STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155367	A. BUILDING 00 B. WING	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE -SYCAMORE VILLAGE CARE CENT	2905 W SYCAMORE ST KOKOMO, IN 46901

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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 IN00388390. Complaint IN00388390 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684 and F726. Survey dates: August 15, 16, 17, 18, 19, and 22, 2022 Facility number: 000258 Provider number: 155367 AIM number: 100289160 Census Bed Type: SNF/NF: 99 Total: 99 Census Payor Type: Medicare: 3 Medicaid: 75 Other: 21 Total: 99 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 1, 2022.	F 0000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission or agreement with the facts and conclusions set forth the survey report. Our Plan of Correction was prepared and executed as a means to continuously improve the quality of care and comply with all applicable federal and state requirements.¿¿ ¿ The facility respectfully requests a desk review of our responses to this survey.¿	
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)			

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

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	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 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			

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	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 contact the primary responsible party for a resident's fall for 1 of 1 residents reviewed for notification. (Resident G) Finding includes: During an interview, on 08/16/22 at 11:02 a.m., Resident G's daughter indicated the resident had a fall and she was not notified. The record was reviewed on, 08/16/22 02:44 p.m., diagnoses included, but were not limited to, Alzheimer's disease, transient cerebral ischemic attack, seizures, essential hypertension, hypokalemia, anxiety, mood disorder due to known physiological condition, vascular dementia with behavioral disturbance, cognitive deficit, and cardiac murmur. An IDT (interdisciplinary team) fall note, dated 8/6/22 at 02:06 p.m., indicated the resident's secondary responsible party was notified. Documentation was not found to explain the reason the primary responsible party was not contacted. During an interview , on 8/22/22 at 2:30p.pm., the Unit Manager of the ACU (Alzhiemer' care unit), indicated the primary responsible party should be called first and then the secondary responsible party. She indicated a note should have been made to indicate the reason the secondary	F 0580	F 580 (D) Notify of Changes What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident G: Clinical record was reviewed and updated to reflect that the residents responsible party was notified of the event. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ All residents with a fall event have the potential to be affected by the same deficient practice. The facility completed a 30 day look back to ensure that all current residents with fall events have documented notification of the resident's responsible party or documentation to support why secondary party was notified. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ RN/LPN staff were educated on the guideline for notification of changes to include but not limited to notifying the residents responsible party when the resident has a fall. On-going monitoring The DNS or Designee will review all fall risk events daily	09/23/2022

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	responsible party was notified. At the time of exit the facility had not provided a policy on notification. 3.1-5(a)(1)		during clinical to ensure that the residents responsible party was notified of the event and documented in the clinical record. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿ How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿ Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations.¿ If issues/trends are identified, then based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or			

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	possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to review and implement PASARR (preadmission screening and resident review) Level II recommendations for 1 of 1 residents reviewed for PASARR (Resident 94). Finding includes: During an interview, on 8/15/22 at 1:03 p.m., the resident indicated she had been at the facility a month and had not seen the doctor. The resident was on the AACU (advanced Alzheimer's care unit). The record for Resident 94 was reviewed on 8/17/22 at 9:55 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, occlusion and stenosis of bilateral carotid arteries, age related cognitive decline, unspecified psychosis not due to a substance disorder or known physiological condition, anxiety disorder, mood disorder due to a known physiological condition with mixed features, major depressive disorder and unspecified dementia without behavioral disturbance. A physician's order, dated 7/28/22, indicated psych services to evaluate and treat. A progress noted, dated 7/28/22 at 4:58 p.m., indicated the resident's guardian signed the immunization consents and the code status form. The forms were signed by the Area V guardian. The consent for the psychiatric evaluation was not included in the progress note dated 7/28/22.	F 0644	F 644 (D of PASARR and Assessments What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident 94: Clinical record was reviewed to include review of PASARR recommendations and follow up to recommendations is reflected in the clinical record. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ All residents that have recommendations through the PASARR process have the potential to be affected by the same deficient practice. Initial audit: The facility completed a 30 day look back audit of all residents that received PASARR Level II for review of any recommended specialized services and/or rehabilitative services and that there is follow up documented. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Education: SSD and ACUD/SSD were educated on the guideline for Resident Assessment-Coordination with PASARR Program to include but	09/23/2022

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	The note did not include the resident or family were asked about their wishes for code status. A progress note, dated 8/2/22 at 10:45 a.m., indicated the resident had a BIMS (brief interview for mental status) score of 15 which indicated intact cognitive response. A PASARR Level II, dated 8/10/22, indicated according to the PASARR level I, the resident was diagnosed with bipolar disorder, anxiety disorder and mood disorder, however this information was not supported in the medical records. Based on the assessment and the resident's level of care, she met the nursing home criteria for support with hypertension and hands on care needs. The resident would need to be provided supportive counseling from staff, a behaviorally based treatment plan, a dementia work-up, family involvement in care, the facility to obtain archived psychiatric records to clarify her history and a psychiatric evaluation. The reason for the supports indicated the resident would benefit from a dementia work up to determine a diagnosis, would benefit from a psychiatric evaluation to obtain her psychiatric history and to confirm a diagnosis and would benefit from family involvement in care to ensure her treatment needs were being met. A progress note, dated 8/22/22 at 11:22 a.m., indicated the resident's guardian from Area V was talked to and would be at the facility later in the day to complete documents for election of services. The election of services included the psychiatric (psych) evaluation consent. The facility had the physician's order for the		not limited to addressing the recommendations and documenting follow up in the clinical record. On-going monitoring: DNS or Designee will audit all PASARR level II recommendations received to ensure that social services is completing follow up on recommendations and documentation in the clinical record. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿ How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿ Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations.¿ If issues/trends are identified, then based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿	

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	psych evaluation, dated 7/28/22, and had not obtained consent for the services yet. During an interview, on 8/17/22 at 10:34 a.m. with the Area V guardian, she indicated she had signed the advanced directive paperwork for the resident and signed for a DNR (do not resuscitate). She did not get input from the family or the resident about their wishes for CPR (cardiopulmonary resuscitation) when she decided on the DNR status. During an interview, on 8/19/22 at 2:31 p.m., ACU (Alzheimer's care unit) Unit Manager (UM) 2, indicated the physician gave her an order on 8/18/22 to have a neurology work up although she had not entered the order into the electronic health record. She was not aware a psych evaluation had been recommended by the PASARR Level II and a consent for ancillary services had not been signed yet. She did not know who should have reviewed the PASARR Level II recommendations and make sure they were completed. The resident's family had been in the facility to visit. During an interview, on 8/22/22 at 11:30 a.m., the DNS (Director of Nursing Services) indicated the psychiatrist or Nurse Practitioner (NP) for psychiatry were at the facility weekly. Resident 94 had not been scheduled for the psychiatric evaluation because a consent had not been obtained. During an interview, on 8/22/22 at 2:45 p.m., UM 2, indicated the social services director was supposed to review the PASARR level II recommendations and make sure they were completed. The social services director was no longer employed at the facility.			

