STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155717	A. BUILDING 00 B. WING	04/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALPHA HOME - A WATERS COMMUNITY	2640 COLD SPRING RD INDIANAPOLIS, IN 46222

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00345145, IN00345543, IN00349638, IN00350319, IN00351165, and IN00351761. Complaint IN00345145 - Substantiated. Federal/State deficiencies related to the allegations are cited at F575, F585, F609, F697, and F755. Complaint IN00345543 - Substantiated. Federal/State deficiencies related to the allegations are cited at F921. Complaint IN00349638 - Substantiated. Federal/State deficiencies related to the allegations are cited at F585, F677, F684, F689, and F921. Complaint IN00350319- Substantiated. Federal/State deficiencies related to the allegations are cited at F677 and F921. Complaint IN00351165 - Substantiated. Federal/State deficiencies related to the allegations are cited at F695. Complaint IN00351761 - Unsubstantiated due to lack of evidence. Survey dates: April 19, 20, 21, 22, and 23, 2021 Facility number: 000376 Provider number: 155717 AIM number: 100275510 Census Bed Type: SNF/NF: 51	F 0000		

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

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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	Total: 51 Census Payor Type: Medicare: 4 Medicaid: 42 Other: 5 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 30, 2021.			
F 0575 SS=C Bldg. 00	483.10(g)(5)(i)(ii) Required Postings §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.			

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	Based on observation, interview, and record review, the facility failed to post contact information for the State Ombudsman. This deficient practice had the potential to effect 51 of 51 Residents who resided at the facility. Findings include: During an anonymous interview, a resident indicated they were not able to obtain the contact information for the State Ombudsman. It was not posted and when they asked for the information staff would not give it to them. On 4/9/20/21 at 9: 00 a.m., during a random observation of the facility, the posting for the State Ombudsman contact information was not seen in the facility. On 4/21/21 at 11:05 a.m., during a walking tour observation and interview the Administrator (ADM) indicated the Ombudsman information should have been posted and available to all residents. A wall across from the Nurses' Station, was observed with Residents' Rights and Department of Health information posted in frames. The ADM indicated it should have been posted but it was not there. She pointed out a nail on the wall where it should have been. On 4/21/21 at 1:00 p.m., Resident B's record was reviewed. An Activity Note, a late entry note for 01/05/2021 at 1:30 p.m., Resident B "... was observed advising another resident on how to declare a plan against staff and facility; his counsel was both disruptive and contrary to building guidelines with possible psycho-social distress backlash. Instantly, the other resident became aggressive with the information [Resident] gave him but was quickly advised by	F 0575	="" b=""> Preparation and/or execution of this plan of correction in general, or this corrective action in particular, 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: May 23, 2021. **Facility is respectfully requesting paper compliance for all deficiencies in this POC.** The facility immediately posted the State Ombudsman name and phone number. All Resident who reside in the facility had the potential to be affected by this finding. All residents/families were re-educated on how to contact the State Ombudsman. All staff were in-serviced by the DON/designee, May 5 & 20, 2021, on State Ombudsman policy including a review of where to direct residents to obtain the Ombudsman contact information. The Administrator and /or designee will conduct random	05/23/2021

