STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155233	A. BUILDING 00 B. WING	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF BATESVILLE, THE	958 E HWY 46 BATESVILLE, IN 47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00387606, IN00388538, IN00390117, and IN00394763. Complaint IN00387606 - Unsubstantiated due to lack of evidence. Complaint IN00388538 - Unsubstantiated due to lack of evidence. Complaint IN00390117 - Unsubstantiated due to lack of evidence. Complaint IN00394763 - Unsubstantiated due to lack of evidence. Survey dates: November 9, 10, 14, 15, 16, and 17, 2022 Facility number: 000138 Provider number: 155233 AIM number: 100266500 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type: Medicare: 18 Medicaid: 32 Other: 18 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is December 12, 2022. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jalena Ball	Administrator	12/16/2022

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

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	Quality review completed on November 30, 2022.			
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, observation, and record review, the facility failed to administer prescribed wound treatments and obtain weights for 2 of 19 residents reviewed for quality of care. (Residents 27 and 39) Findings include: 1. During an interview and observation on 11/09/22 at 11:48 A.M., Resident 27 indicated she had open areas on her lower legs that seeped. The dressings were to be changed daily. The dressing had not been changed since Sunday, 11/06/22. The resident unzipped her compression sock on her right leg and the date written on the 4" (inch) x (by) 4" dressing, located on her shin, was 11/06/22. During an interview on 11/10/22 at 11:25 A.M., the resident indicated the staff had changed the dressing on her leg last night and today. The dressing change to the resident's right shin was observed on 11/15/22 at 10:44 A.M., with the ADON (Assistant Director of Nursing). When the dressing was removed, a large amount of yellow	F 0684	**F-684** It is the policy of the facility to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Including documenting daily weights and wound treatments per policy. Residents who reside in the facility have the potential to be affected by this finding. A facility wide skin sweep was completed on 12/1/22. A facility wide audit of weights was completed on 12/1/22. Any changes or corrections were addressed and changed as indicated. DON/Designee will monitor the wound treatments, and weights for	12/13/2022

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	exudate was noted on the old dressing. The ADON indicated the calcium alginate dressing pads turn yellow from exudate. The dressing contained both calcium alginate and silver alginate. During an interview on 11/15/22 at 11:07 A.M., the ADON indicated dressing changes were documented on the EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) . During an interview on 11/16/22 at 10:12 A.M., LPN (Licensed Practical Nurse) 5 indicated the resident had cellulitis in her lower legs in August. The Infection Control Log for August 2022, was provided by the DON (Director of Nursing) on 11/16/22 at 2:30 P.M. The record indicated the resident had cellulitis, with an onset date of 08/16/22, and was treated with the antibiotic Cephalexin until 08/23/22. The EMAR/ETAR for September, October, and November 2022, was provided by the Regional Director of Operations on 11/16/22 at 4:14 P.M., and included, but was not limited to, the following physician's order for the wound treatment: - Cleanse area with wound cleanser, apply calcium/silver alginate, secure with border gauze every day shift for wound, BLE (Bilateral Lower Extremities) scattered open areas, with a start date of 08/25/22 and a discontinued date of 11/06/22. The records lacked documentation the dressing changes had been completed on the following dates: - September 14, - September 16,		10 residents weekly for a period of 4 weeks. The tool will then be used for 5 residents weekly for 4 weeks. Then weekly for 1 resident ongoing for a period of no less than 6 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Administrator/Designee on_12/1/22 & 12/6/22_for all nursing staff the following was reviewed: 1. All weights, daily, weekly and admission, assessments and MD notifications 2. Skin assessments, wound assessments – policy and procedure 3. Dressing changes and policy and procedure Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator	

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	- September 22, - October 3, - October 6, - October 8, - October 9, - October 11, and - October 23. The November record indicated the dressing frequency had been changed to every other day with a start date of November 7, 2022. 2. Resident 39 was observed in her room on 11/09/22 at 11:40 A.M. The resident was in bed with the head of her bed somewhat elevated. The resident was wearing oxygen and indicated she was waiting for lunch. There were no signs or symptoms of discomfort or distress. The resident's clinical record was reviewed on 11/16/22 at 3:00 P.M. A Quarterly MDS assessment, dated 10/10/22, indicated the resident was moderately cognitively impaired. The resident required extensive staff assistance with most of her ADLs (Activities of Daily Living). Both of the resident's lower extremities were impaired, and she used a wheelchair. The diagnoses included, but were not limited to, stroke, diabetes, and heart failure. The resident's current physician's orders included an open-ended order, with a start date of 01/03/22, to obtain the resident's weight, daily. Staff were to call the MD if the resident gained more than 3 pounds a day. The resident's weights were not obtained, and the spaces were blank in the ETAR for August, September, and October 2022 on the following days:		weekly until resolution.	

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	- 08/03/22, - 08/04/22, - 08/05/22, - 08/10/22, - 08/13/22, - 08/16/22, - 08/17/22, - 08/18/22, - 08/27/22, - 08/29/22, - 09/01/22, - 09/02/22, - 09/05/22, - 09/10/22, - 09/13/22, - 09/15/22, - 09/16/22, - 09/17/22, - 09/19/22, - 09/20/22, - 09/22/22, - 09/24/22, - 09/28/22, - 09/29/22, - 09/30/22, - 10/01/22, - 10/02/22, - 10/03/22, - 10/04/22, - 10/06/22, - 10/07/22, - 10/08/22, - 10/09/22, - 10/10/22, - 10/11/22, - 10/12/22, - 10/19/22, - 10/23/22, - 10/27/22, and - 10/28/22.			

