of 24 residents whose care plans were reviewed. (Resident 56, 5 and 38) Findings include: 1. During an interview, on 3/29/2022 at 10:00 A.M., Resident 56 indicated she had a fall recently and	F 0657	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident 5 has had care plan reviewed and updated to reflect current interventions, person centered care, refusals, and preferences • Resident 56 had care plan reviewed and updated to reflect current interventions, person	05/01/2022

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	broke her nose and busted her lip. A clinical record review was completed on 3/31/2022 at 3:07 P.M., Resident 56's diagnoses included, but were not limited to: anxiety, diabetes, functional quadriplegia and depression. A Quarterly MDS (Minimum Data Set) assessment, dated 2/25/2022, indicated the resident required only supervision for bed mobility, transfers, dressing, toilet use and eating. A Nurse's Note, dated 1/3/2022 at 2:00 A.M., indicated Resident 56 had an unwitnessed fall in her room. The resident was attempting to ambulate to the bathroom with the walker and loss her balance falling forward. Resident 56 received a laceration to her upper lip and had reported she was light headed. A current care plan, dated 9/28/2021, indicated Resident 56 was at risk for falls related to impaired mobility/balance, antihypertensive/ antidepressant/ antianxiety medication use, history of falls, pain, and Spinal cord compression. Interventions included, but were not limited to: encourage to ask for assistance when attempting to do activities that require to bend over when in the wheelchair, monitor psychotropic medications for side effects and report to physician, do not leave unattended in shower, anticipate and meet resident's needs, keep area free from clutter, spills, glares and assure proper lightening, keep call light in reach, keep frequently used items within reach, and complete fall risk assessment per facility protocol. A Nurse's Note, dated 1/4/2022 at 9:08 A.M.,		centered care refusals and preferences • Resident 38 had care plan reviewed and updated to reflect current interventions, person centered care refusals and preferences How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility have the potential to be affected by alleged deficient practice • Facility to complete audit of all resident's care plans conducted to ensure care plans are reviewed and updated to reflect current interventions, person centered, care, refusals and preferences, facility will audit 10 Resident Care plans weekly x 4 and 5 residents Care plans weekly until 100% of Resident care plans reviewed. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • IDT in-serviced on the Care Planning Process with emphasis on their role including use of IDT CARE PLAN Review sheet to ensure all areas are addressed. • IDT in-serviced on Clinical Morning Meeting process with emphasis on their role including identifying changes that require care plan updates.	

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	indicated the IDT (Interdisciplinary Team) had met to review the resident's fall on 1/3/2022 that resulted in a transfer to the emergency room. The resident obtained a subdural hematoma and a laceration with disposable sutures to her upper lip. The resident reported that she believes she became dizzy when she got up in the early morning hours to toilet self. The interventions were for neuro checks to continue, therapy evaluation, and orthostatic blood pressure checks. The care plan lacked the intervention of orthostatic blood pressures to prevent further falls. During an interview, on 4/4/2022 at 1:55 P.M., the Director of Nursing indicated the care plan had not been updated after the fall and did not know if the orthostatic blood pressures were completed. A current care plan, dated 10/8/2021, indicated Resident 56 had a behavioral problem related to hallucinations, i.e. staff members are outside her window, they are pointing laser lights in her room, dressing in costumes, and false allegations against staff. Interventions included, but were not limited to: caregivers to provided opportunity for positive interaction and attention. Stop and talk with him/her as passing by. Remove from situation and take to alternate location as needed. Provide a program of activities that is of interest and accommodates residents status. During an interview, on 4/04/2022 at 10:46 A.M., the Social Service director indicated the care plans were not person centered and did not have interventions specific to the hallucinations and or delusions.2. A record review of Resident 5 was completed on 3/31/2022 at 11:11 A.M., diagnosis		• Audit Tool “Comprehensive Care Plan Audit Tool” will be completed as part of all resident Quarterly and annual assessments or upon change of condition to ensure accuracy of MDS and Care Plans How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • Audit Tool “Comprehensive Care Plan Audit Tool” will be completed as part of all resident Quarterly and annual assessments or upon change of condition to ensure accuracy of MDS and Care Plans within 7 days of the ARD. • DON/ designee will complete “Clinical Meeting Audit” to ensure that all items discussed in clinical meeting have been appropriately care planned. • Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	included, but were not limited to: diabetes mellitus type 2, prostate cancer and nondisplaced fracture of greater trochanter of right femur. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/13/2022, indicated that Resident 5 had a BIMS (Brief Interview Mental Status) score indicating severe cognitive impairment. Resident 5 required extensive assistance with two staff members for bed mobility, transferring and toileting. Resident 5 had a recent surgery requiring an SNF (Skilled Nursing Facility) stay and repair of fracture including the hip. A Physician's Order, dated 10/21/22, indicated administration of Insulin Glargine Solution 100 unit/ml10 units subcutaneously at bedtime. A review of the MAR (Medication Administration Record) indicated Resident 5 had refused blood sugar testing and Insulin Glargine Solution administration 16 times in December 2021, 10 times in January 2022, 16 times in February 2022, and 16 times in March 2022. Resident 5 had blood sugar documentation of 465 on 12/12/2021, 442 on 12/15/2021, 454 on 12/25/2021 and 446 on 3/7/2022. Nurses' Notes reviewed from December 2021 through March 2022, had no documentation of physician notification of Insulin Glargine Solution or blood sugar testing refusal. A Care Plan dated 10/21/2021 indicated Resident 5 has diabetes mellitus and will be free from any signs or symptoms of hyperglycemia. Interventions included, "Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness". The Care Plan had no updates indicating Resident 5 had refused			

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	administration of Insulin Glargine Solution and blood sugar testing. During an interview on 4/4/2022 at 11:00 A.M., LPN 15 indicated Resident 5 should have a care plan related to refusal of medication and the physician should be notified of refusals. A Nurses' Note on 11/29/2021 at 9:55 A.M., indicated " ...On 11/29 ED (Executive Director) and DON (Director of Nursing) were notified by nursing staff that resident fell in his room. Nursing staff conducted a head to toe, pain and skin assessments. Orders were received from MD for X-Ray and pain was managed. As per MD order resident sent to ER (Emergency Room) for evaluation. As per report received from hospital [Resident 5] did sustain a fracture right side hip. [Resident 5] remains in the hospital for treatment at this time ...." On 2/2/2022 at 5:45 P.M., indicated Resident 5 is scheduled for right hip surgery on February 8, 2022. On 2/12/2022 at 5:33 A.M., indicated " ...Staff reported to this writer that resident was on floor. This writer rushed to res room. Resident observed on floor lying on his right-side legs point towards entrance. Wheelchair behind his head ...This writer went back for neuro (neurological) assessment resident c/o (complained of) pain 10/10 to right leg on pain scale of 0-10. [Physician name] notified and ordered to send res to ER for eval and treatment ...." On 2/19/2022 at 4:39 A.M., indicated " ...Resident found on floor next to bed...pain to R leg ...." A Nurses' Note on 2/21/2022 at 11:09 a.m.,			