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	Activity staff and given another approach on how to handle concerns. Resident began to calm down...still a bit agitated -- he was redirected back to his room and given a snack." On 1/6/2021 at 10:24 a.m., an Activity Note Text indicated Resident B "... was observed advising another resident on how to declare a plan against staff and facility; his counsel was both disruptive and contrary to building guidelines with possible psycho-social distress backlash. Instantly, the other resident became aggressive with the information [resident] gave him but was quickly advised by Activity staff and given another approach on how to handle concerns. Resident began to calm down...still a bit agitated -- he was redirected back to his room and given a snack." The Activity Director was not available for interview, during the survey period. On 4/23/21 at 9:45 a.m., during an interview the ADM indicated the Activity Director was not available again and would not be back. On 4/22/21 at 11:00 a.m., the ADM provided a current undated policy titled, "Ombudsman Program." This policy indicated, "Information will be provided on the State Long-Term Care Ombudsman...and program services will be made available to residents and families. The Ombudsman Program facilitates the resident's right to request immediate access to the State Ombudsman without fear of reprisal...The social service staff will maintain the current name and phone number of their area ombudsman and ensure this information is furnished at admission and upon request. Ombudsman information will be displayed on the information board and may be displayed elsewhere...."		monitoring for posted information and resident interviews to ensure Residents know where to get the Ombudsman contact information. Then, the results of the monitoring will be presented to the QAPI committee at the monthly QAPI meetings. Any concerns will have been addressed. Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored weekly by the administrator until resolved.	

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	On 4/22/21 at 11:00 a.m., the ADM provided a current undated policy titled, "Resident Rights." This policy indicated, "...Self Determination- You may choose your own activities, schedules and health care and any other aspect significant to and affecting your life within the facility. You may interact with visitors of your choice or with members of the community both inside or outside of the facility...You may organize or participate in groups of your choice...The facility must listen to and act upon requests or concerns of the group...." This Federal tag relates to Complaint IN00345145. 3.1-4(j)(3)(C)			
F 0585 SS=E Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or			

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	complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific			

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	allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on interview and record review, the facility	F 0585	Residents B P and C are no longer residents of the facility.	05/23/2021

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	failed to ensure grievances were documented, followed up with an investigation, and addressed with residents for 3 of 3 residents reviewed for grievances (Residents B, P, and C). Findings include: 1. On 4/19/21 upon request at the entrance conference the Administrator (ADM) provided copies of the facility grievances for December, January, February, March, and April. The December grievance log listed one entry, dated 12/9/20, logged by the Social Service Director (SSD). The entry indicated "Medication concern" the resolution indicated "education on medication times." There was no resident name on the log. The January, February, and March logs were blank, with no entries. The April log contained one entry, dated 4/5/21, the nature of the question was listed as "Pain" and was logged by the (former) Director of Nursing (DON). On 4/20/21 at 3:30 p.m., during an interview the (new) Director of Nursing indicated she could not provide any documentation of grievance follow-ups per her corporate office. She was only able to provide the list. When asked about names of residents on the logs she indicated she wasn't supposed to give that information on the log. Resident B had only been at the facility for 2 months, December and January and there were no grievances for Resident B. The December grievance was Resident P. On 4/20/21 at 1:00 p.m., the closed medical record		Residents who reside in the facility have the potential to be affected by this finding. All residents were interviewed to ensure all grievance are addressed.All staff were in-serviced by the DON/designee, May 5 & 20, 2021, including a review of the facility's Grievance Policy. The Administrator and /or designee will conduct random interviews, of 3 residents weekly for 4 weeks, then monthly for 3 months to ensure compliance that resident grievances are documented, follow-up with an investigation. QAPI team, will track and trend, the results of the interviews presented to the QAPI committee at the monthly QAPI meetings. Any concerns will have been addressed. Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the administrator weekly until resolved. Review of grievances will continue to be an on-going part of the monthly QAPI meeting agenda going forward.	

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	for Resident B was reviewed. The diagnoses included but were not limited to chronic ulcer of the skin of other sites with necrosis (death of cells in organ or tissues) of bone, and Raynauld's Syndrome (a condition where some areas of the body feel numb and cool). On 12/27/2020 at 1:43 p.m., an Activity Note indicated, "Met with [Resident B] today and all was well with respect to other matter of him believing he was not receiving on-time care. Resident sketched me a very nice Christmas card -- Resident was pleasant and had only good things to report about facility." On 12/26/2020 at 2:01 p.m., an Activity Note indicated, "Resident came to my office and accused the Nurse on duty of mistreatment concerning his care. I addressed the nature of things with both concerned and attempted to deescalate dilemma. [Resident B] was still a bit agitated -- Activities redirected resident with a cigarette smoke break." On 12/13/2020 at 12:49 p.m., a Social Service Note indicated, "Writer in today to follow up with resident re: Grievance, resident stated he was doing fine and doesn't have any issues at this time. Resident stated he has been getting his pain meds and hasn't had any issues with meds or care that has been given ...will continue to follow up and monitor." On 12/12/2020 at 4:22 p.m., a Social Service Note indicated, "Writer in today to f/u with resident re: concerns or issues re: grievance. Resident stated he was doing fine, resident was in his room drawing...resident states that's how he passes time, he really likes to drawing ...resident stated he didn't have any more issues and that everyone			

