STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155670	A. BUILDING 00 B. WING	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NEWBURGH	5233 ROSEBUD LANE NEWBURGH, IN 47630

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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 IN00386806, IN00377622, IN00377128, and IN00384048. This visit was in conjunction with Investigation of Complaint IN00387611. Complaint IN00386806 - Substantiated. No deficiencies related to the allegations were cited. Complaint IN00377622 - Unsubstantiated due to lack of evidence. Complaint IN00377128 - Unsubstantiated due to lack of evidence. Complaint IN00384048 - Unsubstantiated due to lack of evidence, Complaint IN00387611 - Substantiated. Federal/State deficiencies related to the allegations are cited at F692 and F804. Survey dates: August 3, 4, 5, 8, 9, 10, 11, 2022 Facility number: 011049 Provider number: 155670 AIM number: 200258520 Census Bed Type: SNF/NF: 71 Total: 71 Census Payor Type: Medicare: 4 Medicaid: 50 Other: 17 Total: 71 These deficiencies reflect State Findings cited in	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective 9-1-22 to the annual recertification survey completed on 8-11-2022. We respectfully request a paper review and will provide any additional information requested.	

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

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	accordance with 410 IAC 16.2-3.1. Quality review completed on August 18, 2022.			
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 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			

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	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 implement a comprehensive person-centered care plan for each resident in order to meet medical needs that are identified in the comprehensive assessment. Staff did not implement care plan interventions, or follow MD orders for 3 of 5 residents reviewed for implementation of the care plan intervention for respiratory care, urinary care, and weight management while on enteral feedings. (Resident G, Resident 10, Resident 44) Findings include: 1. On 8/8/22 at 9:03 A.M., Resident G's clinical record was reviewed. Diagnosis included, but were not limited to, COPD (chronic obstructive pulmonary disease). The most recent quarterly MDS (minimum data set) Assessment, dated 7/22/22, indicated Resident G had a significant cognitive impairment, and required extensive assistance of 2 (two) staff for bed mobility, transfers, and toileting. Current physical orders included, but were not limited to: Elevate head of bed to alleviate shortness of breath while lying flat in bed due to diagnosis of COPD, every shift, started 4/11/22. On 8/9/22 at 7:45 A.M., Resident G was observed	F 0656	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident G's head of bed was elevated per the plan of care. Resident G was assessed with no negative outcome. Resident #10 received foley catheter care and the drainage bag was emptied per the plan of care. Resident #10 was assessed with no negative outcome. Resident #44's weight was obtained with no significant change noted. MD made aware of weights. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. All residents with foley catheters were assessed to ensure appropriate foley catheter care and	09/01/2022

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	lying in bed, with the head of the bed all the way down flat. On 8/10/22 at 10:24 A.M., the same was observed. During an interview on 8/9/22 at 8:06 A.M., RN (registered nurse) 17 indicated she was unsure if Resident G's head of the bed should be raised, and assumed it could have been raised if the resident wanted it raised. 2. On 8/9/22 at 8:20 A.M., Resident 10's clinical record was reviewed. Diagnosis included, but were not limited to, neurogenic bladder and paraplegia. Resident 10's clinical record indicated Resident 10 was cognitively intact. The most recent quarterly MDS (minimum data set) Assessment indicated resident 10 had an indwelling catheter. Current physician orders included, but were not limited to, "Foley catheter care Q [every] shift and as needed" dated 6/4/22 and "Empty catheter drainage bag at least once every eight hours to when it becomes 1/2 to 2/3 full every 8 hours" dated 5/6/22. A current indwelling urinary catheter care plan, initiated 7/5/22, indicated "Resident is at risk for infection/complications related to Indwelling Catheter r/t [related to]Neurogenic bladder." Interventions included, but were not limited to, "...document catheter output every shift...catheter/peri [perineal] care at least every shift and as needed." The facility failed to provide Foley catheter care on the following days/ shifts: July 8- day shift July 20- night shift July 21- night shift July 27- day shift		drainage bags emptied every shift by the DNS/Designee on 8/30/2022. All residents with a diagnosis of COPD were audited to ensure the plan of care reflects that the head of bed needs elevated, if appropriate, by the DNS/Designee on 8/30/2022. All residents were audited to ensure weights were obtained per order by DNS/Designee on 8/30/2022. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing staff was educated on following physician orders and plans of care by the DNS/Designee on 8/30/2022. **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;** QAPI tool Foley Catheter, weights, and COPD will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	July 28- day shift August 1- day shift August 2- day shift August 3- day shift August 6- day shift The facility failed to empty the Foley catheter drainage bag on the following days/ times: July 8- 5:00 A.M. July 8- 1:00 P.M. July 15- 5:00 A.M. July 20- 5:00 A.M. July 20- 9:00 P.M. July 21- 5:00 A.M. July 21- 9:00 P.M. July 22- 5:00 A.M. July 23- 9:00 P.M. July 24- 5:00 A.M. July 27- 1:00 P.M. July 28- 1:00 P.M. August 1- 1:00 P.M. August 2- 1:00 P.M. August 3- 1:00 P.M. August 6- 1:00 P.M. August 9- 9:00 P.M. During an interview on 8/9/22 at 10:02 A.M., LPN (licensed practical nurse) 27 indicated catheter care should be done every shift and the catheter bag should be emptied every 8 hours. 3. On 8/9/22 at 9:20 a.m., Resident 44's clinical record was reviewed. Resident 44 had diagnoses that included, not limited to Achondrasia, feeding difficulties unspecified, dysphagia oropharyngeal phase. A quarterly MDS (Minimum Data Set) assessment dated 6/23/22, indicated Resident 44's cognition was severely impaired, eating extensive assist x 1. Care plans were reviewed and included, not			