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	indicated "IDT met to review residents fall on 2/19/22 @ 3:30 A.M ... INTERVENTION: Fall mat placed on floor next to bed ...." A review of Nurses' Notes indicated an IDT (Interdisciplinary Team) meeting did not occur for falls documented on 11/27/2021 and 2/12/2022 to develop interventions to prevent further falls. A Physician Progress Note on 2/18/2022 at 9:51 P.M., indicated " ...This is an 82-year-old male being seen as a readmission to the facility. He was hospitalized from 2/12-2/16 s/p (status post) fall in his room. He was found to have a right hip fracture and UTI and is s/p repair with [physician's name] He had a fall with a fracture to that hip in November 2021 as well ...." A Care Plan on 10/21/2021, indicated [Resident 5] is at risk for falls and has a history of falls and [Resident 5] will not sustain serious injury from fall. No new preventative interventions were developed for falls that occurred on 11/27/2021 and 2/12/2022. During an interview on 4/4/2022 at 10:48 A.M., LPN 15 indicated she is involved with IDT meetings and new interventions to prevent falls should have been placed in the care plan. During an interview on 4/4/2022 at 11:20 A.M., the DON indicated IDT meets the next morning after a fall unless on a Friday or the weekend and interventions should be placed for a new fall. On 4/4/2022 at 2:00 P.M., the DON provide the policy entitled, "Care Planning -Interdisciplinary Team". The policy indicated, " ...Our facility's Care Planning/Interdisciplinary Team is responsible for the development of an individualized			

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	comprehensive care plan for each resident. 1. A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS) ...."3. A clinical record review was completed, on 3/31/22 at 1:40 P.M., and indicated the Resident 38's diagnoses included, but were not limited to: delusional disorders, retention of urine, major depressive disorders, chronic embolism, and thrombosis of deep veins of right lower extremity, and dementia without behavioral disturbances During an interview on 4/1/2022 at 11:59 A.M., the MDS Nurse indicated that she has been helping revise the care plans. If a new pressure area was noted a care plan is put in right away by the nurse that found the pressure area and the next morning it is reviewed by the IDT in the morning meeting and revised if needed. On 4/1/2022 at 1:33 P.M., the Director of Nursing provided a policy titled, "Goals and Objectives, Care Plans", dated April 2009, and indicated the policy was the one currently used by the facility. The policy indicated "...5. Goals and objectives are reviewed and /or revised: a. When there has been a significant change in the resident's condition...." This Federal tag relates to complaint IN00375599. 3.1-35(d)(2)(b)(e)			
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 care plan, must-			

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	(i) Meet professional standards of quality. Based on observation, record review and interview, the facility failed to follow the five rights of medication administration for 4 of 7 residents observed for medication administration. (Resident 6, 25, 38 & 81) Finding includes: During an observation on 4/1/2022 at 7:46 A.M., of the medication pass on the 700 hall, LPN (Licensed Practical Nurse)18 was observed opening packets of medication for Resident 6 without comparing the medication being administered to the MAR (Medication Administration Record) for accuracy. At 7:51 A.M., LPN 18 was observed opening packets of medication for Resident 25 and administering an oral inhalant without verifying accuracy of administered medications with the MAR. At 8:08 A.M., LPN 18 was observed opening packets of medication and placing in a medication cup without verifying the accuracy of the medications with the MAR. These medications were not observed to be administered but placed into the medication cart without identifying resident information. At 8:32 A.M., LPN 18 was observed opening packets of medication for Resident 38 without comparing the medication being administered to the MAR. During an interview on 4/1/2022 at 8:43 A.M., LPN 18 indicated the five right to medication pass (right person, medication, dose, route, and time) and indicated the medication packets should be	F 0658	**658- Services Provided Meet Professional Standards** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · LPN 18 removed from schedule pending education and training. LPN 18 Completed Medication Administration education and had supervised med pass administration completed successfully before returning to the floor to pass medications. · Residents 6,25,38 and 81 were not affected **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** **All residents in the facility have the potential to be affected by alleged deficient practice** · LPN 18 removed from schedule pending education and training. LPN 18 Completed Medication Administration education and had supervised med pass administration completed successfully before returning to the floor to pass medications. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**	05/01/2022

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	checked against the MAR (Medication Administration Record) for accuracy. On 4/4/2022 at 2:00 P.M., the DON provide the policy entitled, "Administering Medications". The policy indicated, " ...10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route of administration before giving the medication ...." 3.1-35(g)(1)		· All Licenses staff in-serviced on the 5 rights of medication with emphasis on comparing medication being administered to MAR **How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · DON/ designee will complete medication pass observations/ audits to ensure compliance. · Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance. [EK1]Need documentation of her training for POC binder [EK2]Education for Nurses and QMAs	

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			Quality Assurance Tool **Quality Indicator: Medication Pass** **Compliance = # of yes responses x 100** **Percentage of Compliance_____** **Signature of Assessor/Date:_____** **X = Yes 0 = No** **Criteria/Questions** **Residents** **Comments** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** Hand Hygiene Preformed prior to handling medication(s) and after administering medication(s) if resident contact was necessary	

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			The correct medication was administered to the resident. The correct dose was administered to the resident Medication administered with a physician's order	

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			Medications administered as ordered (e.g., before, after, or with food such as antacids). Medications administered before the expiration date on the label. Medications administered to the resident via the correct route	

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			Medication held and physician notified in the presence of an adverse effect, such as signs of bleeding or abnormal lab results with anticoagulants Checked pulse and/or blood pressure prior to administering medications when indicated/ordered Staff ensured medications were administered to the resident (e.g., left medications at bedside).	

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			Resident was properly positioned to receive medications (e.g., head of the bed is elevated at an angle of 30-45°). Resident was properly informed of the medications being administered Medication cart was locked if left unattended in resident care area.	

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			If a controlled medication was administered, make sure the count in the cart matches the count in the facility's reconciled records. Insulin suspensions - "mix" or "roll" the suspension without creating air bubbles.	

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			Shake a drug product that is labeled "shake well," such as Dilantin Elixir. 5 Rights of Medication Administration were followed (Right Patient, Right Medication, Right Dose, Right Route Right Time) Nurse Compared MAR to MEDICATIONS	

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			Compliance: Count only yes/no boxes for Total # of completed boxes For any question that does not apply to specific quality indicators use N/A and do not count in completed boxes **Trends Identified:**_____	

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to provide assistance for removal of facial hair for 2 of 2 residents reviewed for activities of daily living. (Resident 25 & 38) Findings include: 1. A clinical record review was completed on 3/31/2022 at 3:15 P.M., and indicated Resident 25's diagnoses included, but were not limited to: type 2 diabetes, chronic obstructive pulmonary disease, hypertension, chronic kidney disease	F 0677	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Residents 25 and 38 were provided with ADL care related to facial hair How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	05/01/2022

