STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155183	A. BUILDING 00 B. WING	07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MARTINSVILLE, THE	2055 HERITAGE DR MARTINSVILLE, IN 46151

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00407829, IN00411958, IN00412402, IN00412391, and IN00412383. Complaint IN00407829 - Federal/State deficiencies related to the allegations are cited at F679. Complaint IN00411958 - No deficiencies related to the allegations are cited. Complaint IN00412402 - No deficiencies related to the allegations are cited. Complaint IN00412391 - No deficiencies related to the allegations are cited. Complaint IN00412383 - No deficiencies related to the allegations are cited. Survey dates: July 10, 11, 12, 13 and 14, 2023 Facility number: 000096 Provider number: 155183 AIM number: 100290890 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 2 Medicaid: 41 Other: 28 Total: 71	F 0000	Preparation or execution of the plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions ser forth in the statement of deficiencies. The Plan of correction is prepared and executed solely because it is required by Federal and State law. Please consider this plan of correction as our credible allegation of compliance to the Compliant survey conducted on July 10, 2023. We cordially request that this plan is considered for desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Broc Bennett	Administrator	08/03/2023

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

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 19, 2023.			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the 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			

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	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 interview and record review, the facility failed to follow physician order to notify the physician of blood glucose greater than 200 mg/dL (milligrams/deciliter) for 1 of 5 residents reviewed for unnecessary medications. (Resident F) Finding includes: On 7/12/23 at 2:45 p.m., Resident F's clinical record was reviewed. The diagnoses included, but were not limited, to dementia, Alzheimer's disease, and diabetes mellitus. The July 2023 Physician's Orders indicated to monitor blood glucose two times a day and to notify physician of blood glucose less than 70 mg/dL or greater than 200 mg/dL, initiated on 5/5/23. The July 2023 Medication Administration Record indicated the following:	F 0580	It is the policy of the facility to ensure the safety of the residents. It is the individual responsibility of the employees to assure residents are kept safe and MD orders are followed as ordered. It is the policy of this facility to notify the physician of blood sugars outside of the ordered parameters. All diabetic residents have a potential to be affected by this alleged deficient practice. A 30 day look back audit of all residents with blood sugar parameters and notification of physician for any results outside the parameters and was completed by 8/2/23. Resident F had two blood sugar outside of the parameters, the NP/MD were notified on 7/14/2023. The DON/Designee in-serviced the	08/15/2023

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	- On 7/2/23 at 5:00 p.m., Resident F's blood glucose was 284 mg/dL. - On 7/6/23 at 5:00 p.m., Resident F's blood glucose was 212 mg/dL. - On 7/7/23 at 5:00 p.m., Resident F's blood glucose was 273 mg/dL. - On 7/8/23 at 5:00 p.m., Resident F's blood glucose was 243 mg/dL. - On 7/9/23 at 5:00 p.m., Resident F's blood glucose was 248 mg/dL. - On 7/10/23 at 5:00 p.m., Resident F's blood glucose was 206 mg/dL. - On 7/13/23 at 5:00 p.m., Resident F's blood glucose was 245 mg/dL. The clinical record lacked the documentation of the physician notification of the blood glucose being greater than 200 mg/dL. On 7/14/23 at 12:33 p.m., the Director of Nursing (DON) indicated the clinical record lacked documentation of physician notification of blood glucose greater than 200 mg/dL. On 7/14/23 at 12:50 p.m., the DON provided the facility's policy, "Blood Glucose Monitoring," undated, and indicated it was the policy being used by the facility. A review of the policy indicated,"...12.) Notify physician if blood glucose is outside resident's parameters for blood glucose as ordered by their physician..." 3.1-5(a)(2)		nursing staff on parameters for blood sugar monitoring to follow the parameters of the physicians orders and to notify when blood sugars outside of parameters. Additionally, any staff who fails to comply with the points of the in-service will be further educated/or progressively disciplined as indicated. In-Service completed on 7/18/23 The DON/Designee will audit residents receiving blood glucose monitoring 5 residents x a week x 4 weeks, then 3 residents x a week for 4 weeks, then 3 residents monthly x 4 months. The results of the audits will be reported monthly to the Facility QA committee for evaluation of compliance, ongoing monitoring for continuous improvement, and to determine if any modifications to the action plan are necessary after the implementation.	
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this			