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	else here has been great, he did express concern over running out of pain meds, stated he talked with nurse already ...overall resident doing well and very cooperative with this writer. resident also seemed to be in very good spirits. Will continue to monitor and follow up." On 4/22/21 at 12:21 p.m., during an interview the SSD indicated Resident B had been at the facility since 12/2/20, he was a fairly young person, and he had drug seeking behaviors. He signed out AMA (against medical advice) in January because he wanted pain medication. If a resident has an allegation (of abuse) she would notify the DON. If a resident reports abuse emotional, physical, or sexual, the ADM and DON would suspend the employee while they investigated. The SSD would do the follow-up with the resident in 3 days. She did referrals for psych visits also. She had abuse training at hire and in-services were given throughout the year. On 4/20/21 at 3:30 p.m., during an interview the (new) DON indicated employees should not have confronted residents with face to face accusations. Concerns should have been reported to management for investigation. The Activity Director (AD) was not a supervisor and should not have been counseling employees and residents. She could not find any grievances related to Resident B and staff members. On 4/23/21 at 9:45 a.m., an interview with the ADON, Assistant Director of Nursing (ADON) and DON was requested but was not possible. The ADM indicated they had given notice and were not returning to the facility. On 4/23/21 at 12:05 p.m. in an interview, the SSD indicated the resident (Resident B) had told her			

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	the nurse had yelled at him. She was required to report that to ADM and DON because that was verbal abuse. The nurse was [Licensed Practical Nurse (LPN) 16] - they walked him out, so he was suspended, and he never came back. On 4/23/21 at 12:30 p.m. the ADM indicated she could not find any investigations related to Resident B and LPN 16. But she had pulled a copy of LPN 16's timecard which indicated he was terminated on 12/29/20. 2. On 4/21/21 at 11:00 a.m., a record review of Resident P's medical record indicated the diagnoses included, but were not limited to renal failure, hypertension and schizophrenia (a mental health disorder). On 12/10/21 at 4:01 p.m., a Social Service progress note indicated, "It was reported to this writer that resident had voiced a grievance. Resident stated the evening nurse yelled at him when he asked for his pain medicine. Resident stated he asked for pain meds [medication] and nurse stated, 'I don't like you' then threw his hands up and yelled out "Jesus Christ." Grievance given to Administrator. Writer assured resident he was safe and that we were going to follow up with resident. Resident will be referred to psych services and will continue to monitor. Resident stated he was doing fine but at times pain can be horrible." On 4/23/21 at 11:37 a.m., during an interview with the ADM and the SSD, the SSD indicated Resident P had never made a grievance complaint about anything. He didn't talk. In December she was new and must have mixed up the residents when she put the note in chart. She believed it was Resident B who had voiced the grievance. The ADM indicated the medical record would be			