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	stage 3, hypothyroidism, hyperlipidemia, and dementia with behavioral disturbances. On 3/29/22 at 12:20 P.M., observed Resident in main dining room for lunch and had a lot of facial hair on her chin. During an observation and interview, on 3/30/22 at 9:50 A.M., Resident 25 indicated she wishes someone would bring in a razor and shave her facial hair because it is so embarrassing. A review of Resident 25's activity of daily living care plan indicated she requires supervision by one staff with personal hygiene and oral care and limited assistance by one staff with bathing/showering. During an interview on 4/1/2022 at 9:37 A.M., the Administrator indicated staff should ask resident's if they want to be shaved, and she should have been shaved. 2. A clinical record review was completed, on 3/31/22 at 1:40 P.M., and indicated Resident 38's diagnoses included, but were not limited to: delusional disorders, retention of urine, major depressive disorders, chronic embolism, and thrombosis of deep veins of right lower extremity, and dementia without behavioral disturbances An Admission MDS (Minimum Data Set) assessment, dated 1/15/2022, indicated Resident 38's BIMS (Brief Interview for Mental Status) score of 0, severely impaired cognition. On 3/29/2022 at 10:29 A.M., observed lying in bed with hair on his cheeks, chin and above the lip. On 3/30/22 at 9:25 A.M., observed the resident		All residents in the facility have the potential to be affected by alleged deficient practice • Audit completed of residents in the facility and all with facial hair offered ADL care. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Staff in servicing conducted related to ADL care for dependent resident, utilizing the ADL policy with emphasis on facial hair. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • DON/ designee will complete ADL care Audits to monitor residents ADL status including facial hair • Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	lying in bed, he is unshaved, his facial hair is resembling the beginnings of a beard, hair looks greasy and unkept. During an interview on 3/31/22 at 9:30 A.M., the Director of Nursing indicated that the resident is difficult to shave but he should be shaved. On 3/31/2022 at 10:30 A.M., the Director of Nursing provided a policy titled, "Activities of Daily Living (ADLs), Supporting", dated March 2018, and indicated the policy was the one currently used by the facility. The policy indicated "... Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with a. Hygiene (bathing, dressing, grooming, and oral care)...." 3.1-38(3)(D)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 0684	What corrective action(s) will be	05/01/2022

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	Based on record review and interview, the facility failed to complete physician ordered dressing changes for a non-pressure wound in 1 of 2 residents reviewed for non-pressure wounds. (Resident 80). Finding includes: A clinical record review was completed on 4/1/2022 and indicated that resident 80's diagnoses included, but were not limited to: dementia, type II diabetes, depression, and cellulitis. A nurse note, dated 3/25/2022 at 12:24 P.M., indicated resident 80 was seen by the wound doctor for skin issues on the right and left lower legs. New orders were given for treatment. Current physicians orders dated 3/25/2022 stated to cleanse the left and right lower leg, cover with calcium alginate (wound treatment), and wrap with gauze daily for wound healing. A Treatment Administration Record (TAR) dated March 2022, indicated these treatments were not completed on 3/28/2022. During an interview on 4/4/2022 at 11:07 A.M., LPN (Licensed Practical Nurse) 22 indicated that the dressing changes should be documented daily on the TAR by a check mark. A blank space indicated that it was not done or documented. A non-pressure wound care policy was requested but not provided. 3.1-37(a)		accomplished for those residents found to have been affected by the deficient practice? • Resident 80 skin tear was assessed, and no abnormal findings noted. Residents skin tear continues to heal as expected. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility have the potential to be affected by alleged deficient practice • TAR audit completed to determine any additional missing treatments for last 30 days • Full house skin sweep completed What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • All Licensed nursing staff in-serviced Quality of Care and treatment with emphasis on documentation of completed nursing services such as signing of EMAR/ETAR • All Licensed nursing staff in serviced on utilizing PCC for EMAR/ETAR and utilizing reports to ensure that task are completed each shift How the corrective action (s) will	

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			be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • DON/ designee will complete Quality of Care related to Treatment Audit to include monitoring of EMAR/ETAR • Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent			

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	new ulcers from developing. Based on observation, interview and record review the facility failed to implement interventions to prevent the development of a resident identified at risk for one out of one residents reviewed for skin integrity. (Resident 38) Finding includes: A clinical record review was completed, on 3/31/22 at 1:40 P.M., and indicated Resident 38's diagnoses included, but were not limited to: delusional disorders, retention of urine, major depressive disorders, chronic embolism, and thrombosis of deep veins of right lower extremity, and dementia without behavioral disturbances. . The record indicated the resident was admitted on 12/28/2021. An Admission MDS (Minimum Data Set) assessment, dated 1/15/2022, indicated Resident 38's BIMS (Brief Interview for Mental Status) severely impaired cognition and he needed extensive assist with activities of daily living. A Braden Assessment, dated 12/28/2021, indicated he is at risk for pressure areas with a score of 16. On 3/30/2022 at 9:25 A.M., observed the Resident 38 sitting up in his bed eating breakfast, his feet were bare with no boots in place, and his right foot had an black and red area on the edge/ plantar area of the foot. On 3/31/2022 at 9:22 A.M., observed the resident lying in bed with socks on his feet, no boots in place, and right foot against the foot board of the bed.	F 0686	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident 38 will continue to be evaluated for healing and appropriate treatment modality weekly by the wound care physician. Resident 38 will continue with low- air loss mattress, pressure reducing boots as ordered and care planned. Heels Up device was added to residents' orders and care plan. Resident 38 had footboard removed and LAL mattress pump was relocated to side of the bed. 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 in the facility have the potential to be affected by alleged deficient practice • Full house skin sweep completed with any new or abnormal assessments reported to the Physician. • Audit completed of all residents to ensure all who are at risk for skin breakdown have preventative interventions in place and that interventions are listed in Care plan and Kardex • Nursing staff educated on Nursing staff in-serviced on preventative wound care with emphasis importance of placing	05/01/2022

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	155831	A. BUILDING 00 B. WING	04/04/2022

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	During an interview, on 3/31/2022 at 10:01 A.M., CNA (Certified Nursing Assistant) 16 indicated he gets up sometimes, and she's getting him up today, she does not think he has any other skin issues except the area on the bottom. During an interview, on 3/31/2022 at 10:15 A.M., RN (Registered Nurse) 12, indicated he only had the area on his sacrum and bruising on his arms. During an interview, on 3/31/2022 at 10:20 A.M., RN (Registered Nurse) 12 indicated the skin is checked weekly by the nurse, she indicated it will pop up in the Medication or Treatment Administration Record and a skin assessment is form is filled out. On 3/31/2022 at 10:56 AM., observed the RN (Registered Nurse) 12 remove Resident 38's socks and indicated that is eschar on the right side and bottom of the foot, and ball of left foot looks like pressure from staying in bed may have been hanger from the low air loss machine and the foot board, the right heel was palpated by nurse and she indicated the heel was soft and mushy but blanchable. A Physician Order, dated 3/29/2022, indicated float heels while in bed, every shift for prevention. A Physician Order, dated 3/29/2022, indicated pressure reducing/relieving boots as tolerated every shift. A Physician Order, dated 3/39/2022, indicated low air loss mattress, check placement and function of mattress/pump every shift. Set to resident comfort every shift.		skin preventative interventions such as floating heels and pressure relieving boots. • Nursing staff educated on use of Kardex / pocket care plan and what interventions are listed and in place for each resident What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Nursing staff in-serviced on preventative wound care per policy with emphasis importance of placing skin preventative interventions such as floating heels and pressure relieving boots • Nursing staff educated on use of Kardex and what interventions are listed and in place for each resident • DON /designee will validate treatments continue to be completed as ordered and pressure relieving devices are in place. • Wound team to make weekly rounds on residents identified with skin impairment to ensure treatments continue to be completed per order and devices are in place for prevention of skin breakdown, notify Physicians as changes are needed and that the plan of care is current/up-dated as needed. • DON/designee will conduct rounds each shift to ensure preventative pressure relieving	