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	subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on interview and record review, the facility failed to ensure a resident was free from misappropriation of medication for 1 of 1 resident reviewed for misappropriation of property. (Resident 65) Findings include: During an interview on 7/14/23 at 3:30 p.m., the Director of Nursing (DON) indicated the nurses did a shift change narcotic count at 2:00 p.m. on 6/22/23, and the count was correct. During the next shift change count at 10:00 p.m., the resident's Dilaudid (a narcotic medication used to treat pain) count was off by 2 pills. An agency nurse, LPN 4, called the DON to report the the count was off. The DON came into the facility and LPN 4 started to cry and indicated she did not know what happened to the missing pills. The DON asked her to perform a drug test and the nurse refused because she had to go get her kids. The nurse was reported to the agency and was not permitted to return. On 7/14/23 at 3:39 p.m., Resident 65's clinical record was reviewed. The diagnoses included, but were not limited to, end stage renal disease, personal history of traumatic fracture, and diverticulosis. A review of the current, July, 2023, physician's orders indicated on 5/24/23 the resident was ordered hydromorphone (Dilaudid) 2 milligrams as needed for pain.	F 0602	It is the policy of this facility to ensure all alleged violations involving misappropriation of resident property. All residents have the potential to be affected by the alleged deficient practice. The facility replaced Resident #65 medication at the facilities expense on 6/24/23. The DON completed an audit for missing controlled substances on 6/24/23, all controlled substances were correct and accounted for. All Nurses have been educated on counting narcotic medication between shifts. This in-service completed on 7/18/23 staff were also educated on the Abuse Policy including misappropriation. In-servicing was completed by the DON. DON and /or designee in-serviced nurses/QMA's on the reporting of abuse to the appropriate persons – administrator/don/designee. Additionally, any staff who fails to comply with the points of the in-service will be further educated/or progressively disciplined as indicated. In-service completed on 7/18/23 The DON/Designee will audit the narcotic shift to shift count sheets to look for misappropriation of medications will be done 5 x	08/15/2023

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	A review of the Medication Administration Record (MAR) indicated on 6/22/23, the resident's Dilaudid count was 73 at 2:00 p.m. On 6/22/23 (no time), the count was corrected to reflect 70 pills remained. During an interview on 7/14/23 at 3:51 p.m., the Executive Director (ED) indicated he did an investigation of the missing pills. The investigation findings were inconclusive and the medication was never found. On 7/14/23 at 4:10 p.m., the ED provided the "ABUSE PREVENTION PROGRAM," undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "It is the policy of this facility to prevent ... misappropriation of resident property ... This facility will not tolerate resident abuse of treatment by anyone including staff members ... staff of other agencies ... 7. Misappropriation of resident property: is the deliberate misplacement, exploitation, or wrong, temporary or permanent use of a resident's belongings ... without the resident's consent..." 3.1-28(a)		weekly x 4 weeks, then 3 x weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 months. This will be audited monthly at the QA committee meeting until no further concerns are observed. The results of the audits will be reported monthly to the Facility QA committee for evaluation of compliance, ongoing monitoring for continuous improvement, and to determine if any modifications to the action plan are necessary after the implementation.	
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident,			

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	encouraging both independence and interaction in the community. Based on observation interview, and record review, the facility failed to provide activities designed to meet a resident's need and interests for 5 of 5 residents reviewed for activities. (Resident B, Resident C, Resident D, Resident E, and Resident F) Findings include: 1. During an observation on 7/11/23 at 11:21 a.m. through 12:00 p.m., Resident B was observed to be in the dining room. The scheduled activity of Trivia (scheduled at 11:30 a.m.) was not observed. During an observation on 7/12/23 at 10:58 a.m. through 11:45 a.m., the scheduled activity of Pretty Nails (scheduled at 11:00 a.m.) was not observed. On 7/13/23 at 11:30 a.m., the scheduled activity of Trivia was not observed. On 7/13/23 at 10:40 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to dementia, depression, and anxiety. A care plan, initiated on 3/21/23 and current through target date 9/11/23, indicated Resident B was dependent on staff for activities, cognitive stimulation, and social interaction due to her decline in health. She had little or no activity involvement and takes much encouragement to participate. The staff would provide her with weekly program invites, setup assistance, and cues to stay activities. During an interview on 7/14/23 at 2:16 p.m., the	F 0679	It is the policy of the facility to ensure that residents receive activities that are centered around each resident and that the activities occur as posted. All residents have a potential to be affected by this alleged deficient practice. The Activity Director/designee will do an audit of the resident's activity preferences and care plans updated. If the resident is unable to tell what they like the family will be contracted and asked. Audit completed by August 9, 2023. The Activity director/designee in-serviced the activity staff on the importance of ensuring that activities are being completed as posted and per resident preference. Additionally, any staff who fails to comply with the points of this in-service will be further educated/or progressively disciplined as indicated. The in-service was completed on 7/18/23 The activity director/designee will audit the activities that are posted to ensure they are completed the activity director/designee will check 10 activities a week x 4 weeks, then 5 activities week x 4weeks, then 3 activities week for 4 months. An audit of ensuring the activities met the residents' preferences. audit 10 residents a week to see if the activity met	08/15/2023