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	A current policy titled, "Resident Assessment-Coordination with PASARR Program," dated 2021 and received from the DNS on 8/22/22 at 11:04 a.m., indicated, "...This facility coordinates assessments with the preadmission screening and resident review [PASARR] program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs...PASARR Level II...determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs...The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority...Recommendations, such as any specialized services, from a PASARR level II determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care..." 3.1-16(d)(1)(B)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to clean and clip a resident's fingernails for 1 of 2 residents for activities of daily living. (Resident 10)	F 0677	F 677 (D) ADL Care provided for dependent residents What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident 10:	09/23/2022

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	Finding includes: During an observation, on 08/15/22 at 03:42 p.m., the resident's fingernails on his right hand had a dark brown substance under and on the fingernails. He was eating food with his right hand. During an observation, on 08/17/22 at 03:21p.m., the resident was laying in the bed with the head of bed elevated. The resident had on a clean gown and clean sheets were on in his bed. He just had a bath. The fingernails on both of his were hands long, jagged and pointed with brown substance on the fingernails of the right hand. During an observation, on 8/18/22 at 10:44 a.m., the resident's fingernails were noted to be long, jagged and pointed. The right hand had a brown substance on and under the fingernails. There was bleeding noted from the wounds on his head. During an observation, on 8/19/22 at 11:30 a.m., the resident indicated he had his fingernails trimmed. The fingernails on the right hand had been trimmed, but some of the brown substance remained. The fingernails on the left hand had some of the fingernails trimmed. The record was reviewed, on 08/16/22 02:58 p.m., Diagnoses included, but were not limited to, unspecified dementia with behavioral disturbance, type 2 diabetes mellitus with diabetic neuropathy, cerebral infarct, chronic pain, restlessness and agitation, psychotic disorder with delusions, hallucinations, pseudobulbar affect, and major depressive disorder. A Nurse Practitioner progress note, dated 8/12/22 at 12:55p.m., indicated the resident's head trauma		Resident received nail care to include trimming and cleaning. Clinical reviewed and plan of care residents need for assistance with nail care. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ All residents that require assistance with nail care have the potential to be affected by the same deficient practice Initial audit: the facility completed an audit of all residents to ensure nail care was provided and the residents plan of care reflected needs regarding nail care. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Education staff were educated on the guideline for nail care to include but not limited to assisting residents with nail care to include trimming and cleaning. Documentation of refusals if resident is placing a barrier to care being provided. On-going monitoring: DNS or Designee will observe residents to ensure nail care is being provided per plan of care. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿ How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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	was from his repeated scratching. A care plan, dated 12/29/22, indicated the resident had a physical function deficit, the interventions included, but were not limited to, 2 person extensive assist with self care and personal hygiene. A care plan, dated 11/24/2021, indicated the resident had a self care deficit. The interventions included, but were not limited to, provide assistance with ADLs (activities of daily living). During an interview, on 8/17/22 at 11:18a.m., CNA 3 indicated the brown substance on his fingernails were from scratching his head wounds. His fingernails were cleaned daily. At the time of the exit the facility did not provide a policy for ADL care. 3.1-38(a)(3)(E)		program will be put into place¿ Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations.¿ If issues/trends are identified, then based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.	
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 interview and record review, the facility failed to assess and document the improvement or worsening of a resident's ongoing skin condition for 1 of 3 residents reviewed for non pressure skin conditions (Resident D).	F 0684	F 684 (D) Quality of Care What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident D:	09/23/2022

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	Finding includes: During an interview on 8/18/22 at 2:27 p.m., Resident D's family indicated the resident had ongoing issues with redness under her bilateral breasts and skin folds under the abdominal area and in the groin area. The resident had the redness under her bilateral breasts since June and the resident complained of pain from the redness. The staff were supposed to put powder on the reddened areas on each shift. The family did not understand how the red areas could continue if the facility was providing treatment to the reddened skin. The record for Resident D was reviewed on 8/17/22 at 3:28 p.m. Diagnoses included, but were not limited to, immobility syndrome, chronic obstructive pulmonary disease, type 2 diabetes mellitus, unspecified dementia without behavioral disturbance, congestive heart failure, erythema intertrigo (skin on skin friction which includes mild redness to intense inflammation with oozing, exudate and crusting). A progress note, dated 6/19/22 at 4:16 p.m., indicated the resident had excoriation under her bilateral breasts and under her bilateral abdominal folds. A facility grievance, dated 7/14/22, indicated the resident's daughter had concerns which included the resident had redness on her bottom and upper part of the left thigh on 7/14/22. The resident's skin was assessed and a yeast rash was present. A physician's order, dated 7/16/22, indicated clotrimazone-bethamethasone (a treatment for fungal infections) 1-0.5% cream to apply to		Clinical record was reviewed and updated with a skin assessment that reflects residents current skin condition and treatments. Plan of care was reviewed and updated. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ All residents with ongoing skin condition have the potential to be affected by the same deficient practice. Initial audit: The facility completed an audit of all residents with current treatments to ensure their clinical record accurately reflected an assessment of the skin condition, and appropriate treatment plan of care. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Education staff were educated on the guideline for Skin Assessment to include but not limited to assessing and documenting the improvement or worsening of a resident's ongoing skin condition and changes to treatment as needed. On-going monitoring: The DNS or Designee will review skin assessment for documentation that include accurate assessment of improvement or worsening of skin condition and changes to treatment as needed. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times	

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	bilateral buttocks every shift for 14 days. A physician's order, dated 7/17/22, indicated nystatin-triamcinolone (a treatment for fungal infections) to apply to rash on the bilateral buttock and peri area for 14 days. A facility grievance form, dated 8/17/22, indicated the resident's daughter had stated the resident's skin under her bilateral breasts and pannus (excess skin in the abdomen which hangs over the pubic region) was reddened. The resident's skin was assessed and a new physician's order was obtained. A physician's order, dated 8/18/22, indicated to apply gold bond powder to bilateral breasts and the abdomen every shift for redness. A physician's order, dated 8/18/22, indicated to place a sheet of interdry (a skin protectant for skin fold and other skin to skin contact) under each breast and pannus every day shift for redness. A skin assessment, dated 8/10/22 at 1:49 p.m., indicated the resident had redness and pre-existing skin issues. The area of the redness and pre-existing skin issues were not documented. A skin assessment, dated 8/17/22 at 5:15 a.m., indicated the resident had no redness, rash or pre-existing skin conditions. During an interview, on 8/19/22 at 3:03 p.m., the DNS (director of nursing services), indicated the the skin assessments did not show the area of the skin affected by the redness since it would trigger a computer system the facility no longer used. The resident had a yeast infection which had improved so the treatment had changed from the		weekly x 4 weeks, then weekly x 4 months.¿ How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿ Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations.¿ If issues/trends are identified, then based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿	

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	155367	A. BUILDING 00 B. WING	08/22/2022

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	antifungal to the gold bond powder. The facility did not document if the affected skin was improving or worsening. The staff would communicate with each to know the condition of the skin. The DON did not know if the resident's skin was clear on 8/17/22 and then worsened when the daughter voiced concerns on 8/17/22. A current policy, titled, "Skin Assessment", dated 2021 and received from the DNS on 8/22/22 at 11:04 a.m., indicated, "...It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment...A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury...Note any skin conditions such as redness, bruising, rashes, blisters, skin tears, open areas, ulcers, and lesions...Thoroughly inspect each surface of a skin fold...Consider moisture and weight exerted by opposing skin and/or body parts [i.e. Abdominal pannus]when determining pressure versus moisture related etiology. Pressure injuries may result from tissue pressure of high concentration of adipose tissue, and may be in areas other than bony prominences...Documentation of skin assessment...Document observations...." This Federal Tag relates to Complaint IN00388390. 3.1-37(a)			

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure fall interventions were implemented for 1 of 4 residents reviewed for falls (Resident 24). Findings include: During an observation on 8/16/22, Resident 24 was laying in the bed with the bed against the wall, the mat was not at the bedside, and the bed was not in the lowest position. During an observation, on 08/17/22 04:13p.m. the resident was laying in the bed with the bed against the wall, the mat was not at the bedside, and his bed was not in the lowest position. During an observation, on 08/18/22 10:56 a.m., the resident was laying in the bed with the bed against the wall, the bed was in lowest position and the mat was not at the bedside. Resident 24's record was reviewed on 08/16/22 03:07 p.m. Diagnoses included, but were not limited to, encephalopathy unspecified, chronic obstructive pulmonary disease, morbidly obese, peripheral vascular disease, major depressive disorder, muscle weakness, difficulty walking, and	F 0689	F 689 D) Free from Accidents Hazards/Supervision/Devices What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident 24: Clinical records reviewed for fall interventions and environment observed for interventions to be in place per plan of care. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ All residents at risk for falls have the potential to be affected by the same deficient practice. Initial audit: The facility completed an audit of all residents for fall interventions to ensure their environment had interventions in place per the plan of care/Kardex. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Education: Nursing staff were educated on the	09/23/2022