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	During an interview, on 3/31/2022 at 11:26 A.M., RN (Registered Nurse) 12 indicated he should have boots on his feet. During an interview, on 3/31/2022 at 11:21 A.M., CNA (Certified Nursing Assistant) 16, Indicated they have not been putting boots on him. She indicated she did look for some boots but none were found in the room. A Care Plan, dated 2/10/2022, indicated intervention boots to bilateral feet at all times when in bed to protect heels. A Care Plan, dated 2/10/2022, indicated intervention LAL mattress- set at resident comfort level. On 4/1/2022 at 10:20 A.M., the Director of Nursing provided a policy titled, "Prevention of Skin Ulcers/Injuries", dated July 2017, and indicated the policy was the one currently used by the facility. The policy indicated "...The purpose of this procedure is to provide information regarding identification of skin ulcer/injury risk factors and interventions for specific risk factors. 3. Inspect the skin on a daily basis when performing or assisting with personal care or ADLs. a. Identify any signs of developing pressure injuries. For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency, b. inspect pressure points(sacrum, heels, elbows, etc)...." 3.1-40		devices are in place per plan of care. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • DON/designee will conduct rounds each shift to ensure preventative pressure relieving devices are in place per plan of care. • Wound team to make weekly rounds on residents identified with skin impairment to ensure treatments continue to be completed per order and devices are in place for prevention of skin breakdown, notify Physicians as changes are needed and that the plan of care is current/up-dated as needed. • The DON/Designee is responsible for the completion of the Skin/ Wound Audit weekly for 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to prevent injuries from falls for 1 of 4 residents reviewed for accidents. (Resident 5) Finding includes: A record review of Resident 5 was completed on 3/31/2022 at 11:11 A.M., diagnosis included, but were not limited to: diabetes mellitus type 2, prostate cancer and nondisplaced fracture of greater trochanter of right femur. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/13/2022, indicated that Resident 5 had a BIMS (Brief Interview Mental Status) score indicating severe cognitive impairment. Resident 5 required extensive assistance with two staff members for bed mobility, transferring and toileting. Resident 5 had a recent surgery requiring an SNF (Skilled Nursing Facility) stay and repair of fracture including the hip. A Nurses' Note on 11/29/2021 at 9:55 A.M., indicated " ...On 11/29 ED (Executive Director) and DON (Director of Nursing) were notified by nursing staff that resident fell in his room. Nursing staff conducted a head to toe, pain and skin	F 0689	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident 5 had IDT fall review completed, all resident interventions were reviewed, and care plan was updated. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility have the potential to be affected by alleged deficient practice • An Audit of resident falls completed for last 60 days and all fall events reviewed to ensure that IDT note was written, and care plan was updated with intervention. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • IDT was educated on facility Fall policy with emphasis on IDT	05/01/2022

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	assessments. Orders were received from MD for X-Ray and pain was managed. As per MD order resident sent to ER (Emergency Room) for evaluation. As per report received from hospital [Resident 5] did sustain a fracture right side hip. [Resident 5] remains in the hospital for treatment at this time ...." On 2/2/2022 at 5:45 P.M., indicated Resident 5 is scheduled for right hip surgery on February 8, 2022. On 2/12/2022 at 5:33 A.M., indicated " ...Staff reported to this writer that resident was on floor. This writer rushed to res room. Resident observed on floor lying on his right-side legs point towards entrance. Wheelchair behind his head ...This writer went back for neuro (neurological) assessment resident c/o (complained of) pain 10/10 to right leg on pain scale of 0-10. [Physician name] notified and ordered to send res to ER for eval and treatment ...." On 2/19/2022 at 4:39 A.M., indicated " ...Resident found on floor next to bed ...pain to R leg ...." On 2/21/2022 at 11:09 a.m., indicated "IDT (Interdisciplinary Team) met to review residents fall on 2/19/22 @ 3:30 A.M ... INTERVENTION: Fall mat placed on floor next to bed ...." A review of Nurses' Notes indicated an IDT meeting did not occur for falls documented on 11/27/2021 and 2/12/2022 to develop interventions to prevent further falls. A Physician Progress Note, on 2/18/2022 at 9:51 P.M., indicated " ...This is an 82-year-old male being seen as a readmission to the facility. He was hospitalized from 2/12-2/16 s/p (status post) fall in		review and Care Plan Updates. • All falls will be reviewed by the IDT team the following business day as part of the daily clinical meeting to determine root cause and other possible interventions to prevent future falls. Care plans will be updated as appropriate. • DON/Designee will conduct rounds weekly to ensure fall interventions are implemented per plan of care How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • DON/ designee will complete the Fall Management audit tool • Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	his room. He was found to have a right hip fracture and UTI and is s/p repair with [physician's name] He had a fall with a fracture to that hip in November 2021 as well ...." A Care Plan, on 10/21/2021, indicated [Resident 5] is at risk for falls and has a history of falls and [Resident 5] will not sustain serious injury from fall. No new preventative interventions were developed for falls that occurred on 11/27/2021 and 2/12/2022. During an interview, on 4/4/2022 at 10:48 A.M., LPN (Licensed Practical Nurse) 15 indicated she is involved with IDT meetings and new interventions to prevent falls should have been placed in the care plan. During an interview, on 4/4/2022 at 11:20 A.M., the DON indicated IDT meets the next morning after a fall unless on a Friday or the weekend and interventions should be placed for a new fall. On 4/4/2022 at 2:00 P.M., the DON provide the policy entitled, "Falls and Fall Risk, Managing". The policy indicated, " ...Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. 5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant ...." 3.1-45(a)(1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence.			