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	During an interview on 11/17/22 at 10:15 A.M., LPN (Licensed Practical Nurse) 5 indicated the resident had orders to be weighed daily, and they were supposed to notify the MD if she gained more than 3 pounds in one day. The staff would weigh her when she would allow it. She didn't like to get weighed in the morning; she would usually let staff weigh her around 1:00 P.M. because she would be up for the smoke break. If a resident refused to be weighed, they would document the refusal. If it became a pattern that the resident refused, they would notify the MD. The resident's current Care Plans included a care plan that indicated the resident had a diagnosis of Congestive Heart Failure. The care plan was initiated on 08/11/19. The current interventions included, but were not limited to, an intervention with a start date of 09/16/19 to obtain the resident's weight daily. Staff were to notify the MD if the resident gains more than 3 pounds in one day. The current, undated facility policy, titled "PHYSICIAN ORDERS--(FOLLOWING PHYSICIAN ORDERS) was provided by the Administrator on 11/16/22 at 4:19 P.M. The policy indicated, "...It is the policy of the facility to follow the orders of the physician..." 3.1-37(a)			
F 0686 SS=G Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-			

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	(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to prevent residents from acquiring in house pressure ulcers and weekly assessments of a pressure ulcers for 4 of 6 residents reviewed for pressure ulcers. This deficient practice resulted in one resident's pressure ulcer being identified at a Stag 3 and two residents' wounds identified with deep tissue injuries. (Residents 15, 36, 13, and 70) Findings include: 1. During an observation on 11/16/22 at 2:53 P.M., the Wound Nurse and QMA (Qualified Medication Aide) 9 entered Resident 15's room and explained they were going to change the dressing on her buttocks. They each washed their hands and donned gloves. QMA 9 assisted the resident in turning onto her right side. The Wound Nurse removed the old dressing, removed her gloves and donned clean gloves. The wound was approximately 9 cm (centimeters) x (by) 11 cm x 2 cm deep. The wound bed was pink and red with a half dollar sized amount of slough (yellowish colored dead tissue) in the center. The wound was cleaned with wound cleanser, packed with hydrogen peroxide soaked gauze, covered with an absorbent dressing and secured with tape.	F 0686	**F-686** It is the policy of the facility to ensure the resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Residents who reside in the facility have the potential to be affected by this finding. A facility wide skin sweep was completed on 12/1/22. All pressure ulcers were reviewed with the wound NP to ensure all wounds were staged appropriately and had appropriate treatments and orders in place. Any changes	12/13/2022

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	The clinical record was reviewed on 11/14/22 at 11:22 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 03/30/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, anemia, heart failure, diabetes, stroke, anxiety, and respiratory failure. The resident required extensive assistance of two staff members for ADLs (Activities of Daily Living). The resident was at risk for pressure ulcers. The "CNA (Certified Nurse Aide) Bath Checklist", dated 05/25/22, was provided by the DON on 11/16/22 at 9:28 A.M. The checklist indicated the resident had no open areas were documented. The "Weekly Skin Check" record, dated 05/29/22, was provided by the DON on 11/16/22 at 9:28 A.M. The skin check indicated the resident had no new loss of skin integrity. A Wound NP assessment, dated 05/30/22, indicated the resident had a Stage 3 (full thickness tissue loss) pressure ulcer, measuring 2.8 cm x 1.1 cm x 0.1 cm depth, to her right buttocks. A Wound NP assessment, dated 06/13/22, indicated the right buttocks wound measured 6.2 cm x 4.7 cm and was covered with 100% slough. A wound culture was obtained on 06/13/22. The culture results, dated 06/16/22, indicated there was "Heavy Proteus mirabilis" (a bacteria) in the wound. The resident was started on Keflex (an antibiotic) for the positive wound culture. A Progress Note, dated 06/16/22 at 9:00 A.M., indicated the resident was sent to the hospital for		or corrections were addressed and changed as indicated. DON/Designee will monitor skin assessments, weekly wound evaluations and following physicians orders for 10 residents weekly for a period of 4 weeks. The tool will then be used for 5 residents weekly for 4 weeks. Then weekly for 1 resident ongoing for a period of no less than 6 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Administrator/Designee on_12/1/22_& 12/6/22___for all nursing staff the following was reviewed: 1. Turning and repositioning, preventative skin care 2. Pressure ulcer injuries and staging 3. Dietary prevention for pressure ulcers 4. Following Physicians Orders Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee	

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	a change in condition. The emergency room note, 6/16/22, indicated the resident presented with altered mental status with positive wound culture. History of UTI, non-ambulatory, bed bound, medical decision indicated sever sepsis. The wound was foul in smell and most likely the source of the patient's infection. During an interview on 11/16/22 at 3:14 P.M., the Wound Nurse indicated the pressure ulcer on the buttocks, from 06/13/22, wasn't identified until after the shoulder was healed, "It just popped up'. The resident's skin was fragile. 2. The clinical record for Resident 36 was reviewed on 11/15/22 at 11:41 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 09/28/22, indicated the resident was rarely/never understood. The diagnoses included, but were not limited to, stroke, hypertension, neurogenic bladder, diabetes, non-Alzheimer's dementia, hemiplegia/hemiparesis, seizure disorder, depression, and tracheostomy status. The resident required extensive assistance of two or more staff for most ADLs. She was at risk for developing pressure ulcers, and had one, unhealed facility acquired Unstageable pressure ulcer at the time of the assessment. An NP Wound Assessment, dated 08/01/22, indicated the resident had a Stage 2 pressure ulcer to the right upper buttock that measured 2.44 cm x 2.53 cm x 0.5 cm. There was a scant amount of sanguineous drainage. The wound had 100% epithelial tissue. The treatment was to apply Triad (a hydrophilic wound paste that absorbed moderate levels of wound exudate) paste and leave the area open to air.		be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	An NP Wound Assessment, dated 08/15/22, indicated the resident's wound to the right upper buttock was healed. The Triad treatment was discontinued when the wound healed. No new interventions were put into place after the wound healed. An NP Wound Assessment, dated 09/08/22, indicated the resident had an Unstageable pressure ulcer to the right upper buttocks that measured 1.22 cm x 1.33 cm x 0.10 cm. There was a moderate amount of serosanguinous drainage. The treatment was to cleanse the wound, apply Medi honey, and cover with bordered gauze. Pressure and Offloading interventions included to ensure compliance with turning protocol and a specialty bed. An NP Wound Assessment, dated 09/29/22, indicated the resident had an Unstageable pressure ulcer to the right upper buttock that measured 0.53 cm x 1.26 cm x 2.0 cm with 5.0 cm tunneling at 9 o'clock. The wound was covered in 100% slough/eschar with a moderate amount of serosanguinous drainage. The wound treatment changed to cleanse the wound, apply iodoform gauze packing and cover with a bordered gauze. An NP Wound Assessment, dated 10/20/22, indicated the resident had an Unstageable pressure ulcer to the right upper buttocks that measured 0.38 cm x 0.78 cm x 1.5 cm with 4.0 cm tunneling at 9 o'clock. The wound was covered in 100% granulation with a moderate amount of purulent drainage. The wound treatment remained the same. An NP Wound Assessment, dated 11/10/22, indicated the resident had an Unstageable			