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	corrected to reflect the right grievance with the correct resident. There were no records of the investigation. 3. A confidential interview conducted during the survey indicated, a resident and the resident representative had made multiple complaints to facility staff regarding not receiving medications as ordered resulting in missed medications, not receiving treatments as ordered resulting in trips to the hospital, not receiving showers as requested resulting in fungal infections, and poor housekeeping conditions. The complaints were not followed up or resolved. Indicated, upon admission to the facility, the resident had problems getting the correct medications. A resident representative had indicated, the resident had been on maintenance antipsychotic medications for a long period of time, and due to facility error, the resident had missed getting his medications. It took over a month and a trip to the hospital before the resident got his medications straightened out. The resident had incontinence of bladder and would get sore in the groin. Antifungal treatments were either not available or not applied to the skin as ordered and showers were not given resulting in the resident having skin breakdown that was not treated. There was an episode where the resident reported he'd soiled himself and asked to be cleaned up, but 30 hours later had still had no bath or antifungal cream to relieve pain and itching to the groin. The resident had called an ambulance and went to the ER due to pain and open sores on his groin and back where he had scratched so they were bleeding, all due to no medication. The resident representative overheard staff "chiding" the resident for requesting a shower, and they put him off with statements of "we will see if we can get to it", but staff would not give him a shower.			

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	Resident C's record was reviewed on 4/19/21 at 1:12 p.m. Diagnoses on Resident C's profile included, but were not limited to, schizophrenia. Admission Physician's orders for Resident C, indicated there were no orders written for antipsychotic medications. A Physician's order for Resident C, dated 12/22/20, indicated Vitamin A&D Ointment (used to treat minor skin irritations and decreased itching) apply to dry skin topically every 8 hours as needed for dry skin. Treatment Administration Records (TAR's), dated December 2020 - March 2021, indicated the records lacked documentation the medication was every administered. Shower documentation for Resident C, dated 12/22/20 - 3/31/21, indicated the resident received 17 showers to include 12/23/20, 12/29/20, 1/1/21, 1/7/21, 1/12/21, 1/15/21, 1/20/21, 1/27/21, 2/2/21, 2/7/21, 2/8/21, 2/11/21, 2/15/21, 3/9/21, 3/10/21, 3/15/21, and 3/26/21. The resident had refused a bath on 2/23/21 and 2/25/21. The resident record lacked documentation to indicate he had received 2 or more showers weekly per his preference or as needed for incontinence. Grievance Logs, dated December 2020 - March 2021 indicated there was no documentation of grievances or concerns from Resident C or the resident's representative. On 4/23/21 at 11:28 a.m., LPN 18 indicated, if a resident or resident representative had a grievance, she would report it to the Social Service Designee (SSD) and the SSD was responsible for following up and making sure it was resolve. If the SSD was unavailable, the ADM was notified to follow up. Grievances and the			

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	follow up by nursing were documented in the nurse's notes. On 4/22/21 at 11:00 a.m., the ADM provided an I Would Like to Know form, dated 2/9/16, and indicated, the form was the one currently being used by the facility to inform residents, resident representatives, and staff about the grievance process. The form indicated, "Purpose: To provide a [process] by which a resident or a resident's representative can have their questions/concerns brought to the proper source to be answered/addressed and resolved as much as possible to the satisfaction of the resident or their representative and to have this activity documented including: A. Question and Details, B. Action taken [and by whom], C. Dates/Times, D. Response back to resident/representative, E. Documentation complete, F. Filing in [I Would Like to Know] binder ...Procedure: 1. When a resident or a resident's representative presents a question/concern, a staff member obtains the [I Would Like to Know ...] form. A staff member completes the form for the resident or resident representative ...2. If the question/concern is related to alleged abuse and/or alleged neglect, then immediately follow the facility Abuse Policy and Procedure Protocol ...10. When the question/concern has been answered or has been resolved to the greatest degree possible, the assigned Department Head will contact the appropriate party to discuss what has been done...." On 4/22/21 at 11:00 a.m., the ADM provided a Grievances/Complaints/Missing Property policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "It is the policy of the facility to see that the residents and their responsible parties are			