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	Activity Director (AD) indicated Resident B's activity preference was to have nails done and to do puzzles. 2. During an observation on 7/11/23 at 11:21 a.m. through 12:00 p.m., Resident C was observed to be in the dining room. The scheduled activity of Trivia was not observed. During an observation on 7/12/23 at 10:58 a.m. through 11:45 a.m., the scheduled activity of Pretty Nails was not observed. On 7/12/23 at 2:35 p.m., Resident C was observed to be resting in bed with no music on. On 7/13/23 at 11:30 a.m., the scheduled activity of Trivia was not observed. On 7/13/23 at 11:00 a.m., Resident C's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, and anxiety. A care plan, initiated on 10/13/22 and current through target date 10/2/23, indicated Resident C enjoyed observing others, watching some television, social interactions, snacking, arranging her belongings, talking to her baby dolls, family visitors, and family outings. She required maximum encouragement/cues to attend group programs. An Activity Resident Interview, dated 4/24/23 at 3:11 p.m., indicated listening to music was very important; doing things with groups of people was very important; doing her favorite activities was very important; going outside to get fresh air when the weather was good was very important; and participating in religious services or practices		their preference x 4 weeks, and then 5 residents per week x4 weeks, then 2 residents per week x 4 months. Care plans will be updated to match their preferences. The results of the audits will be reported monthly to the Facility QA committee for evaluation of compliance, ongoing monitoring for continuous improvement, and to determine if any modifications to the action plan are necessary after the implementation.	

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	was very important. During an interview on 7/14/23 at 2:11 p.m., the Activity Director (AD) indicated Resident C's activity preference was to pack her belongings and listening to music. 3. During an observation on 7/11/23 at 11:21 a.m. through 12:00 p.m., Resident D was observed to be in the dining room. The scheduled activity of Trivia was not observed. During an observation on 7/12/23 at 10:58 a.m. through 11:45 a.m., the scheduled activity of Pretty Nails was not observed. On 7/13/23 at 11:30 a.m., the scheduled activity of Trivia was not observed. On 7/12/23 at 2:45 p.m., Resident D's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, Alzheimer's disease, and diabetes mellitus. A care plan, initiated on 10/13/22 and current through target date 8/22/23, indicated Resident D enjoyed watching television, engaging in some social interactions, and joining sing-along groups when given the cues. She preferred to stay in bed and required cues, invites and/or encouragement to stay active. The Annual Minimum Data Set (MDS) assessment, dated 1/27/23, indicated to have books, newspaper, and magazine to read was very important; listening to music was very important; being around animals was very important; doing things with groups of people was somewhat important; doing her favorite activities was very important; going outside to get fresh air when the			

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	weather was good was very important; and participating in religious services or practices was very important. During an interview on 7/14/23 at 2:18 p.m., the Activity Director (AD) indicated Resident D's activity preference was to go on outings, watching television, and listening to music. 4. On 7/13/23 at 10:20 a.m., Resident E was observed to be lying in bed with no music or television on in the room. On 7/13/23 at 11:24 a.m., Resident E was observed to be lying in bed with no music or television on in the room. On 7/13/23 at 1:52 p.m., Resident E was observed to be lying in bed awake with no music or television on in the room. On 7/14/23 at 10:15 a.m., Resident E was observed to be lying in bed with no music or television on in the room. On 7/14/23 2:10 p.m., Resident E was observed to be lying in bed with no music or television on in the room. On 7/13/23 at 11:37 a.m., Resident E's clinical record was reviewed. The diagnoses included, but were not limited to, cerebral infarction (stroke), diabetes mellitus, and anxiety. The Admission MDS assessment, dated 2/26/23, indicated the interview for activity preference was not assessed. The care plan, undated, indicated Resident E enjoyed listening to the television and to music.			