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	§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 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, record review and interview, the facility failed to obtain physician orders for a Foley catheter for 1 of 2 residents reviewed for urinary catheters. (Resident 54) Finding includes:	F 0690	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident 4's physician orders were reviewed and all appropriate	05/01/2022

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	A record review of Resident 54 was completed on 3/30/2022 at 1:44 P.M., diagnosis included, but were not limited to: stage 4 pressure ulcer to right buttock, osteomyelitis, and acute kidney injury. A Quarterly MDS (Minimum Data Set) Assessment, dated 3/22/2022, indicated that Resident 54 had a BIMS (Brief Interview Mental Status) score indicating no cognitive impairment and had an indwelling catheter. Physician's Orders, on 2/17/2022, indicated catheter care every shift and record catheter output every shift. No physician orders indicated when to change the Foley catheter or drainage system. A Care Plan, on 12/13/21, indicated Resident 54 had a urinary catheter and catheter care and treatment per current MD orders. During an interview, on 4/4/2022 at 11:24 A.M., the DON (Director of Nursing) indicated the Foley catheter is not changed on routine basis unless the catheter needs changed. She indicated the bags are changed weekly on Sundays by the third shift nurse. She indicated an order should be written for changing the Foley catheter when needed and changing of the drainage bag system weekly. On 4/4/2022 at 12:15 P.M., a policy was requested for Foley catheters A policy was not provided. 3.1-41(a)		Foley Catheter orders implemented including when to change the Foley catheter/ drainage system How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility with Catheters have the potential to be affected by alleged deficient practice • An Audit of residents with catheters to ensure that all residents have all appropriate Foley Catheter orders implemented including when to change the Foley catheter/ drainage system What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • IDT was educated on Foley Catheter Maintenance Orders and care • Nursing staff educated on Foley Catheter Maintenance orders and care • IDT will review all new admissions in clinical meeting for catheters and ensure that all Foley Catheter Maintenance orders are implemented • IDT will review all new MD orders in clinical meeting for new catheters and ensure that all Foley Catheter Maintenance orders are implemented	

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			How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • DON/ designee will complete the Catheter audit tool to ensure that all residents have necessary catheter orders • Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight			

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	range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to provide the ordered therapeutic diet for 1 of 2 residents reviewed for nutrition with hemodialysis (HD) treatment. (Resident 71). Finding includes: A clinical record review completed on 4/1/2022 at 11:35 A.M., indicated that residents 71's diagnoses included but were not limited to: end stage renal disease, anxiety, depression, and delusional disorder. A current order indicated resident 71 should receive double protein at breakfast and lunch for end stage renal disease. A nutrition note dated 3/2/2022 at 2:19 P.M., indicated a diet recommendation for double protein at breakfast and lunch. During an observation on 4/1/2022 at 11:53 A.M., resident 71's lunch tray was noted to include fries, carrots, a piece of fish on a bun, pudding, and juice. The meal ticket on the tray indicated a renal diet tray and listed baked fish on a bun, mayonnaise, carrots, corn, fruit, and a fruit drink. The notes section of the tray ticket listed: coffee and milk only for only cereal.	F 0692	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident 71 was not affected by alleged deficient practice How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility with Catheters have the potential to be affected by alleged deficient practice • An Audit of all resident's diet orders completed to ensure that diet orders are accurate and up to date on tray cards being served from kitchen What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Dietary Staff educated on tray card updating and accuracy • IDT will review all new MD orders in clinical meeting and ensure that dietary communication has been	05/01/2022

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	In an interview on 4/1/2022 at 1:35 P.M., the dietary manager indicated double protein would mean two servings of the protein portion of meal, and if double protein is ordered, the ticket should state "double protein" in the notes section. 3.1-46		completed. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • Dietary Manager / designee will complete the Tray Card Audit tool to ensure that all residents have necessary catheter orders • Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral			

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	feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview and record review, the facility failed to ensure a feeding bag was labeled with its contents, time, date, and initialed for one out one resident reviewed for tube feeding management. (Resident 242) Finding includes: On 3/29/2022 at 2:56 P.M., observed two bags one with light brown liquid and the other with clear liquid not labeled with contents, date, time, or initials. On 3/30/2022 at 9:33 A.M., observed two bags one with light brown liquid and the other with clear liquid not labeled with contents, time, date, or initials. During an interview on 4/1/2022 at 9:43 A.M., the Director of Nursing indicated that the tube feeding bags should be labeled with the contents a date, time, and initials on the bag. A policy was requested, and one was not provided. 3.1-44(a)(1)	F 0693	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident 242 did not have a negative outcome related to the alleged deficient practice • Resident 242 enteral feeding bags were replaced and dated How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility with enteral tubes have the potential to be affected by alleged deficient practice • An Audit of residents with enteral tubes completed to ensure that all residents have all appropriate enteral orders and that bags are labeled and dated What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Licensed Nursing Staff were educated on appropriate enteral	05/01/2022

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	155831	A. BUILDING 00 B. WING	04/04/2022

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			feeding maintenance with emphasis on labeling and dating bags/ feeding • Angel Care Representatives educated on checking residents with enteral feedings to ensure that bags/ feeding is labeled and dated during rounds • DON to conduct weekly rounds to ensure that bags/feeding is labeled and dated appropriately How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • DON/ designee will complete the Enteral Feeding audit tool to ensure that all residents have necessary enteral orders and that bags/ feeding is labeled appropriately • Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to ensure posting of cautionary and safety signs indicating the use of oxygen; and provide necessary respiratory care and services for 2 of 3 residents reviewed for respiratory care. (Resident 31 & 242) Findings include: 1. During an interview, on 3/29/2022 at 11:41 A.M., Resident 31 indicated she only gets her breathing treatments at 9:00 A.M. and 9:00 P.M. During an observation, on 3/29/2022 at 11:42 A.M., Resident 31's oxygen tubing was dated 3/13/2022, and the water humidification bottle was undated. A clinical record review was completed on 3/31/2022 at 11:47 A.M. Resident 31's diagnoses included, but were not limited to: chronic obstructive pulmonary disease, anxiety, chronic pain and chronic respiratory failure. Current physician orders, dated 12/31/2021, indicated to change the oxygen tubing, humidifier, and equipment and nebulizer setup every Sunday	F 0695	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident 242 did not have a negative outcome related to the alleged deficient practice • Resident 31 did not have a negative outcome related to the alleged deficient practice • Resident 242 had oxygen tubing and humidification replaced • Resident 31 had oxygen, nebulizer tubing equipment and humidification replaced How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility with oxygen / nebulizers have the potential to be affected by alleged deficient practice • An Audit of residents with oxygen or use of nebulizers completed to ensure that all	05/01/2022

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	night shift, initial and date new equipment A current care plan dated, 3/17/2022, indicated Resident 31 was at risk for respiratory distress. Interventions included, but were not limited to change oxygen tubing nasal canula and humidifier every Sunday. During an observation, on 3/31/2022 at 2:32 P.M., RN (Registered Nurse) 21 indicated the date was 3/13/2022 on the tubing and it had not been changed and the water bottle should have a date on it. 2. A clinical record review was conducted on 4/1/2022 at 11:00 A.M., and indicated Resident 242's diagnoses included, but not limited to: atrial fibrillation, dementia without behavioral disturbance, anxiety disorder, benign prostatic hyperplasia and acute and chronic respiratory failure with hypoxia. On 3/29/22 at 3:06 P.M., observed Resident 242 on oxygen 2L/NC tubing and the humidifier bottle undated and without initials or signage on the door to indicate oxygen is in use. On 3/30/2022 at 9:33 A.M., observed oxygen on 3 L/NC, humidifier water and tubing was undated and no initial or signage on the door to indicate oxygen is in use. A Physician Order, initiated on 3/25/2022, indicated change oxygen tubing, humidifier, and equipment every Sunday night shift. Initial and date new equipment, every night shift every Sunday. On 4/01/22 at 9:39 A.M., the Director of Nursing indicated the humidifier and tubing should be labeled with a date and they are changed every		residents have all appropriate orders for routine changing of equipment and that all oxygen and nebulizer equipment is labeled and dates in residents' rooms. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Licensed Nursing Staff were educated on appropriate oxygen and nebulizer maintenance with emphasis on changing, labeling, and dating the equipment • Angel Care Representatives educated on checking residents with oxygen or nebulizer equipment to ensure that labeling and dating is present during rounds • DON to conduct weekly rounds to ensure oxygen and nebulizer equipment is labeled and dated appropriately How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • DON/ designee will complete the Respiratory Equipment audit tool to ensure that all residents have necessary respiratory orders, and that bags/ feeding is labeled appropriately • Audit will be completed weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to	