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	legal blindness. A fall progress note, dated 8/3/22 at 03:00 p.m., indicated the intervention for this fall was to place the bed against the wall. A care plan, dated 4/30/22, the resident was at risk for falls. The interventions were for the bed brakes to be locked, the bed to be in lowest position, the call light or personal items available and in easy reach, a hoyer lift for transfers, to keep the environment well lit and free of clutter, a mat at the bedside, and a wheelchair for mobility when the resident was out of bed. A kardex for the resident's care, indicated safety interventions for the bed breaks to be locked, the call light or personal items available and in easy reach, to keep the environment well lit and free of clutter, and the bed against the wall. At the time of exit the facility did not provide policy for falls. 3.1-45(a)(2)		guideline for fall prevention to include but not limited to ensuring safety and fall interventions are in place per the plan of care and Kardex. On-going monitoring: DNS or Designee will observe resident's environment for fall risk intervention in place per plan of care/Kardex. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿ How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿ Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations.¿ If issues/trends are identified, then based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-			

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	(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to review a resident's previous records and assess for side effects of urinary stents for 1 of 1 residents reviewed for urinary tract infections (Resident 55). Finding includes: During an observation, on 8/15/22 at 12:39 p.m., there was a sign on the resident's door to indicate transmission based precautions were to be used and to contact staff prior to entering the room. The staff indicated the resident was on contact precautions for a urinary tract infection (UTI) and was being treated with antibiotics.	F 0690	F 690 (D) Bowel/Bladder Incontinence, catheter, UTI What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident 55: Clinical record was reviewed and updated to reflect resident's diagnosis of urinary stents. The plan of care was updated for urinary stents and risks for urinary tract infection with interventions in place. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ All residents	09/23/2022

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	The record for Resident 55 was reviewed on 8/17/22 at 2:45 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, acute cystitis without hematuria, mechanical complication of indwelling ureteral stent, chronic kidney disease stage 3, unspecified hydronephrosis and dementia without behavioral disturbance. A hospital report, dated 11/29/21, and uploaded into the facility electronic health record on 4/20/22, indicated the resident had a UTI. The resident had a right ureteral stent and and significant dilation of the right renal pelvis and possible stent obstruction. The resident was admitted for the UTI, possible pyelonephritis (inflammation of the kidney due to a bacterial infection), and possible stent obstruction. The resident would benefit from placement in a skilled nursing facility at the memory care unit. A progress note, dated 6/19/22 at 10:00 a.m., indicated the resident returned from a leave of absence with her family and the family indicated the resident had blood in her urine while at home and an odor in the urine was noted. The resident indicated she had stomach pain. The physician was notified. A progress note, dated 6/20/22 at 6:00 a.m., indicated the resident touched her abdomen and stated it hurts. The resident rubbed her abdomen and went back to sleep. A progress note, dated 6/21/22 at 9:19 a.m., indicated the nurse practitioner (NP) was in the facility to see the resident. The resident made complaints of abdominal discomfort and new orders were given for labs and and X-ray of the kidneys, ureter and bladder.		admitted with indwelling urinary devices have the potential to be affected by the same deficient practice Initial audit: The facility completed a review of all residents admitted or re-admitted to the facility to ensure any indwelling urinary devices were identified and have appropriate treatment, plan of care and monitoring in place. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Education: Licensed staff will be educated on the guideline for special needs to include but not limited to reviewing admission records for indwelling urinary devices and to include in diagnosis, plan or care and appropriate monitoring. On-going monitoring: DNS or Designee will review new admissions and re-admits for indwelling urinary devices to ensure the clinical record is updated with appropriate diagnosis, plan of care and monitoring. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿ How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿ Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to	

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	A progress note, dated 6/21/22 at 10:58 a.m., indicated the resident's son had called and had concerns regarding the resident having a possible UTI. He indicated the resident had foul smelling dark urine when she was on leave with him. A urine sample had been obtained and the results were pending. The son provided information about the resident's previous urologist. A progress note, dated 6/21/22 at 5:32 p.m., indicated the X-ray results were received and showed the resident had a right ureteral stent present. The NP was notified and no new orders were given. A progress note, dated 6/22/22 at 6:58 p.m., indicated the resident had a new diagnoses for the presence of a right ureteral stent. A care plan, dated 6/22/22, indicated the resident had an alteration in her kidney function related to the presence of a right ureteral stent. The interventions included, but were not limited to, right ureteral stent. There was no care plan for the stent or for the potential for urinary tract infections prior to 6/22/22. A progress note, dated 6/24/22 at 5:13 p.m., indicated the physician reviewed the results of the urinalysis and new orders were given for an antibiotic. A progress note, dated 6/25/22 at 7:30 a.m., indicated the resident had blood in her brief and was very weak and dizzy. The resident was very shaky, weak, and had unclear speech. The physician was notified and an order to sent the		make recommendations.¿ If issues/trends are identified, then based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿	

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	resident to the emergency room was received. A hospital record, dated 6/25/22, indicated the resident had a urinary tract infection with right hydronephrosis (excess fluid in a kidney due to blockage in the tube which connects the kidney to the bladder, the ureter). The urologist would remove and replace the stent. A hospital discharge summary, dated 6/28/22, indicated the resident had ESBL in her urine and would be treated for 10-14 days. The resident had a procedure for a retained stent with a hydronephrotic right kidney. When the stent was removed there was purulent(containing pus), foul smelling and bloody urine obtained. Another stent was inserted. A physician's order, dated 8/8/22, indicated contact precautions. A physician's order, dated 8/8/22 indicated to obtain a urinalysis due to foul smelling urine. During an interview, on 8/19/22 at 10:16 a.m., the Assistant Director of Nursing Services (ADNS), indicated at the end of June the resident had VRE (vancomycin resistant enterococcus) which was a bacterial infection in her urine. Then after her hospitalization in June she had ESBL (extended spectrum beta-lactamase) bacterial infection in her urine. The facility needed to keep an eye on the resident due to the stents and she would probably need to be in enhanced barrier precautions. The resident did have a urology appointment set up. The resident was admitted to the facility with a UTI, had UTI on 6/22/22, was hospitalized for the UTI on 6/25/22 and had another UTI on 8/5/22. During an interview, on 8/19/22 at 2:15 p.m., the			

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	ACU (Alzheimer's care unit) Unit Manager (UM) 2 indicated the resident had been there since December of last year, would use the restroom on her own and was hospitalized in June with complaints of abdominal pain. She had just completed an antibiotic for a UTI. She had a large amount of blood from her urine and was sent to the hospital. After she was admitted, the facility found out she had stents which was not on her documentation and the facility was thrown for a loop with that information. She now had an appointment for follow up with a urologist. A care plan, dated 8/3/22, indicated the resident had a UTI and had the potential for UTI due to a history of chronic UTIs. The interventions included, but were not limited to, assist with toileting or incontinence care as needed, observe and report signs and symptoms of UTI such as frequency or pain. A current policy titled, "Infection Prevention and Control Program," dated 2021, and received from the Director of Nursing Services at admission indicated, "...An effective infection prevention and control program is necessary to identify risk factors which could cause an infection, and when an infection is identified to control the spread of infections and outbreaks...Program development and oversight emphasize the prevention and management of infections. Program oversight preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents...." Upon exit the facility had not provided a policy on comprehensive care plans. 3.1-41(a)(2)			

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F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to identify significant weight loss and potential causes for the significant weight loss for 1 of 3 residents reviewed for nutrition (Resident 70). Finding includes: During an observation, on 8/15/22 at 12:18 a.m., Resident 70 was in the dining room sitting in a high back wheelchair. The wheelchair was pushed away from the table and the resident had his arms extended trying to reach his food and drinks. The resident took the bowl of fruit and tilted it spilling half the fruit on the table. The resident ate approximately 50% of his lunch.	F 0692	F 692 (D) Nutrition/Hydration Status Maintenance What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident 70: Clinical record was reviewed and updated with review of weight change, notification to MD and responsible party and update to the plan of care with	09/23/2022