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	pressure ulcer to the right upper buttocks that measured 0.55 cm x 0.49 cm x 2.0 cm with 4.0 cm tunneling at 9 o'clock. The wound was covered in 100% granulation tissue with a moderate amount of purulent drainage. The wound treatment remained the same. The clinical record lacked the MD notification of the resident's wound increasing in size and wound drainage. A Complete Care Plan was provided by the DON on 11/16/22 at 1:20 P.M. The Care Plan contained the following: - Altered Skin Integrity to the right buttock, interventions included, monitor daily for increase in size, notify MD and family as needed, and treatment per order. -At risk for skin breakdown due to diagnosis CVA (cerebrovascular accident) with weakness, incontinence of bowel, and use of a urinary catheter. Interventions included, but were not limited to, Braden scale quarterly and as needed, ensure toileting at least every 2 hours, float heels every shift, keep clean and dry, pressure relieving mattress per facility policy, preventive measures as needed, skin assessment per facility policy, supplements per order. The August 2022 ETAR indicated the resident had received the Triad paste daily from 08/04/22 through 08/15/22. During an interview on 11/16/22 at 3:37 P.M., the ADON/Wound Nurse indicated the resident's wound first started as a Stage 2 pressure on 08/01/22 and healed on 08/15/22. The wound had reopened on 09/08/22 as an unstageable. Her			

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	interventions included, a low air loss mattress, turning and reposition per protocol, t-time (toileting time). The staff noticed the resident had a wound and brought it to her attention. 3. During an observation on 11/16/22 at 02:01 P.M., Resident 13 had an area to her coccyx that was pencil eraser size with measurable depth. The wound was pink with no drainage noted. The resident's clinical record was reviewed on 11/15/22 at 9:41 A.M. A Quarterly MDS Assessment, dated 10/18/22, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, anemia, heart failure, hypertension, malnutrition, depression, and psychotic disorder. The resident required extensive assistance of 2 or more staff members with most ADLs. The resident was a risk for pressure ulcers with no pressure ulcer at the time of the assessment. A Progress Note, dated 08/31/22, indicated the resident had an open area to her coccyx and a new order was obtained to cleanse the wound, apply Medi honey, and cover with a bordered gauze every night shift. The September, October, and November 2022 ETAR lacked documentation the treatment was provided the following dates: - 09/02/22, - 09/03/22, - 09/04/22, - 09/09/22, - 09/12/22, - 09/17/22, - 09/19/22, - 09/22/22,			

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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
	- 09/23/22, - 09/25/22, - 10/05/22, - 10/08/22, - 10/19/22, - 10/22/22, - 10/29/22, - 11/06/22, and - 11/13/22. No weekly wound assessments could be provided for the wound. No wound staging was documented in the resident's clinical record. During an interview on 11/15/22 at 2:01 P.M., the ADON/Wound Nurse indicated wound assessments were completed weekly by the NP and she was unsure why the resident had been getting a dressing change to her coccyx. During an interview on 11/15/22 at 3:06 P.M., LPN 5 indicated it was a night shift dressing change and she was unsure what the resident had going on. During an interview on 11/16/22 at 9:04 A.M., LPN 6 indicated the resident stayed in bed per her choice most of the time. She was incontinent of her bowel and bladder. The resident had developed a wound on her bottom that had a treatment completed on night shift. During an interview on 11/16/22 at 2:30 P.M., the DON indicated a nurse had notified the NP of the resident having a wound and obtained treatment orders. The wound should be assessed weekly, and the resident did not have weekly wound assessments. During an interview on 11/16/22 at 3:09 P.M., the			

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	155233	A. BUILDING 00 B. WING	11/17/2022

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	DON indicated the resident treatments should be signed out in the ETAR. If there was a blank in the ETAR then it meant it wasn't done. 4. On 11/10/22 at 9:59 A.M., Resident 70 was observed sitting in a chair in his room. The resident indicated he was at the facility short term after a hospitalization and would be going home soon. The resident did have a wound on his bottom, he was not sure when it developed. There was a current treatment for the wound, but it was almost healed. The resident deferred an observation of the wound. The resident's clinical record was reviewed on 11/16/22 at 2:46 P.M. An Admission MDS assessment, dated 08/28/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension, atrial fibrillation, renal insufficiency, seizure disorder, urinary tract infection in the last 30 days, and COPD (Chronic Obstructive Pulmonary Disease). The resident was at risk for pressure ulcers but had no unhealed pressure ulcers during the assessment review period. The resident utilized a pressure reducing device for his bed. The Facility Admission Assessment, dated 08/24/22, indicated the resident had no skin impairments. A Wound NP Assessment, dated 08/29/22, indicated the resident had a sacrococcygeal (sacrum and coccyx area) pressure ulcer, staged as a suspected DTI (Deep Tissue Injury, a non-blanchable deep red, purple or maroon area of intact skin, non-intact skin, or blood-filled blisters caused by damage to the underlying soft tissues) that measured 5.79 cm x 3.85 cm x 0.05 cm. There was a scant amount of thin, serous (thin, watery fluid) drainage. The wound tissue type was 100%			

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	epithelial tissue, wound colors were listed as pink (5.19 cm 2), black (7.70 cm 2), and red (1.55 cm 2). The treatment was to cleanse the wound and apply a hydrocolloid dressing. The dressing was to be changed every three days. Current preventative interventions included the use of a pressure redistribution mattress, wheelchair cushion, and a specific turning and repositioning program. The August and September 2022 EMARs and ETARs lacked documentation that the hydrocolloid dressing treatment was ever administered. A Wound NP Assessment, dated 09/15/22, indicated the resident had a sacrococcygeal wound that was previously classified as an evolving DTI, but was now classified as an Unstageable pressure ulcer. The wound measured 3.05 cm x 2.55 cm and was 100% covered in slough/eschar (dead skin). There was a moderate amount of serous drainage. The treatment was to cleanse with a wound cleanser, apply Medihoney and a bordered gauze. The September 2022 ETAR contained a physician's order, with a start date of 09/24/22, to cleanse the area with wound cleanser, apply Medihoney and cover with a bordered gauze every day shift for wound care to the coccyx. The treatment was administered as ordered. The ETAR lacked documentation of a wound treatment before 09/24/22. During an interview on 11/16/22 at 2:24 P.M., the ADON indicated the wound was present on admission, it started as a suspected DTI. She was unsure as to why the wound treatments weren't on the ETARs, the orders must have been missed.			