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	Sunday on night shift, and there should be signage on the outside of the door. On 4/1/2022 at 10:20 A.M., Director of Nursing provided a policy titled, "Departmental (Respiratory Therapy) - Prevention of Infection", dated April 2007, and indicated the policy was the one currently used by the facility. The policy indicated "...2. Use distilled water for humidification per facility protocol. 3. Mark bottle with date and initials upon opening. 6. Change the oxygen tubing cannulae and tubing every seven (7) days, or as needed...." 3.1-47(a)(6)		encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review and interview, the facility failed to complete pre/post dialysis assessment and assessment communication on dialysis days for 2 of 2 residents reviewed for dialysis care. (Resident 29 & 59) Findings include: 1. A clinical record review of Resident 29 was completed on 3/31/2022 at 8:29 A.M., diagnosis included, but were not limited to: end stage renal disease, hypertension and atrial fibrillation. A 5-day Medicare MDS (Minimum Data Set)	F 0698	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident 22 did not have a negative outcome related to the alleged deficient practice • Resident 59 did not have a negative outcome related to the alleged deficient practice How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	05/01/2022

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	Assessment, dated 3/18/2022, indicated that Resident 29 had A BIMS (Brief Interview Mental Status) of no cognitive impairment. Resident 29 received dialysis. A Physician Order, on 3/11/2022, "Renal dialysis at [Dialysis Facility] Frequency: Mon, Wed, Fri with chair time @ (at) 8:10 am" Documentation of communication between the facility and dialysis center lacked documentation on 1/20/2022, 1/21/2022, and 3/21/2022. During an interview on 3/31/2022 at 11:40 A.M., RN (Registered Nurse) 21 indicated the communication form should be completed daily when attending dialysis. 2. During an interview, on 3/29/2022 at 10:31 A.M., Resident 59 indicated he received dialysis 3 times a week. A clinical record review was completed on 3/29/2022 at 11:15 A.M., Resident 59's diagnoses included, but were not limited to: end stage renal disease, anxiety, hypertension, seizure disorder and diabetes. A Quarterly MDS (Minimum Data Set) assessment, dated 2/16/2022, indicated Resident 59 was receiving dialysis. Resident 59's current physician orders, dated 3/2022, indicated Resident 59 received dialysis 3 times a week on Monday, Wednesday and Fridays, and to check permacath site daily and upon return from dialysis. A current care plan, dated 6/1/2021, indicated the resident's dialysis was on Monday, Wednesday		All residents in the facility that are receiving dialysis have the potential to be affected by alleged deficient practice • An Audit of residents with dialysis completed to ensure that all residents have a dialysis binder in place with communication forms present. • DON/Designee spoke with each resident's dialysis center related to communication to ensure that communication expectations and requirements were reviewed and understood. Any outstanding issues related to dialysis patients addressed with provider. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Licensed Nursing Staff were educated on End Stage Renal Disease Care To include Post-Dialysis: Nurse to complete the post-dialysis evaluation upon return from the dialysis center. Any abnormal or unusual occurrence resident reports while at dialysis center will be reviewed and reported to the physician if necessary. The care of the resident receiving dialysis services will include ongoing communication, coordination and collaboration between the dialysis center and the facility. How the corrective action (s) will	

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	and Friday at 2:00 P.M. Interventions included, but were not limited to: maintain communication between facility and dialysis clinic. Monitor for signs and symptoms of pain and administer medications as ordered. Perm-cath site care. Resident 59's dialysis communication book indicated there had been a Dialysis/Observation Communication Form completed 7 times in January, 1 time in February and 2 times in March 2022. During an interview, on 3/31/2022 at 10:23 A.M., the Director of Nursing indicated the resident had not been assessed prior to all his dialysis days. On 3/31/2022 at 11:15 A.M., the Director of Nursing provided the policy titled, "End-Stage Renal Disease, Care of a Resident with", dated September 2020, and indicated the policy was the one currently used by the facility. The policy indicated"... Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care. ... 2. Education and training of staff includes, specifically: a. The nature and clinical management of ESRD (including infection prevention and nutritional needs): b. The type of assessment date that is to be gathered about the resident's condition on a daily or per shift basis; c. Signs and symptoms of worsening condition and/or complications of ESRD. ...g. The care of grafts and fistulas. ... 5. The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care...." 3.1-37(a)		be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • DON/ designee will complete the Dialysis audit tool to ensure that all residents have necessary dialysis assessments and communication forms in place • Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0757 SS=D	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary			

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Bldg. 00	Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure residents' medication regimen was free from unnecessary medication in 1 of 6 residents reviewed for unnecessary medications. (Resident 40). Finding includes: A clinical record review completed on 3/31/2022 at 2:26 P.M., indicated resident 40's diagnoses included, but were not limited to: Alzheimer's disease, epilepsy, dementia, and psychotic disorder. A current physician order, dated 2/25/2022, indicated resident 40 should be given tramadol	F 0757	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident 40 did not have a negative outcome related to the alleged deficient practice • MD was notified that resident was receiving tramadol and had no complaints of pain, no new orders were obtained. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	05/01/2022

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	(pain medication) scheduled every 12 hours for moderate to severe pain. An order dated 10/27/2021 indicated resident 40's pain level should be monitored every shift. A MAR (Medication Administration Record), dated March 2022, indicated all documented pain levels for resident 40 were zero, and the tramadol medication was given to resident 40 the same days the pain level was documented as zero. In an interview, on 4/4/2022 at 11:07 A.M., LPN (Licensed Practical Nurse) 22 indicated the pain assessment is documented on the MAR, and the number is documented is the resident's measured pain level. When the pain level is documented, a PAINAD (Pain Assessment in Advanced Dementia) tool is used for those residents not able to communicate. A zero documented would indicate no pain. A policy was provided on 4/4/2022 at 2:00 P.M., by a regional representative titled, "Medication Therapy" states, "...Each resident's medication regimen shall include only those medications necessary to treat existing conditions and address significant risks...." 3.1-48(a)(4)		All residents on scheduled pain medication in the facility have the potential to be affected by alleged deficient practice • Facility to complete audit of all residents on scheduled pain medication, facility will audit 10 Residents weekly x 4 and 5 residents weekly until 100% of Resident orders reviewed. • DON/Designee notified MD of audit results. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Licensed Nursing Staff were educated on Medication Therapy policy with emphasis on assessing residents for pain and appropriateness of medication. • MD notified of audit results related to residents on pain medication and pain levels How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • DON/ designee will complete the Unnecessary Medication Pain audit tool to ensure that residents are receiving pain medication appropriately • Facility to complete audit of all residents on scheduled pain medication, facility will audit 10 Residents weekly x 4 and 5 residents weekly until 100% of	