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	limited to, Resident at risk for fluid imbalance due to poor intake, recent infection, need for assistance with intake, initiated 7/26/22. Interventions included, not limited to, weights as ordered/indicated, notify MD of significant weight changes, initiated 7/26/22. July 2022 physician orders were reviewed and included, not limited to: weight every other day every day shift every other day, order date 7/27/22. Enteral feed order as needed Osmolite 1.2 @ 55ml/hr from 8pm-6am per NG tube if eats <50% for 2 meals, order date 7/27/22. The EMAR (Electronic Medication Administration Record) was reviewed for July and August 2022 and included the following for the above order: July 2022: Weight every other day every day shift every other day, start date 7/27/22 6:00 a.m. 7/27/22 blank, 7/28/22 signed NA. August 2022: Weight every other day every day shift every other day, start date 7/27/22 6:00 a.m. 8/2 blank, 8/4/ wt 92, 8/6/ wt 92.4, 8/8/ blank, 8/10 94.5. Vital signs were reviewed for July and August and the following weights were documented: 7/28- 99.2, 7/29- 99.2, 8/4- 92, 8/6- 92.4. Resident 44's admission weight on 6/16/22 was 114.5. Weights were not obtained every other day as ordered on 7/31/22, 8/2/22, 8/8/22. On 8/9/22 at 11:12 a.m., QMA 23 indicated that if a resident has an order for weights, the Aides obtain the weights as ordered.			

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	During an interview on 8/11/22 at 10:58 A.M., the Administrator indicated the facility did not have a policy related to following the plan of care, but indicated at that time the facility's policy was to follow physician orders and care plan interventions. 3.1-35(a) 3.1-35(g)(1)			
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 observation, interview, and record review, the facility failed to provide adequate supervision and prevent falls for 2 of 4 residents reviewed for accidents. Fall interventions were not in place for residents with multiple falls. (Resident 25, Resident 9) Findings include: 1. On 8/8/22 at 8:46 A.M., Resident 25's clinical record was reviewed. Diagnosis included, but were not limited to, epilepsy, anxiety disorder, history of falling, and Alzheimer's disease. The most recent significant change MDS (minimum data set) Assessment, dated 5/12/22, indicated Resident 25 had a severe cognitive impairment, and required extensive assistance of 2	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #25's fall care plan was reviewed and interventions were updated and the non-skid strips were replaced in the resident's room and bathroom. Resident #9's fall care plan was reviewed and interventions were updated and call light was placed in reach. A wedge cushion was received per hospice and added to the plan of care. A new fall assessment was completed on 8/26/2022.	09/01/2022

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	(two) staff with bed mobility, transfers, and toileting, extensive assistance of 1 (one) staff with eating, and was totally dependent on 1 (one) staff for bathing. Resident 25's care plan included, but were not limited to, "[Resident] at risk for falls r/t [related to] History of falls, Poor safety awareness, Incontinence", dated 3/21/17 and revised 4/21/22. Interventions included, but were not limited to, "Placed sign in room to "Call for assistance, don't fall"" dated 5/11/20, "Non-skid strips at bedside on R) side of bed" dated 12/23/20, "Non-skid strip in front of toilet" dated 6/13/20, "Elbow pads bilaterally to protect skin" dated 1/10/22, "Colored tape to be added to w/c [wheelchair] brakes for better identification by resident" dated 10/13/20, and "Brake extender added to w/c brake both sidses [sic]" dated 12/7/20. Resident 25's falls history included the following: Fall 1 10/31/21 at 9:30 P.M. Resident found on the floor, lying on back beside the bed. Redness noted to the left side of the forehead, near the temple. Emesis noted on the floor by the resident. Due to increased emesis and headache, the resident was sent to the Emergency Room for further evaluation. The resident was unable to verbalize how the fall occurred. Neurological checks initiated after the fall and stopped when resident was sent to the ER. Neuro checks were not initiated again after return from the ER. The falls care plan was not updated with a new intervention. Fall 2 1/8/22 at 6:30 P.M. While self propelling in a wheelchair, Christmas lights that had been		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. All resident's with falls in the last 30 days have been reviewed for appropriate fall interventions and care plan interventions updated as needed All current fall interventions were audited per DNS/Designee to ensure plan of care is followed on 8/29/2022. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All staff were educated on fall prevention and interventions on 8/29/2022 by DNS/Designee. **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;** QAPI tool Falls will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee. If 100% threshold is not achieved an action plan will	