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	made aware upon admission and as indicated of the resident's right to express a complaint or a grievance orally, or in writing at any time ...2. There will be posted information throughout the facility in prominent locations as to the resident's individual right to express a complaint or a grievance ...3. There will be a clearly visible posting of the reasonable expected time for completing a complaint or grievance review as well as the fact that the person [resident/resident's advocate] who presented the complaint/grievance has the right upon request to receive in writing the decision or outcome related to the complaint or grievance...G. Consistent with 483.12(c)(l), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property ...and as required by law...." This Federal tag relates to Complaints IN00345145 and IN00349638. 3.1-7(a)(2) 3.1-7(b)			
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later			

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	than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure their own policy was followed to report and investigate grievances, and allegations of abuse for 1 of 3 residents reviewed for grievances and abuse (Resident B). Findings include: On 4/20/21 at 1:00 p.m., the closed medical record for Resident B was reviewed. The diagnoses included but were not limited to chronic ulcer of the skin of other sites with necrosis (death of cells in organ or tissues) of bone, and Raynaud's Syndrome (a condition where some areas of the body feel numb and cool). On 12/27/2020 at 1:43 p.m., an Activity Note indicated, "Met with [Resident B] today and all was well with respect to other matter of him believing he was not receiving on-time care. Resident sketched me a very nice Christmas card -	F 0609	Based on record review and interview, the facility failed to ensure their own policy was followed to report and investigate grievances, and allegations of abuse for 1 of 3 residents reviewed for grievances and abuse (Resident B). They facility immediately reported the allegation to ISDH. The Resident no longer resides at the facility and could not be reached for questions. Resident who reside in the facility have the potential to be affected by this finding. All Residents were interviewed and found no allegation of abuse existed. All staff were in-serviced by the	05/23/2021

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	- Resident was pleasant and had only good things to report about facility." On 12/26/2020 at 2:01 p.m., an Activity Note indicated, "Resident came to my office and accused the Nurse on duty of mistreatment concerning his care. I addressed the nature of things with both concerned and attempted to deescalate dilemma. [Resident B] was still a bit agitated -- Activities redirected resident with a cigarette smoke break." On 12/13/2020 at 12:49 p.m., a Social Service Note indicated, "Writer in today to follow up with resident re: Grievance, resident stated he was doing fine and doesn't have any issues at this time. Resident stated he has been getting his pain meds and hasn't had any issues with meds or care that has been given. will continue to follow up and monitor." On 12/12/2020 at 4:22 p.m., a Social Service Note indicated,"Writer in today to f/u with resident re: concerns or issues re: grievance. Resident stated he was doing fine, resident was in his room drawing. resident states that's how he passes time, he really likes to drawing [sic]. resident stated he didn't have any more issues and that everyone else here has been great, he did express concern over running out of pain meds, stated he talked with nurse already. overall resident doing well and very cooperative with this writer. resident also seemed to be in very good spirits. will continue to monitor and follow up." . On 4/19/21 upon request at the entrance conference the Administrator (ADM) provided copies of the facility grievances for December, January, February, March, and April.		DON/designee, May 5 & 20, 2021, including a review of the facility Abuse Prevention Program and Grievance Policy. At the daily CQI morning meeting, the progress notes written since the previous daily CQI morning meeting will be reviewed to ensure that any event that meets reportable criteria was initially reported, investigated and had all appropriate protocol followed as per policy and regulation. On week-ends and holidays, the supervisor on each shift will ensure that incidents of abuse or potential abuse as well as grievances, are addressed per policy and regulation. Any concerns will be addressed if found. The Administrator and /or designee will conduct random ongoing audits of the Grievances and daily reports to ensure they are documented, investigated, followed up, and reported to ISDH if required. The results of the audits done by the administrator/designee, will be presented to the QAPI committee at the monthly meetings. Any concerns will be addressed if found. Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Acton Plan will be monitored by the	