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			Resident orders reviewed. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order			

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	unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to complete a gradual dose reduction, failed to have proper indication/diagnosis, failed to monitor and document side effects of psychotropic medications for 4 of 5 residents reviewed for unnecessary medications. (Resident 56, 38, 81 and 40) Findings include: 1. A clinical record review was completed on 3/31/2022 at 3:07 P.M., Resident 56's diagnoses included, but were not limited to: anxiety, depression, diabetes and functional quadriplegia. A Quarterly MDS (Minimum Data Set) assessment, dated 2/25/2022, indicated Resident 56 had received antianxiety and antidepressant medications. Physician orders, dated 3/2022, indicated the	F 0758	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident 56 did not have a negative outcome related to the alleged deficient practice and medication was reviewed for GDR. • Resident 38 did not have a negative outcome related to the alleged deficient practice and AIMS assessment was completed. • Resident 81 did not have a negative outcome related to the alleged deficient practice and medication was reviewed for GDR. • Resident 40 did not have a negative outcome related to the alleged deficient practice and side effect monitoring was added for	05/01/2022

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	resident had received Clonazepam (anticonvulsant) 1 mg (milligram) three times a day for anxiety. A Psychiatric Progress Note, dated 7/1/2021, indicated Resident 56 medications included Clonazepam that started on 1/1/2020. Assessment and Plan: Anxiety disorder. No changes indicated today. Currently therapeutically managing target symptoms. She refused wanting GDR (Gradual Dose Reduction). Continue Klonopin (Clonazepam) 1 mg by mouth three times a day for anxiety. A Psychiatric Progress Note, dated 12/6/2021, indicated Resident 56 medications included Clonazepam started on 1/1/2020. Assessment and Plan: Anxiety disorder. No changes indicated today. Currently therapeutically managing target symptoms. She refused wanting GDR (Gradual Dose Reduction). Continue Klonopin (Clonazepam) 1 mg by mouth three times a day for anxiety. A Psychotropic Medication Evaluation & Behavior Meeting Form, dated 10/21/2021, indicated Resident 56's medication of Clonazepam 1 mg was started on 6/20/2020 and documented as N/A (not applicable) under last review date and date of last GDR (Gradual Dose Reduction). 1. describe residents psychiatric history and behaviors for medication use: resident 56 has a history of crying out, tearfulness, refusing care, and self isolation. 2. List Non-Pharmalogical interventions as care planned or attempted and documented: talk with family and friends, reassure her and provide positive affirmation. 4. Have there been any changes in the function or adverse reactions to the medications since the last psychotropic medication evaluation? No		monitoring adverse effects related to medication use. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents on psychotropic medications in the facility have the potential to be affected by alleged deficient practice • Facility to complete audit of all residents on psychotropic medications, facility will review all residents for GDR in behavior management meeting. • Facility will complete audit to ensure that all residents on psychotropic medications have appropriate AIMS assessment completed. • Facility will complete audit to ensure that all residents on psychotropic medications have appropriate side effect monitoring in place. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Licensed Nursing Staff were educated Physician orders guidelines, with emphasis on following implementation of side effect monitoring upon initiation of psychotropic medication, • IDT/SSD to be educated on behavior management meeting and GDR Process and expectations	

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	documentation. 5. AIMS Score, and Date- not needed. 6. Behavior Trends since last assessment: Increased, Decreased, No changes- No documentation. Behavior meeting committee Summary of Psychotropic Medication Use- summary of findings: No documentation. 2. a. Behavior meeting recommendations to attending physician or psychiatrist. Recommend Gradual Dose Reduction: Include new dosage and directions. No documentation. b. Gradual dose reduction not recommended: include reason as to why it is contraindicated: Circle on and write brief explanation. No documentation. Resident is not clinically stable: No documentation. Resident needs additional assessment: No documentation. GDR in the last 60 days. No documentation. A Psychotropic Medication Evaluation & Behavior Meeting Form, dated 11/18/2021, indicated Resident 56's medication of Clonazepam 1 mg was started on 6/20/2020 and documented as N/A (not applicable) under last review date and date of last GDR (Gradual Dose Reduction). 1. describe residents psychiatric history and behaviors for medication use: resident 56 has a history of crying out, tearfulness, refusing care, and self isolation. 2. List Non-Pharmalogical interventions as care planned or attempted and documented: talk with family and friends, reassure her and provide positive affirmation. 4. Have there been any changes in the function or adverse reactions to the medications since the last psychotropic medication evaluation? No documentation. 5. AIMS Score, and Date- not needed. 6. Behavior Trends since last assessment: Increased, Decreased, No changes- No documentation. Behavior meeting committee Summary of Psychotropic Medication Use- summary of findings: No documentation. 2. a. Behavior meeting recommendations to attending		How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • SSD/ designee will complete the Unnecessary Psychotropic audit tool to ensure that residents are receiving pain medication appropriately • Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	

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	physician or psychiatrist. Recommend Gradual Dose Reduction: Include new dosage and directions. No documentation. b. Gradual dose reduction not recommended: include reason as to why it is contraindicated: Circle on and write brief explanation. No documentation. Resident is not clinically stable: No documentation. Resident needs additional assessment: No changes at this time. GDR in the last 60 days. No documentation. During an interview, on 4/04/2022 at 1:50 P.M., the Social Service director indicated there should have been a review of the clonazepam medication and there was not one done. 2. A clinical record review completed on 3/31/2022 at 2:46 P.M., indicated resident 40's diagnoses included, but were not limited to: Alzheimer's disease, epilepsy, dementia, and psychotic disorder. A physicians order, dated 10/28/2021, indicated resident 40 was to have antipsychotic medication side effects monitored and documented twice daily. A TAR (Treatment Administration Record), dated March 2022, indicated resident 40's medication side effects were not monitored and documented on 3/23/2022 and 3/28/2022. In an interview on 4/4/2022 at 11:07 A.M., LPN (Licensed Practical Nurse) 22 indicated the antipsychotic medication side effects should be documented on TAR every shift , as well as the number and description in a nurse note. 3. A clinical record review was completed on 3/31/2022, at 2:42 P.M., and indicated the Resident 81's diagnoses included, but were not limited to: vascular dementia with behavioral disturbances, anxiety disorder, hypertension, hyperlipidemia, mood disorder, psychotic disorder with delusions			