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	wrapped around the wheelchair became tangled in Resident's right foot and wheelchair wheels. Resident fell out of the wheelchair and landed on her bottom. Neurological checks not completed due to fall being witnessed. Falls care plan updated to include removing Christmas lights from the wheelchair. Fall 3 1/9/22 at 4:00 P.M. Resident attempted to take self to the bathroom in the dining area on the 200 Hall and fell to the floor. Resident suffered a gash to the forehead when hit on the toilet. Resident screamed and was found on the floor crying holding her head. Forehead was bleeding. Resident was taken to the ER where she received 10 (ten) sutures to the forehead. Neurological checks were not completed before ER visit or upon return to the facility early the following morning. An IDT (interdisciplinary team) note, dated 1/17/22 indicated the care plan would not be updated with a new intervention related to the fall on 1/9/22 as the resident was unable to comprehend safety interventions. Fall 4 1/22/22 at 4:30 P.M. Resident found on the floor under the dining room table with blood coming from the head where stitches had been removed 2 (two) days prior. Resident was sent to the ER. Neurological checks were not completed before ER visit or upon return to the facility the same day at 9:38 P.M. Falls care plan was not updated with any new interventions. Fall 5 3/20/22 at 8:15 P.M. Resident found sitting on the		be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	floor next to the bed. Resident indicated she was trying to put self to bed. Neurological checks were not completed. Falls care plan was not updated with any new interventions. Fall 6 7/23/22 at 2:35 P.M. Resident was found on the floor with a laceration to the middle of the forehead, top of septum, and 4th digit to left hand. Resident was sent to the ER and received sutures to the forehead, bridge of nose, and finger. Neurological checks were started 7/23/22 at 2:35 P.M., stopped at 3:30 P.M. when resident was sent to the ER, and began again at 6:30 P.M. through 11:00 P.M. No neuro checks were completed after that time. The falls care plan was updated 7/25/22 for therapy to evaluate and treat related to wheelchair positioning. On 8/10/22 at 10:25 A.M., Resident 25's room was observed with 3 non-skid strips by the bed. The one in the middle was missing 75% of it, and the two on the outsides were folded and coming up from the floor. The bathroom was lacking non-skid strips. The room was lacking a sign to request assistance when getting up. At that time, the resident was observed sitting in the common area behind the 200 Hall nurses station sitting in a wheelchair. Resident 25 lacked elbow pads, and the wheelchair lacked colored tape to the right brake handle. The wheelchair also lacked brake extenders. During an interview on 8/10/22 at 10:55 A.M., the DON (Director of Nursing) indicated she was unsure what had happened to the strips in Resident 25's room or where the call for assistance sign was. At that time, the MDS Coordinator			

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	indicated she was unsure why Resident 25 did not have elbow pads, and would need to delete that as an intervention in the falls care plan. 2. On 8/9/22 at 10:26 A.M., Resident 9's clinical record was reviewed. Diagnoses included, but were not limited to, malignant neoplasm of unspecified part of right bronchus or lung and rheumatoid arthritis. The most recent quarterly MDS (minimum data set) Assessment, dated 7/23/22, indicated Resident 9 had a severe cognitive impairment, and required assistance of 2 (two) staff for all ADLs (activities of daily living). A current falls care plan, revised 4/19/22, indicated at risk for falls due to weakness, cognition, psychotropic drug use, intermittent pain, and wandering. Interventions included, but were not limited to, encourage and assist to wear appropriate non skid footwear (dated 4/15/22), fall mat placed at bedside (dated 6/21/22), place bed against wall (dated 7/7/22), bolstered mattress (7/7/22), and bed kept in low position (dated 7/25/22). Resident 9's falls included: Fall 1: 6/21/22 7:41 A.M., "CNA (Certified Nurse Aide) responded to noise in room and observed resident sitting on [the] floor beside bed. Nurse was notified. Upon entering room resident was observed on floor sitting with back to bed with feet out in front of her. She was observed sitting on pillow. Resident is unable to articulate what happen she states "I just sat on the floor." The new intervention at this time was a fall mat at bedside. Documentation of neurological checks for this unwitnessed fall was requested, and the facility failed to provide documentation.			