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	The December grievance log listed one entry, dated 12/9/20, logged by the Social Service Director (SSD). The entry indicated "Medication concern" the resolution indicated "education on medication times." There was no resident name on the log. The January, February, and March logs were blank, with no entries. The April log contained one entry, dated 4/5/21, the nature of the question was listed as "Pain" and was logged by the (former) Director of Nursing (DON). There was no resident name on the log. On 4/20/21 at 3:30 p.m., during an interview the (new) Director of Nursing indicated she could not provide any documentation of grievance follow-ups per her corporate office. She was only able to provide the list. When asked about names of residents on the logs she indicated she wasn't supposed to give that information on the log. Resident B had only been at the facility for 2 months, December and January, there were no grievances for Resident B. The December grievance was Resident P. On 4/20/21 at 3:30 p.m., during an interview the (new) DON indicated employees should not have confronted residents with face to face accusations. Concerns should have been reported to management for investigation. The Activity Director (AD) was not a supervisor and should not have been counseling employees and residents. She could not find any grievances related to Resident B and staff members. On 4/23/21 at 12:05 p.m. in an interview, the SSD		administrator weekly until resolved.	

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	indicated the resident (Resident B) had told her the nurse had yelled at him. She was required to report that to ADM and DON because that was verbal abuse. The nurse was [Licensed Practical Nurse (LPN) 16] - they walked him out, so he was suspended, and he never came back. On 4/23/21 at 12:30 p.m. the ADM indicated she could not find any investigations related to Resident B and LPN 16. But she had pulled a copy of LPN 16's timecard which indicated he was terminated on 12/29/20. On 4/22/21 at 11:00 a.m., the Administrator provided an I Would Like to Know form, dated 2/9/16, and indicated, the form was the one currently being used by the facility to inform residents, resident representatives, and staff about the grievance process. The form indicated, "Purpose: To provide a [process] by which a resident or a resident's representative can have their questions/concerns brought to the proper source to be answered/addressed and resolved as much as possible to the satisfaction of the resident or their representative and to have this activity documented including: A. Question and Details, B. Action taken [and by whom], C. Dates/Times, D. Response back to resident/representative, E. Documentation complete, F. Filing in [I Would Like to Know] binder ...Procedure: 1. When a resident or a resident's representative presents a question/concern, a staff member obtains the [I Would Like to Know ...] form. A staff member completes the form for the resident or resident representative ...2. If the question/concern is related to alleged abuse and/or alleged neglect, then immediately follow the facility Abuse Policy and Procedure Protocol ...10. When the question/concern has been answered or has been			

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	resolved to the greatest degree possible, the assigned Department Head will contact the appropriate party to discuss what has been done...." This Federal tag relates to Complaint IN00345145. 3.1-28(c) 3.1-28(d) 3.1-28(e)			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to provide or document showers for 5 of 5 residents reviewed for bathing preferences (Residents C, M, K, V, and U). Findings include: 1. A confidential interview conducted during the survey indicated, a resident and the resident's representative had made multiple complaints to facility staff regarding not receiving showers as requested resulting in fungal infections. The resident had incontinence of bladder and would get sore in the groin. There was an episode where the resident reported he had soiled himself and asked to be cleaned up, but 30 hours later had still had no bath or antifungal cream to relieve pain and itching to the groin. The resident's representative overheard staff "chiding" the resident for requesting a shower, and they put him off with statements of "we will see if we can get to it", but staff would not give him a shower.	F 0677	All residents of the facility were re-assessed for shower preference. Residents who reside in the facility have the potential to be affected by this finding. Residents who reside at the facility were re-assessed as to their preference related to shower days/times. The Shower Schedule and the CNA assignments and care plans have been updated. All nursing staff were in-serviced by the DON/designee, May 5 & 20, 2021, including a review of Resident Rights in regards to Resident's Shower preferences. 3 Resident Shower Sheets will be audited to ensure that resident	05/23/2021