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	A Wound NP Assessment, dated 09/29/22, indicated the resident had a sacrococcygeal wound that was previously identified as an unstageable wound, and was determined to be a Stage 3 pressure ulcer that measured 1.15 cm x 0.65 cm x 1.20 cm. The wound was 70% granulation tissue and 30% slough/eschar. There was moderate serous drainage. The treatments were daily dressings with Medihoney and calcium alginate. The resident was discharged home from the facility on 11/16/22. The current, undated facility policy, titled "S.W.A.T.---Skin Weight Assessment Team---Guidelines Pressure Ulcers" was provided by the Administrator on 11/16/22 at 4:19 P.M. The policy indicated, "...It is the policy of the facility to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable...a resident...receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing...ensure all assessments are timely and accurate...monitor treatments for efficacy..." 3.1-40(a)(2) 3.1-40(a)(3)			
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			

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	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 residents' safety related to unauthorized medications at the bedside for 1 of 17 residents observed. (Resident 40) Findings include: During an observation and interview on 11/16/22 at 11:40 AM., Resident 40 was sitting in her wheelchair in her room self administering her medications from a medicine cup that contained 13 pills of various sizes and colors. The resident indicated they had left for an appointment that morning and she did not get their medications prior to leaving. The staff told her they would hold them for her until she returned from her appointment. The staff usually left her medications at her bedside but they were not supposed to now because "State" was in the building. No staff were observed near the the resident's room. They staff were down the hall at the nurse's station. During an interview, down the hall near the nurse's station, on 11/16/22 at 11:41 A.M., QMA (Qualified Medication Aide) 9 indicated the resident did not have an assessment to self administer her medications. She had just given the resident her the medications and thought she had taken them. During an interview on 11/17/22 at 10:02 A.M., the Administrator indicated she did not think their medication administration policy specified that the	F 0689	**F-689** It is the policy of the facility to ensure the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Including not leaving medications at bedside. Residents who reside in the facility have the potential to be affected by this finding. A facility wide audit was completed on 11/17/22 to ensure residents did not have any medication at bedside. Any changes or corrections were addressed and changed as indicated. DON/Designee will medication for 10 residents weekly for a period of 4 weeks. The tool will then be used for 5 residents weekly for 4 weeks. Then weekly for 1 resident ongoing for a period of no less than 6 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped.	12/13/2022

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	nurse had to stay in the presence of the residents while they were taking their medications. No current residents were permitted to self administer their medications. The clinical record was reviewed on 11/17/22 at 2:40 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 09/18/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, diabetes, hypertension, anxiety, depression, and history of stroke. The EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) for November 2022, was provided by the Regional Director of Operations on 11/16/22 at 4:14 P.M. The record indicated the resident had current physician orders that included, but were not limited to, the following medications to be administered in the morning: - Allopurinal 100 mg (milligrams) for gout, - Amlodipine Besylate 5 mg for hypertension, - Lasix 40 mg for edema, - Levothyroxine 88 mcg (micrograms) for hypothyroidism, - Lisinopril 10 mg for hypertension, - Lisinopril 5 mg for hypertension (for a total of 15 mg), - Loratadine 10 mg for allergies, - Paroxetine 40 mg for depression, - Paroxetine 10 mg for depression (for a total of 50 mg), - Potassium Chloride 20 meq (milliequivalent), - a prenatal vitamin, - Prilosec 20 mg for GERD (Gastroesophogeal Reflux Disease), - Vitamin D3 20 mcg for osteopenia, - Iron 325 mg for anemia, and - Gabapentin 100 mg, 2 capsules, for neuropathy.		At an in-service held by the Administrator/Designee on_12/1/22_____for all nursing staff the following was reviewed: 1. Medication administration policy and procedure 2. Medication storage, medication error policy and procedure, medication and treatment cart storage and security. 3. Self-Administration of medication Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	The current undated Medication Administration policy was provided by the Administrator on 11/16/22 at 4:19 P.M. The policy indicated, "...Purpose...To ensure that resident medication are administered in a timely manner and documentation is completed to substantiate administration..." The current undated Medication Self Administration policy was provided by the Administrator on 11/16/22 at 4:19 P.M. The policy indicated, "...Purpose...To provide procedures for determining if the resident can safely self-administer and store medications in their room..." 3.1-45(a)(2)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, interview, and record review, the facility failed to follow the physician's orders related to a PICC dressing for 1 of 1 resident reviewed for PICC (Peripherally Inserted Central Catheter) line. (Resident 29) Findings include: During an observation and interview on 11/09/22 at 1:04 P.M., Resident 29 was lying in bed. She indicated she had an infection recently. There was a PICC inserted in the resident's right upper arm.	F 0694	**F-694** It is the policy of the facility to ensure Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Including proper sterile techniques used for PICC line dressing change.	12/13/2022

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	The dressing was all bunched up. The date had a 10 written on it and the rest was unreadable due to the dressing being folded over. During an observation and interview on 11/09/22 at 1:34 P.M., LPN (Licensed Practical Nurse) 6, assessed the resident's dressing covering her PICC in the right arm. She folded the dressing over and the date was visible and dated 10/17. She indicated the dressing should have been changed since 10/17. The dressing was to be changed weekly. The clinical record for Resident 29 was reviewed on 11/15/22 at 10:48 A.M. A Significant Change MDS (Minimum Data Set) assessment, dated 11/04/22, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, anemia, hypertension, hip fracture, seizure disorder, anxiety, and depression. The resident had received IV (intravenous) medications during the last 14 days of the assessment. A Progress Note, dated 10/17/22, indicated a urine culture and sensitivity was received from the laboratory. The MD was updated, and a new order was received to discontinue the resident's oral antibiotic medication and start Invanz (an intravenous) medication, every day, for 10 days. The facility may place a midline/PICC line. The Assistant Director of Nursing and the resident were notified. The pharmacy IV department was updated to come to the facility to place a midline/PICC. A Midline/PICC Insertion Documentation Form, dated 10/17/22, indicated the PICC for Resident 29 was placed on 10/17/22.		Residents who reside in the facility have the potential to be affected by this finding. A facility wide audit was completed on 11/17/22 to ensure all residents with PICC lines had appropriate orders and dressings in place. Any changes or corrections were addressed and changed as indicated. DON/Designee will monitor PICC line dressing changes for 10 residents weekly for a period of 4 weeks. The tool will then be used for 5 residents weekly. Then weekly for 1 resident ongoing for a period of no less than 6 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Administrator/Designee on__12/1/22____for all nursing staff the following was reviewed: 1. PICC line dressing changes 2.Sterile Dressing changes 3. Clean Dressing changes 4. Documentation of dressing changes Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as	