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	During an observation, on 8/16/22 at 9:41 a.m., the resident was asleep and did not want to eat. A progress note, dated 8/16/22 at 2:20 p.m., stated the resident was sick and did not want to eat. The resident said he did not feel well and wanted to stay in bed. The record for Resident 70 was reviewed on 8/16/22 at 2:46 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hemiplegia and hemiparesis, epilepsy, moderate protein-calorie malnutrition, acute kidney failure, nicotine dependence, hypertension, depressive disorder, bipolar disorder, unspecified dementia with behavioral disturbance and noncompliance with medical treatment and regimen. A physician's order, dated 12/31/21, indicated regular diet, mechanical soft, thickened nectar liquids. May have regular consistency snacks when upright in chair. A physician's order, dated 1/23/22, indicated house supplements every day shift for lunch. A physician's order, dated 6/21/22, indicated weekly weights. The resident had the following weights: a. On 7/22/22 was 155 pounds. This weight was listed as confirmed. b. On 8/5/22 was 144 pounds which was a 7.10% (significant) weight loss in 14 days. This weight was listed as confirmed. A progress note, dated 8/15/2022 at 9:00 a.m., the Registered Dietitian acknowledged the resident's		interventions as recommended by RD or MD How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ All residents with a significant change in weight have the potential to be affected by the same deficient practice. Initial audit: The facility completed and audit of all residents that triggered for a significant change in weight to ensure the medical record is updated with review of weight change, notification to MD and responsible party and update to the plan of care with interventions as recommended by RD or MD What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Education: Licensed staff were on the guideline for Weight Monitoring	

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	weight loss. The resident had been followed by Nutrition At Risk (NAR) in the past. There were no recommendations at this time and the physician was not notified. A care plan, dated 1/20/22, indicated the resident had swallowing and chewing difficulty. Interventions included, but were not limited to, weights per md order, provide assistance with meals, proper positioning at meals. The care plan evaluation did not include the significant weight loss on 8/5/22. During an interview, on 8/22/22 at 3:05 p.m., the DNS noted the physician was not notified and nothing was done for the significant weight loss between 7/22/22 and 8/5/22. The resident had been on NAR in the past and was on weekly weights. A current policy titled, " Weight Monitoring", dated 2021 and received from the Unit Manager 2 on 8/22/22 at 4:3 p.m., indicated, "...Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise...Weight can be useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem...The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: Identifying and assessing each resident's nutritional status and risk factors...Monitoring the		to include but not limited to identifying significant weight loss and potential causes for the weight loss. Updating the medical record with review of weight change, notification to MD and responsible party and update to the plan of care with interventions as recommended by RD or MD On-going monitoring: The DNS or Designee will review weights to ensure there is documentation in the clinical record of review of weight change, notification to MD and responsible party and update to the plan of care with interventions as recommended by RD or MD These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿ How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿	

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	155367	A. BUILDING 00 B. WING	08/22/2022

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	effectiveness of interventions and revising them as necessary...." 3.1-46(a)(1)		Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations.¿ If issues/trends are identified, then based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure physician orders for oxygen were followed for a resident in COVID-19 isolation (Resident J), and to turn on a portable oxygen tank for (Resident 57), and to fill a portable oxygen tank for (Resident 57) for 3 of 3 residents reviewed for supplemental oxygen. Findings include: 1. During an observation, on 8/16/22 at 10:31 a.m., Resident J was in isolation for COVID-19. She was in bed and not wearing oxygen.	F 0695	F 695 (D) Respiratory/Tracheostomy Care and Suctioning What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident Jorders not followed) Clinical record was reviewed and order for oxygen was discontinued	09/23/2022

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	The record for Resident J was reviewed on 8/16/22 at 3:34 p.m. Diagnoses included, but were not limited to, COVID-19 positive, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), anxiety order and hypertension. A physician's order, dated 8/10/22, indicated the resident was to receive 1 to 3 liters per minute (1-3 L/min) nasal cannula (NC) to keep oxygen saturations (sats)(tells how well oxygen is being sent to parts of your body) 92% or more and to call physician if increase was needed. The order was to be discontinued on 8/24/22. A Weights and Vitals Summary dated, 8/10/22 to 8/20/22, indicated the oxygen sats were recorded for the resident while she was on room air. The oxygen sats for 8/13, 8/19, and 8/16/22 were documented as oxygen via nasal cannula. A care plan, dated 9/20/21, indicated the resident was at risk for shortness of breath. Interventions included, but were not limited to, administer oxygen as ordered. During an interview, on 8/22/22 at 4:02 p.m., the Director of Nursing Services (DNS) stated the resident had an order for oxygen and did not know why she was not wearing it or why it was discontinued on 8/20/22. 2. During an observation, on 8/18/22 at 11:05 a.m., the Resident 57 was sitting in his room with his portable tank on 2 L NC. The tank appeared to be empty. RN 3 checked and the tank was empty. During an interview, on 8/18/22 at 11:07 a.m., RN 3 stated there was no oxygen in the tank. The portable tanks usually lasted 2 to 3 hrs. The staff		on 8/20/2022 due to no longer indicated. Review of oxygen saturation during the specified time period showed no indication of respiratory distress from cited. Resident 57: (portable tank not on) Clinical record was reviewed and orders reflect need for supplemental oxygen, plan of care and Kardex reviewed and reflects needs for supplemental oxygen. At the time of the RN filled the portable tank. Review of oxygen saturation during the specified time period showed no indication of respiratory distress from cited. Resident 70: (portable tank empty) Clinical record was and orders reflect need for supplemental oxygen, plan of care and Kardex reviewed and reflects needs for supplemental oxygen. At the time of the DNS was present and checked the oxygen saturation and turned on the portable tank. Review of oxygen saturation during the specified time period showed no indication of respiratory distress from cited. How other residents having the potential to be affected by the	

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	filled the tanks up in the morning and should have been checked by now and filled. She took the resident and filled his portable tank. The record for Resident 57 was reviewed on 8/17/22 at 12:12 p.m. Diagnoses included, but were not limited to, chronic obstruction pulmonary disorder, anxiety disorder, pulmonary histoplasmosis capsulati (an infection caused by breathing in spores of fungus often found in bird droppings) and sarcoidosis(a disease characterized by the growth of tiny collections of inflammatory cells most commonly the lungs and lymph nodes). A physician's order, dated 9/3/21, indicated titrate oxygen at 2-4 liters (2-4 L/min) nasal cannula and to keep oxygen saturations above 90%. Notify the physician if increase of oxygen was needed. A care plan, dated 5/27/20, indicated the resident was at risk for alteration in respiratory status. Interventions included, but were not limited to, administer oxygen as ordered. 3. During an observation, on 8/17/22 at 11:09 a.m., Resident 70 was sitting at the nurses station wearing a nasal cannula. The resident's portable oxygen tank was turned off. The resident had been waiting for an unknown time for the nurse to turn on the tank. The DNS checked the resident's oxygen sats and turned the tank on. During an interview, on 08/17/22 at 11:12 a.m., the DNS indicated he was on oxygen and they were titrating him from 1 to 3 liters to keep sats above 90%. He was waiting for the nurse to turn his tank on. The record for Resident 70 was reviewed on		same deficient practice will be identified and what corrective action will be taken¿ All residents that receive supplemental oxygen therapy have the potential to be affected by the same deficient practice. Initial audit: The facility completed and audit of all residents that receive supplemental oxygen to ensure the physician orders are being followed and that portable equipment is being utilized appropriately and refilled to provide oxygen as ordered. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Nursing staff were educated on the guideline for Oxygen Administration to include but not limited to following physician orders for oxygen administration, ensuring portable tanks are turned on when in use and filled/refilled timely to avoid resident going without oxygen.	