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	Resident C's record was reviewed on 4/19/21 at 1:12 p.m. Diagnoses on Resident C's profile included, but were not limited to schizophrenia, dementia, cognitive communication deficit, repeated falls, and benign prostatic hyperplasia (age-associated prostate gland enlargement that can cause urination difficulty). Review of shower documentation for Resident C, dated 12/22/20 - 3/31/21, indicated the resident received 17 showers to include 12/23/20, 12/29/20, 1/1/21, 1/7/21, 1/12/21, 1/15/21, 1/20/21, 1/27/21, 2/2/21, 2/7/21, 2/8/21, 2/11/21, 2/15/21, 3/9/21, 3/10/21, 3/15/21, and 3/26/21. The resident had refused a bath on 2/23/21 and 2/25/21. The records lacked documentation to indicate he had received 2 or more showers weekly per his preference or as needed for incontinence. The Admission MDS (Minimum Data Set) assessment, completed on 12/29/20, assessed Resident C as having a BIMS (Brief Interview for Mental Status) score of 14 indicated cognitively intact. Indicated the resident preferences for routine and activities, it was very important for the resident to choose between a tub bath, shower, bed bath, or sponge bath. Assessed the resident as requiring extensive assistance with one-person physical assist for walking in room, dressing, toilet use, and personal hygiene. Occasionally incontinent of bladder, frequently incontinent of bowel. No pressure ulcers, wounds or skin problems, and no skin treatments. A Care Plan for Resident C, included, but was not limited to, the resident required staff assistance with ADL's (activities of daily living) due to poor activity endurance. The goal was for the resident to perform ADLs with one assist by discharge to		preferences for showers is being honored, weekly x 4 weeks, then bi-weekly x 2 months, then monthly x 2 months. Afterwards, random audits will continue ongoing. Any concerns will be addressed if found. The results of the audits of the showers to ensure they are documented and administered as to the resident preference, will be presented to the QAPI committee at the monthly QAPI meetings. Any concerns will have been addressed. Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will monitored weekly by the administrator until resolution.	

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	home. Interventions included staff assistance with transfers, toileting, eating, bed mobility, and oral care as needed. Set up and assist with shower 2 times a week and as needed. 2. Resident M's record was review on 4/21/21 at 9:30 a.m. Diagnoses on Resident M's profile included but were not limited to, cerebral infarction, spastic hemiplegia affecting right dominant side (muscles on one side of the body being in constant state of contraction), difficulty walking, and aphasia (loss of ability to understand or express speech) following cerebral infarction. Review of CNA- Bath/Shower Checklists and Shower/Bath documentation in the electronic record for Resident M, dated 12/1/20 - 4/19/21, indicated the records lacked documentation the resident had received showers or that showers had been refused. The Admission MDS assessment, completed on 7/3/20, indicated it was very important to Resident M to choose between a tub bath, shower, bed bath, or sponge bath. A Care Plan for Resident M, dated 10/9/18, indicated the resident preferred 2 showers a week in the evening before she went to bed, and she did not care what day she was showered. The goal was for the resident preferences to be honored daily through the next review. Interventions included Resident M would receive her showers 2 evenings a week before she went to bed at night. 3. Resident K's record was reviewed on 4/21/21 at 10:00 a.m. Diagnoses on Resident K's profile included, but were not limited to, cerebral infarction, hemiplegia and hemiparesis following			

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	cerebral infarction affecting left non-dominant side, difficulty walking, vascular dementia, impulse disorder, seizures, and repeated falls. Review of CNA- Bath/Shower Checklists and Shower/Bath documentation in the electronic record for Resident K, dated 12/1/20 - 4/19/21, indicated Resident M was documented as having received a shower on 1/12/21, 3/12/21, and 3/30/21. The records lacked documentation the resident had received showers in December, February, or April, or had refused a shower. The Admission MDS assessment, completed on 7/21/20, indicated it was very important to Resident K to choose between a tub bath, shower, bed bath, or sponge bath. A Care Plan for Resident K, included, but was not limited to, the resident required staff assistance with ADL's due to impaired balance, and poor activity endurance. The goal was for the resident to remain at the current level of self-care ability, extensive assistance, through the next review. Interventions included staff assistance with transfers, toileting, eating, bed mobility, and oral care as needed. Set up and assist with shower 2 times a week and as needed. 4. Resident V's record was reviewed on 4/21/21 at 2:19 p.m. Diagnoses on Resident V's profile included, but were not limited to, Alzheimer's dementia, syncope and collapse, and cognitive communication deficit. Review of CNA- Bath/Shower Checklists and Shower/Bath documentation in the electronic record for Resident V, dated 12/1/20 - 4/19/21, indicated Resident V was documented as having received a shower on 12/7/20, 12/21/20, and 1/4/21.			