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	Fall 2: 6/25/22 10:19 P.M., "Nurse walking in hallway when Nurse observed resident on floor." At that time, an assessment was completed with no complaints of pain. Resident was unable to verbalize the reason for the fall. Fall was unwitnessed. The new intervention at that time was "Hospice medication review and discussed continuing POC [plan of care]." The facility failed to provide documentation of neurological checks for the unwitnessed fall. Fall 3: 6/26/22 6:32 P.M., "nursing aide alerted nurse that resident observed on floor." The new intervention at that time was to place bed against wall. The facility failed to provide documentation of neurological checks for the unwitnessed fall. Fall 4: 6/30/22 5:22 A.M., "Resident found by CNA sitting in the floor next to her bed. No injury noted, resident confused per her usual." The facility failed to implement a new intervention in Resident 9's plan of care. Fall 5: 7/7/22 4:21 A.M., "resident observed on floor during resident routine rounding, resident unable to recall event, resident denies pain at present time." The new intervention at that time was "Contact hospice for bolstered mattress." The facility failed to provide documentation of neurological checks for the unwitnessed fall. Fall 6: 7/26/22 9:41 A.M., "IDT [interdisciplinary team]			

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	155670	A. BUILDING 00 B. WING	08/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NEWBURGH	5233 ROSEBUD LANE NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review: Nurse heard resident yelling for "HELP" upon entry into room resident was found laying on right side in middle of floor. Resident was unable to let nurse know how she fell, Resident was helped up by nurse and aide. Resident vitals are within normal limits. C/o [complaints of] pain noted. Resident is a poor historian. PRN [as needed] pain medication administered. The new intervention at that time was "Bed kept in low position; Hospice consulted for further intervention. The clinical record lacked documentation of the incident at the time of the fall. The clinical record also lacked documentation of PRN pain medication given at the time of the fall. Fall 7: 7/31/22 9:00 P.M., "Resident observed on the floor next to her bed." The new intervention at that time was "Contact hospice for wedge pillow and medication review for increased restlessness; increased checks for O2 [oxygen] sat [saturation] and encourage O2 use." On 8/4/22 at 9:30 A.M., Resident 9 was observed in bed with eyes closed. The call light was observed on a table, out of the resident's reach. During an interview on 8/10/22 at 9:03 A.M., LPN (Licensed Practical Nurse) 19 indicated Resident 9 utilizes a fall mat, a bolster, and Resident 9's bed is against the wall. At that time, LPN 19 indicated a wedge was ordered from hospice, however, unsure if the wedge arrived at the facility. During an interview on 8/10/22 at 8:47 A.M., the DON indicated a new care plan intervention was required after a fall, and that information was verbally communicated with other staff to follow.			

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	She further indicated neuro checks were required with each unwitnessed fall or if the resident was witnessed hitting their head. She indicated they were aware of an issue with lacking neurological checks following falls, and would need to address. On 8/10/22 at 11:02 A.M., the MDS Coordinator indicated after a resident fall, their care plan should be updated immediately after the IDT note was written. On 8/11/22 at 10:59 A.M., a current non-dated Assessing Falls and Their Causes policy was provided and indicated following a fall, the appropriate interventions for preventing future falls should be documented. On 8/11/22 at 10:59 A.M., a current non-dated Falls and Fall Risk Management policy was provided and 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" 3.1-45(a)(2)			
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			

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	usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview and record review, the facility failed to ensure a resident who experienced weight loss had new interventions instituted and that the registered dietitian and the physician were notified of a significant weight loss for 1 of 3 reviewed for nutrition. (Resident G) Findings include: On 8/4/22 at 8:55 A.M., Resident G was observed lying asleep in bed. A tray with a full plate of food including scrambled eggs and juice was observed sitting on a bedside table in front of her, untouched. The tray lacked a supplemental drink. On 8/4/22 at 9:28 A.M., CNA (certified nurse aide) 5 was observed to enter Resident G's room, walked past Resident G, and handed the roommate a cup of water. CNA 5 then exited the room without addressing Resident G. At that time, the plate in front of Resident G was still untouched, and Resident G was still asleep. During an interview on 8/4/22 at 9:36 A.M., CNA 3 indicated the breakfast trays had been passed that morning between 7:30 and 8:00 A.M. At that time, Resident G's plate was still untouched.	F 0692	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident G's MD and the Registered Dietitian was notified of weight loss on 8/30/2022. Resident G receives assistance with meals as needed. Resident G's nutritional care plan was reviewed and updated as indicated on 8/30/2022. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. All residents were audited to ensure weights were obtained and the MD/NP was notified of any significant change by DNS/Designee on 8/30/2022.	09/01/2022