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	8/16/22 at 2:46 p.m. Diagnoses included, but were not limited to, COPD, atrial fibrillation, acute kidney failure, nicotine dependence, hypertension, and depressive disorder. A progress note, dated 8/16/2022 at 3:29 p.m, the results for a chest X-ray was reported to the physician. Antibiotics were ordered for a diagnosis of pneumonia. A physician's order, dated 2/18/22, indicated continuous oxygen at 1 to 3 liters (1-3 L/min) nasal cannula. Notify the physician if oxygen saturations were below 90%. A physician's order, dated 8/16/22, indicated Cefuroxime Axetil (an antibiotic) 250 milligrams (mg) tablet give 1 tablet twice a day. A physician's order, dated 8/16/22, doxycycline hyclate (an antibiotic) 100 mg tablet give 1 tablet twice a day for 7 days. A care plan, dated 5/27/20, indicated the resident was at risk for respiratory infection. Interventions included, but were not limited to administer oxygen as ordered. A current policy titled, "Oxygen Administration," dated 11/2017 and received from Director Nursing Services (DNS) on 8/17/22 at 2:25 p.m., indicated "...Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control...Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy. The resident's care plan shall identify the interventions for		On-going DNS or Designee will observe residents with supplemental oxygen orders to ensure physician orders are followed, portable tanks are turned on when in use and filled/refilled timely to avoid resident going without oxygen. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿ How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿ Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations.¿ If issues/trends are identified, then based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿	

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	oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to: a. The type of oxygen delivery system, B. When to administer, such as continuous or intermittent and/or when to discontinue. c. Equipment setting for the prescribed flow rates. d. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered. e. Monitoring for complications associated with the use of oxygen...The equipment needed for oxygen administration will depend on the type of delivery system ordered. a. Nasal Cannula - Oxygen is administered through plastic cannulas in the nostrils. Effective for low oxygen concentrations less than 40%. Requires humidification's at flow rates greater than 4 liters/minute. Staff shall notify the physicians of any changes in the resident's condition, including changes in vital signs, oxygen concentrations, or evidence of complications associated with the use of oxygen...." 3.1-47(a)(6)			
F 0726 SS=E Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).			

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	§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on interview and record review, the facility failed to ensure licensed and certified staff were in the building and available to provide insulin injections for 5 of 5 residents on the ACU (Alzheimer's care unit) and AACU (advanced Alzheimer's care unit) who received daily insulin (Resident D, B, C, F and E). Findings include: 1. During an interview, on 8/18/22 at 2:27 p.m., Resident D's daughter indicated on 7/10/22 at 3:19 p.m., the facility nurse called to let her know her mom did not get her morning insulin. The agency QMA (qualified medication aide) who was working was not able to give the insulin. The record for Resident D was reviewed on 8/17/22 at 3:28 p.m. Diagnoses included, but were not limited to type 2 diabetes mellitus, unspecified	F 0726	F 726 (E) Competent Nursing Staff What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident D: Clinical record was reviewed and reflects orders for and insulin. A Review of the residents at the time of the cited event was completed and showed no negative outcome. MD and residents responsible party were notified of the event and notification is documented.	09/23/2022

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	dementia without behavioral disturbance, congestive heart failure and chronic obstructive pulmonary disease. A physician's order, dated 6/14/22, indicated to give Basaglar (a long acting insulin kwikpen 100 units/milliliter (ml) 18 units subcutaneously one time a day for type 2 diabetes mellitus. The administration time was 9:00 a.m. The medication administration record (MAR) dated July 1 through 31, 2022 was left blank for the 9:00 a.m. administration on July 10 of the Basaglar insulin. A progress note, dated 7/10/22 at 2:10 p.m., indicated the agency QMA had not given the resident her morning insulin. The physician was notified and ordered the resident to have the morning dose of insulin now as a one time only order. The family was notified. A facility grievance, dated 7/14/22, indicated the daughter was concerned since the resident did not receive her insulin on 7/10/22. The Director of Nursing Services (DNS) indicated the insulin was held due to the resident's blood sugar reading was 134 and the resident had complaints of nausea after eating. 2. The record for Resident 22 was reviewed on 8/19/22 at 4:40 p.m. Diagnoses included, but were not limited to, diabetes mellitus, unspecified dementia, anemia, and anxiety disorder. A physician order, dated 4/11/22, indicated to give Insulin Lispro (a rapid acting insulin) 100 units/ml solution with a pen injector as per sliding scale subcutaneously before meals: if the blood sugar was 151-200 give 2 units, 201-250 give 4 units,		Resident B: Clinical record was reviewed and reflects orders for and insulin. A Review of the residents at the time of the cited event was completed and showed no negative outcome. MD and residents responsible party were notified of the event and notification is documented. Resident C: Clinical record was reviewed and reflects orders for and insulin. A Review of the residents at the time of the cited event was completed and showed no negative outcome. MD and residents responsible party were notified of the event and notification is documented. Resident F: Clinical record was reviewed and reflects orders for and insulin. A Review of the residents at the time of the cited event was completed and showed no negative outcome. MD and residents responsible party were notified of the event and notification is documented. Resident E: Clinical record was reviewed and reflects orders for and insulin. A Review of the residents at the time of the cited	

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	251-300 give 6 units, 301-350 give 8 units, 351-400 give 10 units and call the physician for blood sugar less than 60 or greater then 400. The MAR, dated July 1 through July 31, 2022 indicated on 7/10/22 the spots for the administration of insulin Lispro and the glucomer cheks for 6:30 a.m. and 11:30 a.m. were left blank. The MAR, dated July 1 through 31, 2022, indicated the July 10 blood sugar reading at 4:30 p.m. was 256 and the resident was administered 6 units of insulin Lispro. There was no progress note, dated 7/10/22, to indicate the physician or the family had been notified of the missed insulin doses. 3. The record for Resident 3 was reviewed on 8/17/22 at 3:49 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and dementia with behavioral disturbance. A physician's order, dated 7/10/22, indicated to give Basaglar Kwikpen solution 100 units/ml to give 25 units subcutaneously two times a day related to type 2 diabetes mellitus. A physician's order, dated 7/10/22, indicated to give Basaglar insulin 25 units one time only for the missed dose. The MAR, dated 7/1/22 through 7/31/22, indicated the dose of Basaglar insulin on 7/10/22 was signed as given. A progress note, dated 7/10/22 at 2:10 p.m., indicated the agency staff stated the routine morning does of insulin was not administered. The physician was notified and a one time order		event was completed and showed no negative outcome. MD and residents responsible party were notified of the event and notification is documented. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ All residents that have orders for insulin administration routine or sliding scale have the potential to be affected by the same deficient practice. Initial audit: the DNS completed 14 look back of staffing schedules to ensure staff were available to meet the needs of residents that require insulin injections. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿	

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	to give 25 units of Basaglar now was given. The family was notified. During an interview, on 8/22/22 at 10:07 a.m., the DHS indicated the resident did not receive her insulin on the morning on 7/10/22 even though it was signed as given. The evening shift nurse LPN 10 did get the order to give the dose later in the day. 4. The record for Resident F was reviewed on 8/18/22 at 4:45 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, aphasia following cerebral infarction, and adult failure to thrive. A physician's order, dated 6/6/22, indicated to give Basaglar Kwikpen 100 units/ml pen injector 55 units in the morning related to type 2 diabetes. The MAR, dated July 1 to July 31, 2022, for the a.m. insulin administration on 7/10/22 at 7:00 a.m. was left blank and the 7:00 a.m. and the 11:00 a.m. glucometer checks were left blank. A progress note, dated 7/10/22 at 2:39 p.m., indicated the agency staff did not give any insulin during the day shift today. The physician was notified and a new order to give the resident 25 units of Basaglar insulin one time only and to continue the usual accuchecks and insulin in the evening. The family was notified. 5. The record for Resident E was reviewed on 8/18/22 at 12:20 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, unspecified dementia with behavioral disturbance and long term use of insulin. A physician's order, dated 7/10/22, indicated		Nurse Managers were educated on the guideline for Sufficient Staffing to include but not limited to appropriate coverage and staffing needs for the building, what to do in the event of a call-off and expectations for coverage. Licensed staff were educated on the guideline for Sufficient staffing to include but no limited to appropriate coverage and staffing needs for the building, what to do in the event of a call-off and not leaving the facility until appropriate relief has arrived. On-going monitoring: DNS or Designee will monitor staffing daily with the scheduler to include review of the previous day worked to ensure there was adequate coverage and review of the upcoming day to ensure there is appropriate coverage. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿	