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	An open-ended physician's order, with a start date of 10/25/22, indicated staff were to change the IV-PICC transparent dressing weekly and as needed. The resident had not suffered any ill effects from the PICC dressing not being changed. The current, undated, facility policy titled, "PICC Catheter Needleless Access Device Change", was provided by the DON (Director of Nursing) on 11/09/22 at 2:44 P.M. The policy indicated, "...To decrease the risk of catheter associated infections...PICC catheter needleless access devices are change at the following times: at least every 7 days..." 3.1-47(a)(2)		indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	
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 follow infection control guidelines for 1 of 1 resident reviewed for tracheotomy care (Resident 36), and failed to appropriately manage residents' respiratory needs related to dating equipment for 2 of 3 residents reviewed for respiratory care. (Residents 40 and 27)	F 0695	**F-695** It is the policy of the facility to ensure Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal	12/13/2022

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	Findings include: 1. During an observation on 11/17/22 at 11:19 A.M., LPN (Licensed Practical Nurse) 2 entered Resident 36's room. She placed a towel over the resident and explained the procedure. She washed her hands, applied gloves, and set up her supplies on the bedside table. She doffed her gloves and donned sterile gloves, retrieved the tracheotomy kit with her left sterile gloved hand and opened it with her right sterile gloved hand. She took the sterile field drape and opened it onto the bedside table, removed all the supplies with her right hand and placed them on the drape. She mixed peroxide and normal saline into the empty package and doffed her gloves. She donned new sterile gloves, removed the resident's oxygen covering the trach, removed the trach cannula with her right hand, retrieved a gauze pad soaked in peroxide with normal saline and cleansed around the trach using her right hand. She retrieved a dry gauze pad and wiped around the tracheostomy with her right hand while hold the trach in place with her left hand. She removed the old collar, put a new collar in place with both gloved hands, and placed a new cannula with her right hand. The oxygen was replaced. During an interview on 11/17/22 at 1:33 P.M., LPN 2 indicated when providing tracheostomy care she should have never touched the supplies with her contaminated gloved hand. She should always have a clean hand and a dirty hand during the procedure. The clinical record for Resident 36 was reviewed on 11/15/22 at 11:41 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 09/28/22, indicated the resident was rarely/never		suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals, and preferences. Including proper changing, labeling, and dating oxygen supplies. Residents who reside in the facility have the potential to be affected by this finding. A facility wide audit was completed on 11/17/22 to ensure that all resident oxygen supplies had been changed, labeled, and dated according to policy. Any changes or corrections were addressed and changed as indicated. DON/Designee will monitor oxygen administration *as* well as tracheostomy care for 10 residents weekly for a period of 4 weeks. The tool will then be used for 5 residents weekly for 4 weeks. Then weekly for 1 resident ongoing for a period of no less than 6 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Administrator/Designee on_12/1/22 _____for all nursing staff the following was reviewed:	

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	understood. The diagnoses included, but were not limited to, stroke, hypertension, neurogenic bladder, diabetes, non-Alzheimer's dementia, hemiplegia/hemiparesis, seizure disorder, depression, and tracheostomy status. The resident had received levofloxacin for an upper respiratory infection from 09/21/22 through 10/01/22. The current, undated, facility policy titled "Respiratory: Tracheostomy Care", was provided by the DON (Director of Nursing) on 11/17/22 at 1:23 P.M. The policy indicated, "...To describe a recommended method for cleaning a tracheostomy site and tube-keeping site and tube free from mucus build-up, maintaining tube patency-reducing risk of infection and maintain skin integrity at stoma site...Establish sterile field on over-bed table and maintain during procedure...open packages to reveal supplies-using insides of packages to form sterile field...Add items to the field by properly dropping items onto the field being sure to keep package between the items to be used and hands...Put on sterile latex free gloves and personal protective equipment [gown, goggles-if indicated]Remember when performing tracheostomy care keep dominate hand sterile [usually right hand] and non-dominate hand clean [usually left hand]..." 2. During an interview and observation on 11/09/22 at 11:55 A.M., Resident 40 indicated she had not had water for her oxygen since September and staff had not changed the tubing in a really long time. The resident was sitting in her room on the side of her bed. She had an oxygen concentrator machine at the end of her bed with an attached water reservoir humidification bottle and tubing. The water bottle was dated 09/28/22 and was dry and empty. There was no date on the		1. Oxygen Administration 2. Trach Care and Emergency Trach Care 3. Policy and Procedure for labeling/dating and changing out oxygen supplies such as bags, humidifier bottles and nasal cannulas Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	tubing indicating when it had been put into service. There was a one inch piece of tape on the tubing that had dirty black flecks of debris, dust, and hair stuck to the tape. No date was written on the tape. During an interview and observation on 11/10/22 at 11:25 A.M., the resident indicated their oxygen tubing had been changed last night. The resident's tubing was dated appropriately, the water bottle was two thirds full, and was dated 11/09/22. During an interview on 11/16/22 at 3:41 P.M., the DON indicated oxygen tubing was changed weekly on Wednesday nights. During an interview on 11/17/22 at 2:17 P.M., LPN 5 indicated oxygen tubing and humidification bottles both should be dated. They were changed weekly on Wednesday and documented in the EMAR/ETAR (Electronic Medication Administration Record / Electronic Treatment Administration Record). The clinical record was reviewed on 11/17/22 at 2:40 P.M. A Quarterly MDS assessment, dated 09/18/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, diabetes, hypertension, anxiety, depression, and history of stroke. The EMAR/ETAR for September and October 2022, were provided by the Regional Director of Operations on 11/16/22 at 4:14 P.M. The record indicated the resident had current physician orders that included, but were not limited to, the following: - Oxygen at 2 liters per minute per Nasal Cannula			