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	and irritability and anger. A Physician Order, dated 9/14/2021, indicated olanzapine 7.5 mg by mouth daily for psychotic disorder with delusions due to known physiological condition. On 4/1/2022 at 12:15 P.M., the Social Worker provided a form they use titled, "Sterling Healthcare Management Psychotropic Medication Evaluation & Behavior Meeting Form," for the last six months, and indicated that they review if contraindicated or a GDR (gradual dose reduction) and she documents it on the form. The Physician signed the following evaluations on 12/16/2021, 1/20/2022, 2/17/2022 and 3/17/2022 agreeing with the behavior meetings recommendations. Reviewing the recommendations, the forms were blank. On 4/4/2022 at 10:23 A.M., the Social Service Director indicated the documentation cannot be found anywhere else and indicated the Resident should have had a gradual dose reduction attempted since the drug was initiated on 9/13/2021. 4. A clinical record review was completed, on 3/31/22 at 1:40 P.M., and indicated the Resident 38's diagnoses included, but were not limited to: delusional disorders, retention of urine, major depressive disorders, chronic embolism, and thrombosis of deep veins of right lower extremity, and dementia without behavioral disturbances. The record indicated the resident was admitted on 12/28/2021. On 3/31/2022 at 12:02 P.M., the Director of Clinical Service indicated that an AIMS (Abnormal Involuntary Movement Scale) needs to be done			

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	on Admission, with any medication increase and every six months. During an interview on 3/31/2021 at 12:10 P.M., the Social Worker Director indicated that he did not have an AIMS on admission and should have had one. 5. A clinical record review was completed, on 3/31/22 at 1:40 P.M., and indicated the Resident 38's diagnoses included but were not limited to: delusional disorders, retention of urine, major depressive disorders, chronic embolism, and thrombosis of deep veins of right lower extremity, and dementia without behavioral disturbances. The record indicated the resident was admitted on 12/28/2021. A Physician Order, dated 1/8/2022, quetiapine fumarate tablet 25 mg (milligram) give 1 tablet by mouth two times a day for depression. During an interview on 3/31/2022 at 12:11 P.M., the Social Worker Director indicated that depression is not an appropriate diagnosis for the antipsychotropic for resident 38. On 4/1/2022 at 8:50 A.M., the Social Worker Director provided a policy titled, Tapering Medications and Gradual Drug Dose Reduction," and indicated the policy was the one currently used by the facility. The policy indicated "... Policy statement 1. After medications are ordered for a resident, the staff and practioner shall seek an approriate dose and duration for each medication that also minimizes the risk of adverse consequences. 2. All medications shall be considered for possible tapering. Tapering that is applicable to antipsychotic medications shall be referred to as gradual dose reduction. 3. Residents			

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	who us antipsychotic drugs shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs...." This Federal tag relates to complaint IN00375599. 3.1-48(a)(6)(b)(1)(2)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5 percent (%) for 2 of 7 residents observed during medication pass. Three (3) medication errors were observed during 25 opportunities for error in medication administration. This resulted in a medication error rate of 12 %. The errors involved 2 residents (Resident 25 and 63) in a sample of 7. Findings include: 1. On 4/1/2022 at 7:51 A.M., Resident 25 was observed being administered omeprazole 20 mg (milligrams), hydralazine 50 mg, ferrous sulfate 325 mg, atenolol 50 mg, levothyroxine 175 mcg (micrograms) by mouth and Fluticasone /salmeterol 100/50 mcg inhalant. A review of Resident 25's Physician Orders indicated levothyroxine was to be given at bedtime and after use of fluticasone/salmeterol to rinse the mouth. Resident 25 did not rinse her mouth after use of the inhalant.	F 0759	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident 25 did not have a negative outcome related to the alleged deficient practice • Resident 67 did not have a negative outcome related to the alleged deficient practice How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility have the potential to be affected by alleged deficient practice • Licensed Nursing Staff were educated on the 5 rights of medication with emphasis on comparing medication being administered to MAR and rinsing	05/01/2022

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	2. On 4/1/2022 at 8:02 A.M., Resident 63 was observed being administered vitamin C 500 mg, memantine 5 mg, ferrous sulfate 325 mg, and acetaminophen 325 mg two tablets. A review of Resident 63's Physician Orders indicated Resident 63 was also to receive omeprazole 20 mg capsule. These were not administered. During an interview on 4/1/2022 at 8:43 A.M., LPN (Licensed Practical Nurse) 18 indicated the five right to medication pass (right person, medication, dose, route, and time) and indicated the medication packets should be checked against the MAR (Medication Administration Record) for accuracy. On 4/4/2022 at 2:00 P.M., the DON provide the policy entitled, "Adverse Consequences and Medication Errors". The policy indicated, " ...5. A "medication error" is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services ...." 3.1-48(c)(1)		mouth after inhaler use. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Licensed Nursing Staff were educated on the 5 rights of medication with emphasis on comparing medication being administered to MAR and rinsing mouth after inhaler use. How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • DON/ designee will complete medication pass observations/ audits to ensure compliance. • Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals			

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Bldg. 00	§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to properly store gel-based medication and oral pills separately, store eye drops, oral inhalants and nasal inhalants separately, and have resident identifying information on suppositories for 2 of 2 medication carts observed for medication storage. (300/400 hall & 500/600 hall) Findings include: 1. On 4/1/2022 at 1:16 P.M., the medication cart for the 300/400 hall was reviewed for proper medication storage. In a drawer of medication cart	F 0761	action(s) will be accomplished for those residents found to have been affected by the deficient practice? • No Residents have had a have a negative outcome related to the alleged deficient practice • Diclofenac gel for resident 69 was bagged and placed in appropriate treatment cart. • Bisacodyl suppositories were removed and disposed of • 500/600 med cart reorganized,	05/01/2022

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	300/300 hall, diclofenac sodium gel for Resident 69 was unbagged and mixed in with Resident 11's oral medication. The medication cart had twenty-one bisacodyl suppositories without resident identifiers or instruction for use. During an interview, on 4/1/2022 at 1:26 P.M., LPN (Licensed Practical Nurse) 14 indicated the gel-based cream and oral medications should not be stored together or mixed with another resident's medications and the suppositories should have patient identifiers on the label. 2. On 4/1/2022 at 1:31 P.M., the medication cart for the 500/600 hall was reviewed for proper medication storage. Fluticasone nasal inhalant was mixed with oral inhalants, albuterol oral inhalant was mixed with eye drops. During an interview on 4/1/2022 at 1:44 P.M., QMA (Qualified Medication Aide) 20 indicated oral inhalants, nasal inhalants and eye drops should be stored separately. On 4/4/2022 at 2:00 P.M., the DON provide the policy entitled, "Storage of Medications". The policy indicated, " ...2. Drugs and biologicals are stored in the packaging, containers or other dispensing system in which they are received. 10. Resident medications are stored separately from each other to prevent the possibility of mixing medications between residents. 3.1-25(j)		and inhalants separated How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents in the facility have the potential to be affected by alleged deficient practice - Facility audited all Medication carts to ensure that all medications and treatments were labeled, dated and stored correctly. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Licensed Nursing Staff were educated on Medication Storage policy How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • DON/ designee will complete medication storage audits to ensure compliance. • Audit will be completed daily x 5, weekly x 4 weeks, bi-monthly for 2 months, monthly for 6 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. • The results of these audits will be reviewed by the CQI committee	

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			overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.	