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	She would receive activities of music of her choice. During an interview on 7/14/23 at 2:04 p.m., the AD indicated Resident E was on One to One and liked to have music on with soothing sounds. 5. During an observation on 7/11/23 at 11:21 a.m. through 12:00 p.m., the scheduled activity of Trivia was not observed. On 7/13/23 at 11:30 a.m., the scheduled activity of Trivia was not observed. On 7/13/23 at 10:00 a.m., Resident F was observed to be resting in bed with no music or television on. On 7/12/23 at 2:45 p.m., Resident F's clinical record was reviewed. The diagnoses included, but were not limited to, dementia, Alzheimer's disease and diabetes mellitus. A care plan, initiated on 3/26/23 and current through target date 7/25/23, indicated Resident F enjoyed keeping up with news; watching television/movies, reading magazines/newspapers, playing cards/games, and listening to music. An Activity Resident Interview, dated 5/5/23 at 3:38 a.m., indicated having books, newspapers, and magazines to read was somewhat important; listening to music he liked was somewhat important; keeping up with news was very important; doing things with groups of people was somewhat important; doing his favorite activities was very important; going outside to get fresh air when the weather was good was somewhat important; and participating in religious			

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	services or practices was somewhat important. During an interview on 7/14/23 at 2:16 p.m., the Activity Director (AD) indicated Resident F's activity preference was to sit outside. During an interview on 7/14/23 at 10:59 a.m., Certified Nursing Assistant (CNA) 1 indicated the activity department was responsible for the scheduled activities. The scheduled activities were not completed by the activity department. On 7/14/23 at 1:59 p.m., the Executive Director provided the facility's policy, "Activities Program," undated, and indicated it was the policy being used by the facility. A review of the policy indicated,"...3) Facility will offer activities both individual and group to enhance the physical, mental, and psychosocial well-being of residents, taking into consideration any limitations that the resident's might have individually or as a group..." This Federal tag relates to Complaint IN00407829. 3.1-33(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to ensure a resident	F 0684	It is the policy of this facility to ensure residents receive treatment	08/15/2023

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WATERS OF MARTINSVILLE, THE	2055 HERITAGE DR MARTINSVILLE, IN 46151

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	received treatment and care in accordance with the plan of care for 1 of 4 residents reviewed for skin conditions. (Resident 21) Finding includes: On 7/11/23 at 2:15 p.m., Resident 21 was observed with multiple scabbed areas and bruises to her upper extremities and forehead. During that time, the resident indicated she did not know how she got the scabbed and bruised areas. She indicated her skin was very thin and she woud get skin tears and bruises very easily. A fresh skin tear was observed to the residents upper right arm and she indicated that was from the staff pulling off an adhesive bandage. On 7/12/23 at 10:02 a.m., the resident's clinical record was reviewed. The diagnoses included, but were not limited to, lack of coordination, difficulty in walking, anemia, muscle wasting and atrophy, seizures, and muscle spasms. An Admission MDS (Minimum Data Set) assessment, dated 5/10/23, indicated the resident was cognitively intact. A progress note, dated 7/10/23 at 10:21 a.m., the nurse practitioner's (NP) indicated the resident had multiple bruises and scabs on bilateral arms, and a laceration on the left side of her face. The NP wrote the resident was at an increased risk of skin breakdown. She recommended good hygiene and skin care to prevent skin breakdown and the application of emollients (lotion) daily. She further indicated she recommended staff to keep the patient's skin clean, dry, apply barrier cream as necessary to prevent skin breakdown, and to avoid pressure on any bony prominence by adhering to turning protocols and floating heels.		and care in accordance with the plan of care to prevent skin breakdown. All residents have a potential to be affected by this alleged deficient practice. A skin sweep was completed, and issues were addressed, and care plans updated. Skin Sweep was completed on 7/10/23 by Healing Partners. Resident #21 was seen by the Wound care group and new treatments/lotions were added on 7/10/23. The DON/Designee in-serviced nursing staff on the Policy Preventative Skin Care to include the importance of applying lotion to dry skin. The in-service was completed on 7/18/23. Additionally, any staff who fail to comply with the points of the in-service will be further educated/or progressively disciplined as indicated. The DON/Designee will audit residents to have lotion and treatments applied as ordered to prevent skin dryness or breakdown. A random audit of 5 residents will be done 5 times weekly x 4 weeks, then 3 residents a week for 4 weeks, then 2 residents a week for 4 months. The results of the audits will be reported monthly to the Facility QA committee for evaluation of compliance, ongoing monitoring for continuous improvement, and to determine if	