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	On 8/8/22 at 9:03 A.M., Resident G's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety disorder, dementia, and abnormal weight loss. The most recent MDS (minimum data set) Assessment, dated 7/22/22, indicated Resident G had a severe cognitive impairment, and required limited assistance of 1 (one) for eating. The MDS also indicated a significant weight loss. Resident G's height was 60 inches. Weights from February 2022 through August 2022 included the following: 2/4/2022 136.9 Lbs 3/5/2022 139.8 Lbs 4/6/2022 146.0 Lbs 5/2/2022 141.4 Lbs 6/6/2022 132.4 Lbs 6/27/2022 131.9 Lbs 7/4/2022 123.0 Lbs 7/18/2022 123.9 Lbs 8/1/2022 107.6 Lbs 8/4/2022 109.4 Lbs 8/8/2022 108.2 Lbs 8/8/2022 108.0 Lbs Current physician orders included, but were not limited to, the following: Diet: no added salt, regular texture and thin liquids, started 4/11/22 Two Cal HN (a dietary caloric supplement) 60cc (milliliters), two times a day, started 4/11/22 The most recent Registered Dietician note, dated 4/18/22, indicated resident was evaluated and noted to have a slight weight gain. The registered dietician recommended at that time to discontinue Two Cal HN 60cc related to good intakes and weight gain.		All residents that require assistance with eating were reviewed to ensure the proper level of assistance is provided. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All licensed nurses were educated on notifying the MD/NP/RD of significant weight changes on 8/29/2022 by the DNS/Designee. All nursing staff was educated on providing assistance at meals when applicable on 8/29/2022 by DNS/Designee **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;** QAPI tool Nutrition/Weights will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	Resident G's clinical record lacked any other notification or note from the Registered Dietician since that visit. A current "potential for nutritional risk" care plan, revised 8/6/22, was reviewed and included, but was not limited to, the following interventions: "Provide and serve supplements as ordered" dated 9/28/21 "RD [registered dietician] to evaluate and make diet change recommendations PRN [as needed]" dated 9/28/21 "Weights as ordered/indicated, notify MD of significant weight changes" dated 9/28/21 A current "assistance with ADLs (activities of daily living)" care plan, revised 3/11/22, was reviewed and included, but was not limited to, the following interventions: "Staff to provide physical assistance with meal intake as needed. Provide cueing and encourage her to participate, provide assistance if [resident] does not initiate task" revised 8/6/22 A behavioral health progress note, dated 6/10/22, indicated "During session resident presented as dysphoric with blunted affect. Resident was sitting in [their] bed eating breakfast at time of encounter. She was holding her fork with [sic] food on it, but was not taking bites. She appeared confused on what to do with fork. Clinician explained how to bring fork to her mouth, but she just provided blank stare. She put fork down and grabbed clinician's hand ..." The clinical record lacked any notification to the physician of a weight loss. On 8/8/22 at 9:46 A.M., Resident G was observed lying asleep in bed. A tray with a full plate of			

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	food including bacon, toast, a banana, two french toast sticks, grits, a full syrup container, and a carton of milk was observed sitting on a bedside table in front of her, untouched. The tray lacked a supplemental drink. CNA 31 was observed to enter the room at 9:50 A.M., and again at 9:57 A.M., to assist Resident G's roommate, but did not address Resident G. During a continuous observation on 8/9/22 from 7:45 A.M. until 8:33 A.M., the following was observed: 7:45 A.M. A meal cart was brought out to the 200 Hall and staff began passing trays 8:15 A.M. CNA 15 brought a meal tray into Resident G's room and sat it on the bedside table. CNA 15 raised the head of the bed, indicated to Resident G "good morning", but Resident G did not respond. CNA 15 removed the lid from the plate, and left the plate in front of Resident G as Resident G continued to sleep, and CNA 15 exited the room and left the door open. A supplement drink was not observed on the tray. 8:21 A.M. CNA 7 passed Resident G's room 8:23 A.M. CNA 7 passed Resident G's room 8:25 A.M. RN (registered nurse) 17 walked into Resident G's room and assisted roommate. RN 17 did not address Resident G who was still sleeping. At that time, CNA 7 passed Resident G's room. 8:27 A.M. CNA 7 passed Resident G's room 8:28 A.M. CNA 7 passed Resident G's room 8:31 A.M. CNA 7 and the SSD (Social Services Director) stood in front of Resident G's room talking. 8:32 A.M. LPN (licensed practical nurse) 9 passed Resident G's room 8:32 A.M. CNA 7 collected empty meal trays from several resident rooms, and loaded them onto the cart in the hall, walking past Resident G's room 8:33 A.M. LPN 9 passed Resident G's room			

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	On 8/9/22 at 9:04 A.M., Resident G was observed with the same untouched tray in front of her, and was asleep in bed. During an interview on 8/9/22 at 9:06 A.M., RN 17 indicated supplement shakes were either administered to residents from the nurses, or sometimes would receive on their meal tray. At that time, RN 17 indicated she only had one resident that received a supplemental shake on that hall, and it was not Resident G. On 8/10/22 at 12:51 P.M., Resident G was observed sitting in the common area behind the 200 Hall nurses station in a wheelchair with a blanket over her and arms bent up with hands laying across the chest. At that time, CNA 7 indicated Resident G did not eat the lunch meal, so it was put up untouched. CNA 7 then left the common area and returned with two small containers of ice cream. CNA 7 assisted to feed one bite of the ice cream to Resident G, then asked her to hold the container, and pushed the resident to the other side of the room where the resident sat the container on the table. CNA 7 picked up the container, attempted to give Resident G a bite, and when Resident G said "no", CNA got up, and disposed of the containers of ice cream. CNA 7 did not encourage Resident G to eat any more after that attempt. During an interview on 8/10/22 at 8:53 A.M., the DON (Director of Nursing) indicated if a resident had a true weight loss, the nurses should notify the practitioner. During an interview on 8/10/22 at 1:42 P.M., the Administrator indicated the Registered Dietician visited the facility weekly on Wednesdays to			