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	Basaglar Kwikpen 100unit/ml solution to give 16 units subcutaneously one time a day related to type 2 diabetes mellitus. The MAR, dated July 1 through July 31, 2022, was blank for July 10th at 9:00 a.m. A progress note, dated 7/10/22 at 2:15 p.m., indicate the agency staff did not give the resident her morning insulin. The physician was notified and a new order to give the morning insulin now as a one time only order was obtained. The family was notified. During an interview, on 8/19/22 at 11:19 a.m., LPN (Licensed practical nurse) 10, indicated on July 10, 2022 she arrived to work at 2:00 p.m. There were two agency QMAs working on the day shift and they stated no one on the ACU or AACU got their insulin on the day shift. The QMAs were not insulin certified. They didn't seek a nurse from section one to give the insulin. The ACU UM 2 was notified immediately. The physician was notified because the residents needed their insulin and he gave orders for the residents who missed the insulin in the morning. During an interview, on 8/19/22 at 2:46 p.m., the ACU UM 2 indicated she was not working on July 10th, was contacted by the evening staff nurse and notified the resident's morning insulin had not been given because the QMA on duty was not insulin certified. She indicated Residents D, B, C, F and E had all missed their morning insulin doses. During an interview, on 8/19/22 at 3:10 p.m., the Director of Health Services (DHS), indicated the QMAs who did not administer the insulins on 7/10/22 worked for an agency. One QMA worked		How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿ Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations.¿ If issues/trends are identified, then based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿	

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(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
	on the ACU and the other on the AACU. The QMA 11 and QMA 12 were not certified to administer insulin. The QMAs had not returned to the facility to work. On 7/10/22 from 9:30 a.m. until 10:55 a.m., there was not a licensed nurse in the building. A current policy, titled, "Medication Administration", dated 2022 and received from the DHS on 8/22/22 at 11:04 a.m., indicated, "...Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection...Administer medication as ordered in accordance with manufacturer specification...Correct any discrepancies and report to nurse manager...." This Federal tag relates to Complaint IN00388390. 3.1-17(b)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---			

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	155367	A. BUILDING 00 B. WING	08/22/2022

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	§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 with dementia had appropriate diagnoses for the prescribed medications for 3 of 6 residents reviewed for unneccessary medications (Resident B, H and	F 0758	F 758 (D) Free from Unnecessary Psychotropic Mes/PRN Use What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿	09/23/2022

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	36). Findings include: 1. The record for Resident B was reviewed on 8/19/22 at 4:40 p.m. Diagnoses included, but were not limited to, diabetes mellitus, unspecified dementia and anxiety disorder. A physician order, dated 2/17/22 and discontinued on 8/8/22 indicated to give depakote delayed release 125 mg (milligram) give one tablet in the evening for dementia with behavioral disturbance.. A physician order, dated 7/25/22 and discontinued on 8/8/22 indicated to give depakote 125mg in the evening related to unspecified dementia with behavioral disturbance. During an interview, on 8/22/22 at 11:02 a.m., the Director of Nursing services (DNS) indicated the resident had not been seen by psychiatric services since she was waiting on Medicaid approval. A care plan, dated 2/28/22 and revised on 4/4/22 indicated the resident had behaviors which included placing herself on the floor, crying, trying to push open internal doors and refusing to bathe. The interventions included, but were not limited to, give medications as ordered by the physician and to attempt interventions before the resident begins to exit seek. A care plan, dated 3/1/22, indicated the resident had behaviors which included throwing her lunch tray into the hallway. The interventions included, but were not limited to, give medications as ordered by the physician and to offer a diversion.		Resident B: Clinical Record and pharmacist recommendation was reviewed and updated to reflect appropriate diagnosis for use of psychotropic medication Resident H: Clinical Record and pharmacist recommendation was reviewed and updated to reflect appropriate diagnosis for use of psychotropic medication Resident 36: Clinical Record and pharmacist recommendation was reviewed and updated to reflect appropriate diagnosis for use of psychotropic medication How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ All residents with a diagnosis of Dementia that receive psychotropic medication have the potential to be affected by the same deficient practice Initial audit: The facility reviewed	

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	A gradual dose reduction (GDR), dated 8/4/22, indicated the resident had received divalproex (Depakote an anticonvulsant) 125 mg (milligram) every evening for dementia with behaviors since 2/22. The recommendation was to please consider discontinuing the medication. The physician response, not dated, was to stop the Depakote. During an interview, on 8/22/2 at 2:56 p.m., the ACU (Alzheimer's care unit) Unit Manager (UM) 2 indicated the pharmacy had recommended the depakote be discontinued due to the resident was on the lowest dose of the medication and it was time to discontinue. The pharmacy did not request the discontinuation of the medication due to the diagnosis of dementia with behaviors linked to the medication. The resident was on the medication for 6 months before the medication was discontinued. 2. The record for Resident H was reviewed on 8/18/22 at 11:49 a.m. Diagnoses included, but were not limited to, dementia with Lewy bodies, major depressive disorder, dementia with behavioral disturbance, aa psychotic disorder with delusions due to a known physiological condition and cognitive communication deficit. During an interview, on 8/19/22 at 2:22 p.m., the ACU UM 2 indicated the resident would wander in her wheelchair, liked to socialize with the other ladies and would participate in some activities. During an interview, on 8/19/22 at 3:28 p.m., the Director of Nursing Services (DNS), indicated the resident was on the Depakote for adjunct therapy for with the Seroquel (an antipsychotic) for the treatment of the psychosis.		all residents with a diagnosis of Dementia for use of psychotropic medication, pharmacist review/recommendations and appropriate documentation. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Education: Licensed staff were educated on the guideline for Unnecessary Drugs-Without indication for Use to include but not limited to ensuring residents with diagnosis of dementia have appropriate diagnoses for the prescribed medication. On-going monitoring: DNS or Designee will audit the clinical record of residents with dementia for pharmacy recommendations that need addressed, current orders or new orders for psychotropic medication to ensure they have appropriate diagnoses for the prescribed medication. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿	

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	A physician order, dated 9/15/21, indicated to give Depakote ER 500 mg (milligram) at bedtime related to the psychotic disorder with delusions due to a known physiological condition. A GDR. dated 3/4/22, indicated the resident had been given Depakote ER 500 mg for dementia with behaviors since 9/2021. Please consider reducing the Depakote ER to 250 mg in the evening. If a GDR was clinically contraindicated, please document the clinical rationale. The physician response, dated 3/9/22, indicated the resident had a recent change of the Seroquel dose and the resident's mood was not stable and changes would likely exacerbate the symptoms. During an interview, on 8/18/22 at 1:52 p.m., the DHS indicated the psychiatric note stated the resident was on the Depakote for dementia with behaviors and the physician order indicated the resident was on the Depakote for psychosis. The two diagnosis did not match, the pharmacy had not given a recommendation for a diagnosis review. She did not know why the physician order and the psychiatry note did not match and the prescriber had not been asked about the discrepancy with the diagnosis. During an interview, on 8/18/22 at 2:12 p.m., the ACU UM 2 indicated she had clicked the wrong diagnosis when she entered the Depakote and it was previously entered in the computer for dementia with behavioral disturbance. 3. Resident 36's record was reviewed, on 08/19/22 02:54 p.m., Diagnoses included, but were not limited to, alzhiemer's disease, subarachnoid hemorrhage, dementia with behavioral disturbance, major depressive disorder, adjustment disorder with mixed anxiety and depressed mood, and visual		How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿ Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations.¿ If issues/trends are identified, then based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿	

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	disturbances. A physician's order, dated 3/31/22, indicated to administer Abilify 1mg one time a day for the diagnosis of adjustment disorder. A physician's recommendation, dated 8/11/22, indicated the resident had been recieving Abilify 1mg from 3/31/22 to 8/11/22 for the diagnosis of adjustment disorder. The pharmacist made the recommendation to discontinue or reduce the medication. The physician's order was to discontinue the medication. During an interview, on 08/19/22 at 02:38p.m., ACU Unit Manager 2 indicated the Abilify was given for the diagnosis of adjustment disorder with mixed anxiety and depressed mood disorder. She indicated the medication was discontinued due to dose reduction guidelines. The resident was on the medication for four months and 11 days before a recommendation had been documented. A current policy, titled, "Unnessary Drugs -Without Indication for use", dated October 2022, recieved from the DNS (director of nursing service), on 08/22/22 at 11:04a.m., indicated, "...It is the facilty policy that each resident's drug regimen is managed and moitored to promote or maintain the resident's highest practible mental, physical and psychosocial well-being free from unnecessaary drugs." '...Indications for use' " is the identified , documented clinical rationale for administering a medication that is based on an assessment of the resident's condition and therapeutic goals and is consistant with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice			