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	A review of the residents care plans indicated on 5/22/23 a care plan was initiated for the problems (focus), "Potential for alterations in skin integrity," and "At risk for skin breakdown." The interventions did not include an intervention for lotion. During an interview on 7/14/23 at 2:04 p.m., the Certified Nursing Assistant (CNA) 3 indicated she was not aware of the resident having any bruising or scabbed arms and she was not sure about any interventions to prevent skin damage. During an interview on 7/14/23 at 2:15 p.m., the Unit Manager indicated the resident was recently seen by the wound nurse practitioner and she ordered lotion for the resident's skin. On 7/14/23 at 2:30 p.m., the current, July 2023, Medication Administration Record indicated on 7/14/23 the resident was prescribed lotion to be applied to legs and arms every shift for xerosis (dry skin). This was the first documented day the resident received lotion. On 7/14/23 at 4:13 p.m., the Director of Nursing provided the policy, "Preventive Skin Care," undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated, "It is the intent of the facility that the facility provide preventive skin care through careful washing, rinsing, and drying to keep resident clean, comfortable ..." 3.1-37(a)		any modifications to the action plan are necessary after the implementation.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning			

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	§ 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 provide respiratory care consistent with professional standards of practice for 3 of 3 residents reviewed for respiratory care. Oxygen equipment was not dated. (Resident 42, Resident 16, Resident 21) Findings include: 1. On 7/11/23 at 9:40 a.m., Resident 42 was observed sitting in his room. Next to his bed was an oxygen concentrator delivery machine. The humidifier, oxygen tubing, and oxygen mask lacked labeling to indicate the date they had been changed. On 7/12/23 at 11:48 a.m., the oxygen humidifier, tubing, and mask were observed to be without labeling to indicate the date they had been changed. On 7/13/23 at 9:50 a.m., the oxygen humidifier, tubing, and mask were observed to be without labeling to indicate the date they had been changed. On 7/11/23 at 2:30 p.m., the resident's clinical record was reviewed. The diagnoses included, but were not limited to, chronic respiratory failure and hypertension.	F 0695	It is the policy of the facility to change the oxygen/nebulizer tubing and date it weekly and to document in the clinical record. All residents that receive oxygen/nebulizers have a potential to be affected by this alleged deficient practice. Residents # 42, 16, and 21, had their tubing changed during survey on 7/13/23 . An audit was completed on all resident with respiratory tubing on 7/13/23 by the Unit Managers. The DON/Designee in-serviced staff on changing the oxygen/nebulizer tubing weekly and dating 7/18/23 and any nurses will be in-serviced when they start. Additionally, any staff who fail to comply with the points of the in-service will be further educated/or progressively disciplined as indicated. The DON/Designee will audit residents with respiratory tubing audit 5 residents a week x 8 weeks, then 3 residents a week for 4 months. The results of the audits will be reported monthly to the Facility QA committee for	08/15/2023

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	Current physician's orders indicated the resident was prescribed oxygen as needed and at night. The oxygen tubing was to be changed and dated on a weekly basis, initiated 3/11/23. 2. On 7/11/23 at 9:45 a.m., Resident 16 was observed lying in her bed receiving oxygen from an oxygen concentrator via tubing and nasal cannula. The humidifier, oxygen tubing, and nasal cannula lacked labeling to indicate the date they had been changed. On 7/12/23 at 11:57 a.m., Resident 16 was observed lying in her bed receiving oxygen from an oxygen concentrator via tubing and nasal cannula. The humidifier, oxygen tubing, and nasal cannula lacked labeling to indicate the date they had been changed. On 7/13/23 at 9:55 a.m., Resident 16 was observed lying in her bed receiving oxygen from an oxygen concentrator via tubing and nasal cannula. The humidifier, oxygen tubing, and nasal cannula lacked labeling to indicate the date they had been changed. On 7/11/23 at 2:40 p.m., the resident's clinical record was reviewed. The diagnoses included, but were not limited to, shortness of breath and hypertension. Current physician's orders indicated the resident was prescribed continuous oxygen, initiated 5/2/23. 3. On 7/11/23 at 10:25 a.m., Resident 21 was observed lying in bed receiving oxygen from an oxygen concentrator via tubing and nasal cannula. The humidifier, oxygen tubing, and nasal		evaluation of compliance, ongoing monitoring for continuous improvement, and to determine if any modifications to the action plan are necessary after the implementation.	