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	155670	A. BUILDING 00 B. WING	08/11/2022

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	review residents. She indicated any resident with a change in condition would be identified in their morning meeting, and that report given to the Registered Dietician on her weekly visit. She indicated Resident G had not been seen by the Registered Dietician due to not being flagged as a weight loss, and therefore, they were unaware of the significant weight loss. On 8/11/22 at 10:59 A.M., a current non-dated Unplanned Weight Loss policy was provided and indicated "The nursing staff will monitor and document the wight and dietary intake of residents in a format which permits comparisons over time ... The staff will report the the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake" This Federal tag relates to Complaint IN00387611. 3.1-46(a)(1)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides.			

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	(iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, interview, and record review, the facility failed to ensure completed staffing sheets were posted daily for 7 of 7 days during the survey. Findings include: On 8/3/22 at 10:0 A.M., a staffing sheet was observed to be posted on the window of the front desk by the main entrance. The staffing sheet indicated the date, total census, and total hours worked each shift. Disciplines included LPN, RN, QMA, and CNA. Specific number of staff and exact hours worked were not included in the posting. On 8/10/22 at 9:19 A.M., staff posting sheets from	F 0732	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the alleged deficient practice. The daily staffing posting will be visibly posted every day. **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;** No residents have the potential to be affected by the alleged deficient	09/01/2022

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	8/1/22 through 8/10/22 were provided. Each staff posting sheet indicated the date, total census, and total hours worked each shift. Specific number of staff and exact hours worked were not included. At that time, the Human Resources Coordinator indicated the staff posting form was put together previous to the new staff in the facility, and was unaware it was not correct. On 8/11/22 at 10:59 A.M., a current non-dated Posting Direct Care Daily Staffing Numbers policy was provided and indicated "The information recorded on the form shall include ... Total number of licensed and non-licensed nursing staff working for the posted shift"		practice. The daily staffing posting will be visibly posted every day. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Executive Director and Director of Nursing Services were educated on the daily staffing posting by the Regional Nurse Consultant on 8/30/22. **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;** The Executive Director/Designee will monitor to ensure the daily staffing form is visibly posted daily.	
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			

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	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 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 interview and record review, the facility failed to ensure residents were free from unnecessary medications for 2 of 5 residents reviewed for unnecessary medications. A GDR	F 0758	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	09/01/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	(gradual dose reduction) was not completed to reduce a psychotropic medication. A resident's as needed anti-anxiety medication was ordered for greater than 14 days. (Resident 32, Resident 55) Finding includes: 1. On 8/8/22 at 10:41 A.M., Resident 55's clinical record was reviewed. Diagnosis included, but were not limited to, Non-Alzheimer's dementia, anxiety disorder, and depression. The most recent significant change MDS (Minimum Data Set) Assessment, dated 7/2/22, indicated Resident 55's cognition was moderately impaired and was currently on hospice. Current physician orders included, but were not limited to, "Ativan Tablet 0.5MG (LORazepam) Give 1 tablet by mouth every 8 hours as needed for anxiety related to ANXIETY DISORDER, UNSPECIFIED" dated 5/30/22. Resident 55's clinical record lacked any physician assessments for lorazepam after the initial 14 days after it was ordered. During an interview on 8/10/22 at 2:06 P.M., LPN (licensed practical nurse) 9 indicated a doctor comes to the facility every Friday to review medications and adjust the resident's medications as needed. 2. On 8/9/22 at 12:48 p.m., Resident 32's clinical record was reviewed. Resident 32 had diagnoses that included, not limited to, acquired absence of right leg above knee, acquired absence of left leg above knee, surgical aftercare following other specified depressive episodes, major depressive disorder, recurrent. A quarterly MDS (Minimum Data Set) assessment dated 6/10/22, indicated Resident 32's cognition was intact, had received		**practice;** Resident #55's Ativan was reviewed by the MD on 8/30/2022. Resident #32's gradual dose reduction was reviewed with the MD on 8/30/2022. **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;** Residents that reside in the facility and utilize psychotropic medications have the potential to be affected by the alleged deficient practice. All residents utilizing psychotropic medications were reviewed by the DNS/Designee to ensure all gradual dose reductions have been reviewed by the MD/NP. All residents utilizing as needed anti-anxiety medication are reviewed by the MD/NP a minimum of every 14 days for continued use. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing staff and social services were educated on the psychotropic medication policy, including GDRs and as needed anti-anxiety medication on 8/30/2022 by the DNS/Designee	