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	155233	A. BUILDING 00 B. WING	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF BATESVILLE, THE	958 E HWY 46 BATESVILLE, IN 47006

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	as needed for shortness of breath with a start date of 5/25/21, - Change oxygen tubing and humidifier every Wednesday on night shift, date both tubing and water with a start date of 05/26/21, a discontinued date of 10/11/22, and a start date of 10/12/22. The September record indicated the oxygen tubing and water bottle had been changed on September 28, 2022. The October record lacked documentation the oxygen tubing and water bottle had been changed on the following dates: - October 5, - October 19, and - October 26. The resident had not had a respiratory infection recently. 3. During an interview on 11/09/22 11:57 A.M., Resident 27 indicated the facility utilized agency nurses because they did not have enough nurses. They used to change the oxygen tubing on Wednesday nights, but they didn't anymore. The clinical record was reviewed on 11/17/22 at 2:49 P.M. A Significant Change MDS assessment, dated 08/24/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, arthritis, anxiety, depression, and lymphedema. The EMAR/ETAR for September and October 2022, were provided by the Regional Director of Operations on 11/16/22 at 4:14 P.M. The record indicated the resident had current physician			

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	orders that included, but were not limited to, the following: - may apply oxygen per Nasal Cannula as needed for shortness of breath with a start date of 02/07/21, - Change oxygen tubing and humidifier (if needed) every Wednesday on night shift, date both tubing and water with a start date of 05/26/21, a discontinued date of 10/10/22, and a start date of 10/12/22. The September record lacked documentation the oxygen tubing had been changed on the following date: - September 21. The October record lacked documentation the oxygen tubing and water bottle had been changed on the following dates: - October 5, - October 19, and - October 26. The resident had not had a respiratory infection recently. The current undated Oxygen Administration policy was provided by the Administrator on 11/16/22 at 4:19 P.M. The policy indicated, "...Tubing, humidifier bottles...will be changed, cleaned and maintained no less that [sic] weekly...Each will be labeled with date, time and initialed by staff completing this service to equipment..." 3.1-47(a)(6)			

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F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to provide the required RN (Registered Nurse) on duty for eight hours a day for 2 of the 17 days reviewed. Findings include: During an interview on 11/17/22 at 1:57 P.M., the DON (Director of Nursing) indicated she was usually here Monday through Friday. The DON and RN 12 were the only two RNs currently working in the facility. When neither herself nor RN 12 were working, a corporate RN would usually comes to the facility. They did not currently have any nursing waivers. The as worked nursing schedule indicated there had not been an RN on duty for eight consecutive hours on Saturday, 11/05/22 and Sunday, 11/06/22. During an interview on 11/17/22 at 3:23 P.M., the	F 0727	**F-727** It is the policy of the facility to ensure Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. The facility is engaged in continual efforts to recruit and retain licensed nurses in order to comply with RN coverage dictated by CMS. These efforts are documented and available for review. No resident has been negatively impacted by this finding. Residents who reside in the facility have the potential to be affected by this finding.	12/13/2022

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	DON indicated the facility did not have a policy for RN coverage, They followed state and federal regulations. 3.1-17(b)(3)		The facility will provide 8 continuous hours of Registered Nursing services 7 days per week. DON/Designee will monitor RN labor hours 5 days weekly for a period of 4 weeks. The tool will then be used 3 days weekly for 4 weeks, then weekly ongoing for a period of no less than 6 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Administrator/Designee on_12/1/22_____for the DON, ADON and Staffing Coordinator the following was reviewed: 1. Federal regulation related to RN staffing requirements 2. Scheduling strategy to ensure 8hrs of consecutive RN coverage is present daily. Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any	

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			written Action Plan will be monitored by the Administrator weekly until resolution.	
F 0732 SS=D Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.			

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	§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to post nurse staffing daily for the survey time period 11/09/22 through 11/17/22. Findings include: During an observation on 11/09/22 at 2:44 P.M., the nurse staffing was posted by the therapy gym and dated for 11/08/22. During an observation on 11/10/22 at 9:20 A.M., the nurse staffing was posted by the therapy gym and dated for 11/09/22. During an observation on 11/14/22 at 11:00 A.M., the nurse staffing was posted by the therapy gym and dated for 11/13/22. During an observation on 11/14/22 at 3:59 P.M., the nurse staffing was posted by the therapy gym and dated for 11/13/22. During an observation on 11/15/22 at 9:04 A.M., the nurse staffing was posted by the therapy gym and dated for 11/13/22. During an observation on 11/15/22 at 12:25 P.M., the nurse staffing was posted by the therapy gym and dated for 11/13/22. During an observation on 11/15/22 at 4:10 P.M., the nurse staffing was posted by the therapy gym and dated for 11/13/22. During an observation on 11/16/22 at 9:30 A.M.,	F 0732	**F-732** It is the policy of the facility to post the nurse staffing data daily at the beginning of each shift. Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. Residents who reside in the facility have the potential to be affected by this finding. An audit was completed to ensure proper posting and storage of previously posted daily staff information was present. Any changes or corrections were addressed and changed as indicated. DON/Designee will monitor the daily staffing posting 5 days weekly for a period of 4 weeks. The tool will then be used 3 days for 4 weeks, then weekly ongoing for a period of no less than 6 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Administrator/Designee on_11/23/22____for the ADON	12/13/2022

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	the nurse staffing was posted by the therapy gym and dated for 11/15/22. During an observation on 11/16/22 at 1:29 P.M., the nurse staffing was posted by the therapy gym and dated for 11/15/22. During an interview on 11/16/22 at 1:30 P.M., the DON (Director of Nursing) indicated LPN (Licensed Practical Nurse) 2 was responsible for the posting the staffing. It should be posted at the beginning of each day. During an interview on 11/17/22 at 5:05 P.M., LPN 2 indicated she had been posting the staffing for the previous day to reflect which staff had acutely worked. During an interview on 11/17/22 at 9:36 A.M., the DON indicated the facility had no specific policy for staff posting, they follow the federal regulations.		and Staffing Coordinator the following was reviewed: 1. Policy and procedure for posting daily staffing information Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have			