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	cannula lacked labeling to indicate the date they had been changed. On 7/12/23 at 12:22 p.m., Resident 21 was observed lying in bed receiving oxygen from an oxygen concentrator via tubing and nasal cannula. The humidifier, oxygen tubing, and nasal cannula lacked labeling to indicate the date they had been changed. On 7/13/23 at 10:12 a.m., Resident 21 was observed lying in bed receiving oxygen from an oxygen concentrator via tubing and nasal cannula. The humidifier, oxygen tubing, and nasal cannula lacked labeling to indicate the date they had been changed. On 7/12/23 at 2:50 p.m., the resident's clinical record was reviewed. The diagnoses include, but were not limited to, chronic obstructive pulmonary disease and chronic respiratory failure. Current physician's orders indicated the resident was prescribed oxygen for chronic obstructive pulmonary disease and respiratory failure, and the oxygen tubing and cannula were to be changed weekly, initiated 7/11/23. During an interview on 7/13/23 at 10:45 a.m., the Director of Nursing indicated the oxygen tubing lacked labeling to indicate when it was last changed. 3.1-47(a)(6)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must -			

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	§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was stored in a sanitary manner for 3 of 3 kitchen observations. Food was stored opened underneath a leaking water line and expired food was not discarded. Findings include: 1. During a tour of the facility's walk-in freezer on, 7/12/23 at 10:15 a.m., 7/13/23 at 10:40 a.m., and 7/13/23 at 2:13 p.m., food was observed to be stored beneath the freezer condenser water line, upon which ice had formed. The food included one 30 pound box of capri mixed vegetables open to air, one box with ice formed on it containing a 14 pound bag of capri mixed vegetables, and one box containing white bread open to air. 2. During a tour of the facility's walk-in refrigerator	F 0812	It is the policy of the facility that all food will be served before expiration dates and It is the policy of this facility to ensure food is stored in a sanitary manner. All residents have a potential to be affected by this alleged deficient practice. No residents were affected by this deficient practice. The Dietary Manager/Registered Dietician in-serviced dietary staff on the proper placement of food in the freezers and the importance of removing food from the refrigerators if they are expired. And storage of food in a sanitary manner on 7/17/23. Additionally, any staff that fails to comply with the points of this in-service will be further educated/or progressively	08/15/2023

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	on 7/12/23 at 10:20 a.m., 7/13/23 at 10:45 a.m., and 7/13/23 at 2:18 p.m., expired food was observed to be stored on a shelf. The food included one opened five pound container of cottage cheese with an expiration date of 7/3/23 and one opened five pound container of sour cream with an expiration date of 7/2/23. During an interview on 7/13/23 at 2:30 p.m., the Administrator indicated the expired food should have been removed from the refrigerator and the food stored under the leaking freezer condenser should have been stored elsewhere. The facility used the Indiana State Department of Health Retail Food Establishment Sanitation Sanitation Requirements, effective date, November 13, 2004 as the facility policy and procedure regarding food storage. A review of the policy indicated, "...410 IAC 7-24-177 Food storage Sec. 177... food shall be protected from contamination by storing the food as follows:...(5) In packages, covered containers, or wrappings...", and "...410 IAC 7-24-178 Food storage; prohibited areas Sec. 178. (a) Food may not be stored as follows:...(2) Under the following:...under lines on which water has condensed..." 3.1-21(i)(2) 3.1-21(i)(3)		disciplined as indicated. The Dietary Manager will audit the freezer and refrigerator for expired food and food under the condenser 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months. The results of the audits will be reported monthly to the Facility QA committee for evaluation of compliance, ongoing monitoring for continuous improvement, and to determine if any modifications to the action plan are necessary after the implementation.	