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	155670	A. BUILDING 00 B. WING	08/11/2022

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	antidepressant medication 7 days of the review. Care plans were reviewed and included, not limited to, (resident name) receives psychotropic medication, antidepressant for Depression and sleep aide for Insomnia at risk for adverse side effects. (Resident name) exhibits sporadic tearful episodes Date Initiated: 12/11/2019 Revision on: 7/8/2022 Current physician orders were reviewed for August 2022 and included, not limited to: Citalopram (antidepressant) 10 mg (milligram) oral. A pharmacy note to attending physician/prescriber with a MMR (medication regimen review) date of 3/23/22 was reviewed and indicated Resident 32's antidepressant was due for review and dose reduction if indicated, to document current mental and behavioral status; review the new dose recommended or provide detailed reason(s) that a dose reduction was not indicated. The dose reduction recommendation was from 5 mg to 2.5 mg. The start date of the antidepressant was 9/1/21. There was not a follow up from the physician in the record. On 8/11/22 at 10:47 a.m., the DON provided a physician/prescriber form with a check mark for agree with the dose reduction per (name of Nurse Practitioner) verbal on 8/11/22 at 10:35 a.m. The DON indicated Resident 32's original GDR (Gradual Dose Reduction) was sent to Social Services, and that Social Services employee was no longer employed at the facility. On 8/11/22 at 10:59 a.m., the Administrator provided the current policy on psychotropic management, with a revision date of September		**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;** QAPI tool Unnecessary Psychotropics will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	

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	2020. The policy included, not limited to, psychotropic medications are managed in collaboration with the attending physician, pharmacist, and care team members through assessment, interventions, and reduction, as applicable. Procedure: the facility will initiate a request for a Gradual Dose Reduction (GDR) at least once on the following schedule for each drug. For residents who use antidepressant medications a GDR must be initiated per the following guidelines: during the first year that the resident is admitted to the facility on an antidepressant or after the facility has initiated an antidepressant, a GDR, must be attempted twice in two separate quarters with at least one month in between attempts, unless clinically contraindicated by the physician/N.P. A PRN (as needed) Psychotropic policy was requested and not obtained. 3.1-48(a)(2) 3.1-48(a)(3) 3.1-48(a)(6)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review, and	F 0804	**What corrective action(s) will**	09/01/2022

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	interview, the facility failed to provide food that was palatable, attractive, and at a safe and appetizing temperature for 1 of 1 breakfast trays sampled. Finding included: During the survey from 8/3/22 to 8/11/22 the following random resident interviews were completed: The food is not good. The food is cold. The food is cold and too salty. On 8/5/22 at 7:40 A.M., a breakfast tray was obtained with the following temperatures and tastes: sausage 108 degrees Fahrenheit, taste was cold, sausage was pink in the middle. waffle 110 degrees Fahrenheit, taste was cold. oatmeal 153 degrees Fahrenheit, taste was bland. On 8/11/22 at 8:35 A.M., a current Food Production policy, dated March 2019, was obtained and indicated the sausage should be "155 degrees Fahrenheit for...sausage..." This Federal tag relates to Complaint IN00387611. 3.1-21(a)(1) 3.1-21(a)(2)		**be accomplished for those residents found to have been affected by the deficient practice;** No residents were identified. **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 the alleged deficient practice. All hot food cooking temperature will be monitored to ensure at least 155 degrees and holding temperature is at least 135 degrees. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All staff was educated on ensuring that palatable, attractive, food at a safe temperature is being served by the Executive Director/Designee on 8/30/2022. A new Camduction heat system has been ordered and will be utilized upon receipt to ensure food remains a palatable temperature. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place; QAPI tool Food Service will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies,			

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

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure infection control practices were followed for 4 of 6 residents during observation of perineal care, medication administration, placement for Foley catheter bag and 1 of 1 resident receiving a Covid 19 test. Gloves were not changed between dirty and clean tasks during peri care, staff was observed not wearing a mask with a resident present, a medication was picked up from the top of a medication cart with bare hands and given to a resident, and Foley catheter bag and tubing was touching the floor. (Resident 156, Resident 221, Resident 226, Resident 122, Resident 229, Resident 2) Findings include: 1. On 8/9/22 at 10:04 A.M., CNA (certified nurse aide) 25 was observed performing incontinence care for Resident 156. Prior to beginning, CNA 25 put on a pair of gloves. After removing the visibly soiled brief, CNA 25 cleaned the resident with several wipes, and placed all dirty items in a trash bag. CNA 25 then put a clean incontinence brief onto the resident, then removed her gloves. Gloves were not changed during the task. At that time, CNA 25 indicated she had not been trained on changing gloves from dirty to clean tasks. 2. On 8/10/22 at 10:30 A.M., the SSD (Social Services Director) was observed sitting in her office speaking with Resident 2, as he was within arms length. The SSD was not wearing a mask. 3. On 8/5/22 at 7:14 A.M., QMA (qualified	F 0880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident #156 was assessed, no negative outcome. Resident #2 was assessed, no negative outcomes Resident #226 was assessed, no negative outcomes Resident #221 was assessed, no negative outcomes Resident #122 was assessed, no negative outcomes Resident #45 was assessed, no negative outcomes Resident # 52 was assessed, no negative outcomes **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 resident's that reside in the facility have the potential to be affected by the alleged deficient practice. C.N.A #25 was educated on changing gloves from dirty to clean tasks on 8/29/2022 by the DNS/Designee. Social Service Director was educated on proper mask usage on 8/29/2022 by the Executive	09/01/2022