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	guidelines, clinical standards of practice, medication references, clinical studies, or evidenced-based review articles that are publised in medical and/or pharmacy journals." "...Documentation will be provided in the resident's medical record to show adequate indications for the medication's use and the diagnosed condition for which it is prescribed. A current publication of PDR.net, (physicians desk reference) indicated Depakote was used for seizures, acute mania associated with bipolar disorder with or without psychotic features and migraines. The medication had a black box warning and was not indicated for use in those with organic brain syndrome which includes dementia. A current publication of PDR.net indicated the approved use for apriprazole (Abilify)was to administered orally in adults for schizophrenia and bipolar 1 disorder. The black box warning indicated antipsychotics were not approved for dementia-related psychosis in geriatric patients. The use of aripiprazole should be avoided in the geriatric population, if possible, due to the increased morbidity and mortality in the elderly. The Beers Criteria considers antipsychotics potentially inappropriate medications in elderly patients except for treating schizophrenia. 3.1-48 (a)(4)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;			

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	Based on observation, interview, and record review, the facility failed to ensure a seizure medication and an effervescent tablet were administered correctly resulting in an 11.54% medication error rate for 3 of 26 observed for medication administrations (Residents 195). Findings include: During the medication administration with Licensed Practical Nurse (LPN) 11, on 8/19/22 at 9:22 a.m., the following was observed for Resident 195: LPN 11 prepared the potassium bicarb-citric acid 20 meq(millequivalant) effervescent tablet by placing the tablet in approximately 100mls(milliliters) of water. She placed the cup aside to let the tablet dissolve. She poured the phenytoin suspension into a 30 ml medication cup. She started to go into the resident's room with the medication and was stopped. The nurse measured the phenytoin suspension by using a 1 ml syringe. She filled the syringes 4 times putting the medication in another 30ml medication cup. LPN 11 used the syringe and measured the remaining phenytoin suspension. There was an additional 0.5mls of phenytoin suspension remaining in the cup. She entered the room and turned off the Jevity 1.2 enteral feeding infusing in at 70ml(milliliters)/hr(hour) and administered the medication. During an interview, on 8/19/22 at 9:22 a.m., LPN 11 indicated a syringe should be used to measure the correct dose of phenytoin and not a medication cup. The resident has a history of seizures and it is important to measure the medication correctly. There was 0.5 ml of medication remaining in the medication cup. If you	F 0759	F 759 (D) Medication Errors What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident 195: Clinical record was and orders reflect dosage for seizure medication, holding tube feeding 1 hour before and 1 hour after administration and amount of liquid to dissolve effervescent tablet in for administration. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ Residents that receive enteral feeding with medications administered via tube have the potential to be affected by the same deficient practice. Initial audit: The facility audited the orders for all residents that receive enteral feeding with medications via tube for instructions with the medications for holding tube feeding with med administration	09/23/2022

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	have too much or too little of the medication it can cause a seizures. LPN 11 stated she was going to prepare the potassium tablet. The order did not have instructions on how much water to use so 100mls should be fine since she got enough additional water. The order should be clarified so the correct amount of water is used for the tablet. The record for Resident 195 was reviewed on 8/16/22 at 3:33 p.m. Diagnoses included, but were not limited to, seizures, acute respiratory failure with hypoxia(oxygen deficiency), multiple sclerosis(autoimmune disorder resulting in nerve damage), congestive heart failure and nontraumatic subdural hemorrhage(bleeding in the brain). A physician's order, dated 8/12/22, indicated phenytoin suspension 100mg/ml to give 4ml via g-tube every 12 hours. Hold the tube feeding 1 hour before and after administration. A physician's order, dated 8/11/22, indicated potassium bicarb-citric acid 20 meq effervescent tablet to give via g-tube daily. A current policy titled, "Medication Administration," dated 2022 and received from the Director Nursing Services on 8/22/22 at 11:04 a.m., indicated, "...Review the MAR to identify medication to be administered...Administer medication as ordered in accordance with manufacturer specifications...Shake well to mix suspensions...." A current policy, titled "Medication Order," dated 2022 and received from the Director Nursing Services on 8/22/22 at 4:52 p.m., indicated "...The facility shall use uniform guidelines for the ordering of medication...Medication should be		and amount of liquid for dissolving medication. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Licensed Nursing staff will be educated on the guideline for Medication Administration via Enteral Tube to include but not limited to technique for measuring liquids, dissolving effervescent tablets and holding tube feeding when applicable. On-going DNS or Designee will observe medication administration for residents receiving medications via enteral tube for proper technique. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿ How the corrective action will be monitored to ensure the deficient	

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	administered only upon the signed order...Each medication order should be documented...The order should be recorded on the physician order sheet, and the Medication Administration Record(MAR)...Clarify the order...." A medication administration policy for g-tubes was not received at the time of the exit conference. 3.1-48(c)(1)		practice will not recur, i.e., what quality assurance program will be put into place¿ Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations.¿ If issues/trends are identified, then based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿	
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes			

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	documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on record review and interview, the facility failed to ensure completion of routine vaccinations for 3 of 5 residents reviewed for	F 0883	F 883 (D) Influenza and Pneumococcal Immunizations What corrective actions will be	09/23/2022

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	pneumococcal vaccinations (Resident 18, 33 and 95). Findings include: During a record review, on 8/18/22 at 03:22 p.m., the following was observed: 1. Resident 18 signed a consent on 12/28/21 to receive a pneumococcal vaccination. The resident had not received the Pneumonvax23 vaccine until 8/18/22. 2. Resident 33 signed a consent on 6/14/22 to receive a pneumococcal vaccination. The resident had not received the Pneumonvax23 vaccine until 8/18/22. 3. Resident 95 signed a consent on 7/27/22 to receive a pneumococcal vaccination. The resident has not received a pneumococcal vaccine until 8/18/22. During an interview, on 8/22/22 at 1:52 p.m., the DNS indicated vaccination were now going to be followed by the Infection Preventionist and Director of Clinical Services (DCS). They would review the records and they would be kept up to date. They have not had anyone to do this and fell behind. During an interview, on 8/22/22 at 3:17 p.m., the DNS the facility was waiting for Resident 94's pneumovax to be delivered. The facility requested they requested the vaccination from the pharmacy on 8/20/22. Resident 18 had a signed consent to receive the pneumovax when she was not sick. Her consent was signed on 12/28/21 and she was feeling better so should she should get it.		accomplished for those residents found to have been affected by the deficient practice?¿ Resident 18: Clinical record was reviewed and that the resident received pneumovax 23 on 8/18/22 Resident 33: Clinical record was reviewed and reflect that the resident received pneumovax 23 on 8/18/22 and Covid Vaccine on 9-15-22 Resident 95: no longer resides at the facility Resident 94 (identified in the body of the citation Clinical record was reviewed and reflect that resident received Pneumovax 23 on 8/18/22 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿ All residents that have consented to receive vaccine or immunization have the potential to be affected by the same deficient practice.	