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	access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to label medications appropriately for 1 of 2 medication storage rooms reviewed (39 Hall Medication Room), and label insulin pens for 1 of 3 medication carts reviewed (77 Front Medication Cart) . Findings include: On 11/17/22 at 2:30 P.M, the 39 Hall Medication Storage Room was observed with LPN (Licensed Practical Nurse) 5. The medication refrigerator contained the following: - 2 nearly empty vials of Tubersol serum, with no opened-on date, - 1, 3/4 full vial of Tubersol serum, with no opened-on date, and - 1, 1/5 full bottle of Acetylcysteine 20% Inhalation Solution for Resident 36, with no opened-on date. During an interview, LPN 5 indicated all medications should be labeled with an opened-on date. The TB serum was good for 30 days. During an observation on 11/17/22 at 2:45 P.M. with RN 3, the 77 Front medication cart contained	F 0761	**F-761** It is the policy of the facility to ensure Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Including labeling and dating insulin and tuberculin solution. Residents who reside in the facility have the potential to be affected by this finding. A facility wide audit was completed to ensure all medications were labeled and dated appropriately. Any changes or corrections were addressed and changed as indicated. DON/Designee will monitor	12/13/2022

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	the following insulin medications with no opened-on dates: - 1 Novolog insulin pen for Resident 23 that was 3/4 full, and - 1 Lantus insulin pen for Resident 52 that was 3/4 full. RN 3 indicated she gave Resident 52 insulin from the unlabeled Lantus insulin pen that morning. No residents suffered any ill effects from using the unlabeled medications. The current pharmacy recommendations for storage of select medications, dated September 2022 was provided by the Administrator on 11/17/22 at 4:15 P.M. The recommendations indicated the following, "...Tubersol...Discard vials in use after 30 days...Novolog...use within 28 days of initial use...Lantus...use within 28 days of initial use..." The current, undated facility policy, titled "MEDICATION STORAGE IN THE FACILITY" was provided by the Administrator on 11/17/22 at 4:10 P.M. The policy indicated, "...Medications...are stored safely, securely, and properly following the manufacturer or supplier recommendations.." 3.1-25(j) 3.1-25(o)		medication storage/labeling dating medications in 5 days weekly for a period of 4 weeks. The tool will then be used 3 days weekly for 4 weeks, then weekly ongoing for a period of no less than 6 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Administrator/Designee on__12/1/22_____for all nursing staff the following was reviewed: 1. Medication storage policy and procedure 2. Policy and Procedure for labeling and dating medications when required Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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F 0800 SS=D Bldg. 00	483.60 Provided Diet Meets Needs of Each Resident §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Based on observation and interview, the facility failed to hold food at appropriate temperatures on the serving table for 1 of 2 food temperature observations. Findings include: During an observation on 11/15/22 at 11:00 A.M., Cook 8 had lunch prepared on the steam/cold table on ice. The food temperatures were as followed: - Egg Salad at 46.6 egress, - Chilled Beets at 50.2 degrees, - Pureed Egg Salad at 35.9 degrees, and - Pureed Chilled Beets at 33.5 degrees. Cook 8 indicated, the egg salad had been sitting in the refrigerator for 2 hours before she removed it and sat it in ice. She would serve it to the residents when the temperature was between 40-45 degrees. She proceeded to plate the food for the residents to deliver to their rooms. During an interview on 11/15/22 at 11:13 A.M., the Dietary Manager indicated the cold food holding temperatures should be at 40 degrees or below. She wasn't sure why the food was temping warmer than 40 degrees because the egg salad had been in the refrigerator for 2 hours and the beets had been in them since that morning. She was unsure of what the facility procedure was, and she would	F 0800	**F-800** It is the policy of the facility to ensure Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Including ensuring proper food temperatures when serving resident meals. Residents who reside in the facility have the potential to be affected by this finding. A 100% audit of November and December food temp logs has been conducted and any corrections or changes as indicated. Dietary Manager/Designee will utilize QAPI tool entitled “Food Temperatures” 5 days weekly for a period of 4 weeks. The tool will then be used 3 days weekly for 4 weeks, then 1 time weekly for a period of no less than 6 months. If facility is within compliance at the end of 6 months; then monitoring	12/13/2022

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	find out. The concerns were brought to the Administrator's attention on 11/15/22 at 11:20 A.M. She had gone to the kitchen to address the concern. During an interview on 11/15/22 at 11:32 A.M., the Administrator indicated the food was not served to any residents and was replaced. The current facility policy, titled "Monitoring Food Temperatures for Meal Service", dated 2010, was provided by the Administrator on 11/15/22 at 11:52 A.M. The policy indicated, "...Cold foods and beverages which are not 41 degrees or below will be chilled on ice or in the freezer..." 3.1-21(a)(2)		can be stopped. At an in-service held by the Registered Dietitian on__11/29/22_____for all nursing staff the following was reviewed: 1. Preventing Food-Borne Illness 2. Monitoring Food Temperatures 3. Retail Food Safety Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	
F 0803 SS=D Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.;			

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	§483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. Based on interview and observation, the facility failed to provide menus and palatable meals for 3 of 24 residents reviewed. (Residents 27, 40, and 10) Findings include: 1. During an interview and observation on 11/09/22 at 11:41 A.M., Resident 27 indicated the chicken did not taste like chicken. They had a lot of pork. The food tastes poor. If you got a grilled cheese they would lay it on top of the vegetables. They had not gotten a menu for at least a year. They used to give out a menu for the week. They do not know what they are having until their meal is served. If they wanted something different it took a long time to get it and you may not get it at all. They were supposed to be able to get a salad if they wanted it but they cannot get it anymore. The soup had no taste. It was just like water. The	F 0803	**F-803** It is the policy of the facility to ensure that all residents have access to a daily menu as well as provide each resident with a nourishing, palatable, well-balanced diet that meets his/her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Including giving residents copies of the Food Menu monthly. Residents who reside in the facility have the potential to be affected by this finding. *A facility wide audit was*	12/13/2022

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	155233	A. BUILDING 00 B. WING	11/17/2022