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	medication aide) 41 was observed gathering medications for Resident 221. QMA 41 popped an omeprazole 40mg (milligram) tablet out of the container, and it landed on the top of the medication cart. QMA 41 then popped out another one, and it too landed on the top of the medication cart. QMA 41 picked up one of the tablets with bare hands, and placed it into the medication cup with all of the other medications for that resident, then administered them to Resident 221. At that time, QMA 41 indicated although she should not have done that, she didn't want to keep wasting the pills.4. During an observation on 8/10/22 at 2:08 P.M., Resident 226 was observed in bed. Resident 226's Foley catheter bag and tubing were resting on the floor. During an interview on 8/11/22 at 10:00 A.M., the Administrator indicated catheter bags and tubing should be off of the ground. 5. On 8/11/22 at 8:39 A.M., LPN (licensed practical nurse) 19 entered a yellow zone room with only a surgical mask and eye protection on. During an interview on 8/11/22 at 9:15 A.M., LPN 19 indicated the resident was on the yellow zone precautions due to being a new admission. LPN 19 further indicated to enter a yellow zone room, staff must wear a shield, mask, and gown. 6. On 8/4/22 at 8:41 a.m., QMA 23 was observed to perform a COVID-19 test. QMA 23 donned gloves and a gown. She had on a face shield and surgical mask. QMA 23 entered Resident 122's room and performed a nasal swab to Resident 122, put the swab in the test card, doffed her gown and gloves, left the room, touching her surgical mask two times, took the test card to the cart, no hand hygiene was performed. QMA 23 moved the cart down the hallway to room 229. Resident 45 and		Director/Designee. QMA #41 was educated on medication handling during administration on 8/30/2022 by the DNS/Designee. LPN #19 was educated on hand hygiene and appropriate PPE on 8/29/2022 by the DNS/Designee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All staff were educated on proper donning and doffing PPE and hand hygiene with return demonstration on 8/30/2022 by the DNS/Designee. The Executive Director/Designee will audit daily to ensure hand hygiene items, including soap and ABHS are always available. All staff were educated to notify the Executive Director immediately if these items are unavailable. All nursing staff were educated on ensuring indwelling catheters are cared for in a manner to prevent the possibility of infection by the DNS/Designee on 8/29/2022. All licensed nurses and QMAs were educated on infection control practices during medication administration to prevent possible contamination of medication by the DNS/Designee on 8/30/2022 All nursing staff were educated on proper performance of ADL care including but not limited to	

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	Resident 52 were in the room. QMA 23 donned gloves and a gown and entered the room, she had on a face shield and surgical mask, no hand hygiene was performed before donning PPE (Personal Protective Equipment) or entering the room. On 8/11/22 at 10:00 a.m., the Infection Preventionist indicated the required PPE to be worn while performing a COVID-19 nasal swab was gloves, gown, N95 mask, face shield, or eye goggles. On 8/11/22 at 10:59 a.m., the Administrator provided the current training checklist for the COVID- test kit that was observed to be used. The checklist included, not limited to: perform hand hygiene and don gloves, N-95/KN-95, gown, and face shield. On 8/11/22 at 8:35 A.M., a current non-dated Standard Precautions policy was provided and indicated "Gloves are changed as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a "dirty" site to a "clean" one)" On 8/11/22 at 8:35 A.M., a current non-dated Administering Oral Medications policy was provided and indicated "For unit dose tablets or capsules. Place packaged medications directly into the medication cup" 3.1-18(b) 3.1-18(l)		perineal care for male and female residents by the DNS/Designee on 8/30/2022. **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;** A Root Cause Analysis was conducted with input from the facility Medical Director/IP/DNS. Solutions and systemic changes were identified. The LTC infection control self-assessment was reviewed and updated as necessary. QAPI tool Infection Control will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee. If 100% threshold is not achieved an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting. DNS/IP/ED/Designee will monitor each area daily for a minimum of 6 weeks or until compliance is reached. DNS/IP/ED/Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate infection control techniques and complying with the solutions identified for a minimum of 6 weeks or until compliance is maintained.	

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			The facility through the QAPI program will review, update and makes changes to DPOC as needed for sustaining substantial compliance for no less than 6 months.	