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	During an interview, on 8/22/22 at 3:35 p.m., the Director of Clinical Services (DCS) indicated the next COVID-19 clinic will be this Friday 8/26/22. Resident 33 was scheduled to have his second dose then. He did not receive it earlier because there was an outbreak of COVID-19 in the building. A current policy titled, "Influenza/Pneumococcal Immunization Guideline," dated 2022 and received at entrance from the Executive Director, indicated, "...LivingCenters will offer and encourage that each resident receive immunization against Influenza annually, as well as lifetime immunization against Pneumococcal disease. This immunization will be administered unless it is medically contraindicated, the resident has already been communicated or the resident and/or responsible party refuses the immunization...Upon admission to the LivingCenter the resdient and/or responsible party will be given education regarding the risk and benefits of receiving the Influenza and Pneumococcal immunization vaccine...The resident and/or responsible party will be required to sign the Immunization Consent of Declination Form...If the immunization was refused, verify that the Immunization Constanted Declination Form was completed and signed...." 3.1-13(a)		Initial audit: The facility completed and audit of all residents to ensure vaccines or immunizations have been provided per consent and physician order and documented in the clinical record. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿ Education: Licensed staff were educated on the guidelines for Influenza, Pneumonia and Covid vaccine to include but not limited to providing the vaccine/immunization when resident or responsible party consents and per MD order. On-going monitoring: DNS or Designee will observe new orders during daily clinical meeting for vaccination/immunization orders, new admissions or re-admits for consent to receive vaccinations/immunizations and documentation in clinical record when completed.	

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	155367	A. BUILDING 00 B. WING	08/22/2022

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			These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿ How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿ Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations.¿ If issues/trends are identified, then based on QAPI recommendation.¿ If none noted, then will complete audits based on a prn basis.¿	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure soiled incontinence briefs were placed in trash cans and	F 0921	F 921 (D) Safe/Functional/Sanitary/Comforta ble Environment	09/23/2022

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	soiled laundry was removed from the room for 1 of 1 resident reviewed for COVID-19 isolation (Resident J), and the facility failed to ensure staff smoked in designated smoking areas for 2 of 3 facility units reviewed (Alzheimer unit and advanced Alzheimer's unit). Finding includes: 1. During an observation, on 8/16/22 at 10:31 a.m., the resident was in COVID-19 isolation. The room had a very strong urine odor. There was a urine soaked depends in the middle of the floor. There were flies around the residents face, a dirty blanket and a sheet rolled up on the chair. The record for Resident J was reviewed on 8/16/22 at 3:34 p.m. Diagnoses included, but were not limited to, COVID-19 positive, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), anxiety order, and hypertension. During an interview, on 08/16/22 at 10:39 a.m., Certified Nursing Assistant (CNA) 6 was unsure if the resident wore incontinence briefs and the last time the resident was changed. She thought the resident was changed an 1 hour ago. CNA 6 opened the residents door and saw the soiled depends on the floor in the middle of the room. The room had a very strong urine smell. She noticed the pillow case was missing, there were flies in the room, dirty linen in the chair, and the resident had nothing to drink. She stated the resident and room would be cleaned up. During an interview, on 8/17/22 at 11:16 a.m., Housekeeping 8 was not sure when the resident's room was last mopped. During an interview, on 8/17/22 at 11:21 a.m.,		What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?¿ Resident J the time of cited event the brief was picked up and the soiled linen was removed from the room and floor was mopped. no longer in isolation. Resident's plan of care reflects the need for assistance with incontinence care. Resident 24: has had no further concerns regarding staff outside her window or smoking. Smoking outside of Alzheimer's Unit: the area outside of the Alzheimer Unit was reviewed by management staff and cigarette ends were removed at the time of citation and staff educated on designated smoking area. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken¿	

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	Housekeeping 9 was told by management she could mop the residents floor at the end of the day. The resident was in isolation and they could not cross contaminate the rooms. A physician's order, dated 8/10/22, indicated the resident was in droplet isolation for COVID-19 until 8/24/22. A current policy titled, "Resident Rights," dated 2022 and received from the ACU Unit Manager 2 on 8/22/22 at 4:33 p.m., indicated, "...Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely...." A current policy, titled "Safe and Homelike Environment," not dated and received from the DNS on 8/22/22 at 4:52 p.m., indicated, "...In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment...Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment...The facility will provide and maintain bed and bath linens that are clean and in good conditions...General Considerations: Minimize odors by disposing of soiled linens promptly and reporting lingering odors and bathrooms needing cleaning to Housekeeping Department...." A current policy, titled "Infection Prevention and Control Program," not dated and received at entrance, indicated "...LivingCenters will offer and encourage that each resident receive immunications against Influenza annually, as well as lifetime immunications against Pneumococcal disease. This immunization will be administered		Isolation Room All residents in isolation have the potential to be affected by the same deficient practice. Initial Audit: The facility completed an audit of all residents that require isolation precautions to ensure is clean and odor free. Smoking All residents have the potential to be affected by the alleged deficient practice. Initial audit: The facility completed a review of the approved smoking areas for staff to include safe location as well as appropriate receptacles for disposal of cigarettes and trash. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur¿	

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	unless it is mediccally contraindiccated, the resident has already been immunized or the residnet and/or responsible party refuses the immunization...standing order for the Pneumococcal immunization to be adminisgered will be obtained from a resident's attending physician and/or center Medical Director...Upon admission to the LivingCenter the resident and/or responsible party will be given education regarding the risks and benefits of receiving the Influenza and Pneumococcal immunization vaccine...The resident and/or responsible party will be required to sign the Immunization Consent or Declllination Form...Document the administration of the pneumococcal vaccine in the electronic health record Immunization portal...." 2. During an interview, on 8/16/22 at 3;18 p.m., Resident 24 indicated the staff smoke right outside her room at night. There were cigarette ends on the grass outside of the resident's window. During a facility tour, on 8/17/22 at 11:11 a.m., the fenced in area outside the dementia unit had cigarette ends scattered in various location. The Maintenance Staff 4 indicated the nurses would smoke at the table outside the dementia unit and throw the cigarette ends on the concrete. The area was not a designated smoking area. Maintenance Staff 4 also would find cigarette ends in the plant containers, the grass and in the flower beds. There were about 20 cigarette ends by the dementia door which had a bench next to it, 10 cigarette ends by the door to the CNA (certified nurse aide) station and cigarette ends in the grass next to the resident rooms, cigarette ends in the cracks of the concrete and on the concrete patio. The other end of the building had a designated smoking area for staff.		Isolation Education: Housekeeping Staff educated on Resident Rights and Safe Home Like Environment to include but not limited to cleaning isolation rooms and reducing odors Nursing staff on Resident Rights and Safe Home Like Environment to include but not limited to maintaining linens and briefs off the floor, reducing risk for odors. On-going monitoring: DNS or Designee will observe isolation rooms and interview residents that are in isolation as applicable for condition of room cleanliness, items up off the floor and odor free environment. These reviews to be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿	

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	During an interview, on 8/17/22 at 11:19 a.m., the maintenance director indicated, the staff did not need to smoke in the outside area next to the dementia unit as this area was for the residents. The facility had a designated smoking place for staff. During an interview, on 8/17/22 at 11:38 a.m., the Executive Director indicated the area outside the dementia unit was not a designated smoking area. A current policy, titled, "Employee Smoking", not dated and received from the Director of Nursing on 8/17/22 at 2;03 p.m., indicated Sycamore Village Care Center provides our employees, residents, and visitors with a smoke-free environment...Smoking is prohibited in all areas except the designated area for employee smoking...[Refer to any applicable state laws regarding workplace smoking.]...A 'Designated Smoking Area' sign will be posted where smoking is permitted...Violation should be reported to the employee's supervisor as soon as practical...It is the responsibility of all personnel to report smoking violations. The various supervisors are responsible for enforcing these rules...Any and all inquiries concerning smoking regulations should be referred to Human Resources...Violations of this policy will result in disciplinary action up to and including termination...Electronic cigarettes will adhere to the same restrictions as any other smoking product...." 3.1-19(c)		Smoking Education: Facility staff educated on the facility guidelines for staff smoking which included but not limited to; location of designated smoking areas and proper disposal of cigarettes and trash. On-going The ED or will audit/ staff smoking in designated smoking areas, maintained with appropriate disposal receptacles and free from cigarettes and trash on the ground. The reviews will be conducted 5 times weekly x 4 weeks, then 3 times weekly x 4 weeks, then weekly x 4 months.¿ How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place¿ Results of these audits will be brought to QAPI monthly x 6 months to identify trends and to make recommendations.¿ If issues/trends are identified, then based on QAPI recommendation.¿	

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