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	resident received her lunch tray and her grilled cheese was laying on top of her vegetables and was limp. The resident indicated it was greasy and soggy. During an interview on 11/17/22 at 2:33 P.M., the DM (Dietary Manager) indicated residents got a daily packet with activities and the menu for the day. It just showed what was on the menu for the day. The residents do not get a menu the day before for what is available for the next day. The residents do not get a monthly menu. When they get their tray, if they don't like what they get, they can send one of the nurses down to ask the kitchen staff for something else. The clinical record was reviewed on 11/17/22 at 2:49 P.M. A Significant Change MDS (Minimum Data Set) assessment, dated 08/24/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease, arthritis, anxiety, depression, and lymphedema. 2. During an interview on 11/09/22 at 12:07 P.M., Resident 40 indicated she had gotten her teeth pulled to get a partial plate. They were supposed to bring her soft foods but they didn't. They say they don't have cottage cheese or pudding. They do not get menus anymore. They got a paper on their tray when their meal was served saying what was on their plate. The clinical record was reviewed on 11/17/22 at 2:40 P.M. A Quarterly MDS assessment, dated 09/18/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, diabetes, hypertension, anxiety, depression, and history of stroke. 3. During an interview on 11/09/22 at 1:20 P.M.,		*completed to ensure r*esident correct food preferences are up to date and any corrections or changes were made as indicated. All residents were given a copy of the menu. Monthly menus have been added to resident daily activity packets. Dietary Manager/Designee will utilize QAPI tools entitled “Dietary Recommendations and Menus” for 5 residents weekly for a period of 4 weeks. The tool will then be used for 3 residents weekly for 4 weeks. Then weekly for 1 resident ongoing for a period of no less than 6 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Registered Dietitian on__11/29/22_____for all nursing staff the following was reviewed: 1. Menu Review 2. Policy on following Dietary Recommendations 3. Menu posting and delivery to residents Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the	

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	Resident 10 indicated sometimes the food wasn't good. She never got a menu. She never knew what she was getting until her tray came to her room. There were some alternate choices, but she couldn't choose those until she saw the tray and then would order an alternate. During an observation and interview on 11/15/22 at 1:57 P.M., Resident 10 was sitting in her room and indicated the lunch was good that day, but she had not received a menu to choose what she wanted. During an observation and interview on 11/16/22 at 11:37 A.M., Resident 10 had just received her lunch tray. She indicated she didn't get to choose what she wanted. A form sat on the tray that indicated what was for lunch, with a list of alternates food choice of grilled cheese, peanut butter and jelly, or a hamburger. She indicated a menu would be nice so she can choose something before the tray came. The clinical record for Resident 10 was reviewed on 11/15/22 at 3:31 P.M. A Quarterly MDS Assessment, dated 10/05/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, multiple sclerosis, anemia, hypertension, neurogenic bladder, anxiety, and depression. During an interview on 11/16/22 at 9:16 A.M., LPN 6 indicated the residents did not get menus to choose what they wanted to eat. The get their meal and then if they wanted something different the staff would go to the kitchen and order them something else. During an interview on 11/16/22 at 3:30 P.M., the Activities Director indicated the residents used to		monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	

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	get a menu for the day in the daily packet they would distribute in the mornings, but it had faded out and not been in the packets anymore. During an interview on 11/17/22 at 3:51 P.M., the Administrator indicated the resident menu was posted daily in the dining room for the residents to view. They could always ask what was on the menu for the day. When the resident received their tray, and they didn't like what was on it then they could ask the staff to get them something else. The kitchen staff usually knew what the residents liked and disliked. They did not have a facility policy related to menus. 3.1-21(a)(1) 3.1-21(a)(2) 3.1-21(a)(4)			
F 0865 SS=D Bldg. 00	483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) QAPI Prgm/Plan, Disclosure/Good Faith Attmpt §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development,			

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	implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities,			

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	unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee			

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	except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on interview and record review, the facility failed to demonstrate ongoing corrective actions were in place to address unresolved quality deficiencies related to pressure ulcers, that were previously cited on the last annual survey for 1 of 11 care areas reviewed. (pressure ulcers) Findings include: The current facility policy, titled "Quality Assurance / Performance Improvement Program (QAPI)", was provided by the Administrator on 11/17/22 at 4:08 P.M. The policy indicated, "...It is the intent of this facility to conduct an on-going Quality Assurance / Performance Improvement (QAPI) program designed to systematically monitor, evaluate, and improve the quality and appropriateness of resident care..." During the Annual Recertification and complaint survey, from 11/09/22 to 11/17/22, one deficiency was a repeated citation from the last annual survey, F686. The facility's Quality Assurance Committee did not implement on-going appropriate measures to correct identified issues or prevent deficiencies as follows: Pressure Ulcers: Four residents acquired pressure ulcer wounds that the facility failed to prevent, identify, and appropriately administer treatments	F 0865	**F-865** It is the policy of the facility to have a Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities. Including demonstrating ongoing corrective actions were in place to address unresolved quality deficiencies related to pressure ulcers.	12/13/2022

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	to. Cross reference F686 During an interview on 11/17/22 at 4:28 P.M., the Administrator indicated the findings from last survey were addressed in their Plan of Correction. They conducted audits and monitored the issues for a least 6 months. The DON (Director of Nursing) indicated they currently had a QAPI in place for wounds and falls. They started one in June for falls, and May for wounds. They were self-identified concerns when the DON started working in the facility. At 4:56 P.M., the Administrator indicated the DON started in her position in May, put the QAPI into place, but it hadn't been updated as it should have been. Moving forward, it would be addressed. There were issues with communication between the floor staff and management. The "FACILITY PLAN OF ACTION / CONTINUOUS QUALITY IMPROVEMENT" record for in house pressure wounds was provided by the DON on 11/17/22 at 5:00 P.M. The record's last documented date was 05/23/22. 3.1-52(b)(2)		Residents who reside in the facility have the potential to be affected by this finding. A QA audit was completed to ensure the PIP for pressure ulcers was current, monitoring was taking place as indicated by the plan and all residents had appropriate orders in place related to pressure ulcers. DON/Designee will monitor QAPI plans and PIPs 5 days weekly for a period of 4 weeks. The tool will then be used 3 days weekly for 4 weeks, then weekly ongoing for a period of no less than 6 months. If facility is within compliance at the end of 6 months; then monitoring can be stopped. At an in-service held by the Administrator/Designee on_12/1/22_____for the IDT the following was reviewed: 1. QAPI policy and procedure 2. PIP documentation and review related to QAPI Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. At the monthly QAPI meeting, the	

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			monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.	