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	The records lacked documentation the resident had received additional showers or had refused a shower. The Admission MDS assessment, completed on 7/24/20, indicated it was somewhat important to Resident V to choose between a tub bath, shower, bed bath, or sponge bath. The resident was frequently incontinent of bowel and bladder. A Quarterly MDS assessment, completed on 1/19/21, indicated Resident V had BIMS score of 3, indicated severe cognitive impairment. He was assessed as requiring extensive assistance of 1 for toileting and personal hygiene. Physical assistance in part of the bathing/showering process with 1 assist. Always incontinent of bladder and frequently incontinent of bowel. A Care Plan for Resident V, included, but was not limited to, the resident required staff assistance with ADL's due to debility. The goal was for the resident to remain at the current level of self-care ability, one-person assistance, through the next review. Interventions included staff assistance with transfers, toileting, eating, bed mobility, and oral care as needed. Set up and assist with shower 2 times a week and as needed. 5. Resident U's record was reviewed on 4/21/21 at 2:12 p.m. Diagnoses on Resident U's profile included, but were not limited to, hereditary and idiopathic neuropathy (weakness and wasting of muscles generally below the knees, and in the hands), history of transient ischemic attack, schizoaffective disorder (combination of symptoms of schizophrenia and mood disorder, such as depression and bipolar), and dementia. Review of CNA- Bath/Shower Checklists and			

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	Shower/Bath documentation in the electronic record for Resident U, dated 12/1/20 - 4/19/21, indicated Resident U was documented as having received a shower on 1/7/21. The records lacked documentation the resident had received additional showers or had refused a shower. The Admission MDS assessment, completed on 7/24/20, indicated Resident U was unable to participate in questions for preferences. A Quarterly MDS assessment, completed on 3/3/21, indicated Resident U's BIMS score of 3 indicated severe cognitive impairment. He was assessed as requiring extensive assistance of 1 for toileting. Indicated the resident was always incontinent of urine and frequently incontinent of bowel. Full dependence of 1 for showers and bathing. A Care Plan for Resident U, included, but was not limited to, the resident required staff assistance with ADL's due to impaired balance. The goal was for the resident to remain at the current level of self-care ability, extensive assistance, through the next review. Interventions included staff assistance with transfers, toileting, eating, bed mobility, and oral care as needed. Set up and assist with shower 2 times a week and as needed. On 4/21/21 at 11:50 a.m., the Director of Nursing (DON) indicated residents were to be showered twice weekly, unless their preference was for more or less. Resident preferences for showers should have been care planned. On 4/23/21 at 11:28 a.m., Licensed Practical Nurse (LPN) 19 indicated residents received showers twice weekly per the Shower Schedule hanging at the desk. Staff documented showers on a			

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	CNA-Bath/Shower Checklist. The checklist was turned in to the Director of Nursing (DON) or Assistant Director of Nursing (ADON). If the resident refused the nurse was notified, and the resident was reapproached later to see if they would agree to a shower. On 4/21/21 at 11:03 a.m., the Administrator provided a Skin Observation/Assessment (Shower/Baths) policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "It is the policy of the facility to ensure that each resident is provided with a shower and or bathes to maintain proper hygiene as well as comfort. During the shower/bath, the care giver will observe the resident's skin. Conditions that will be observed for include but are not limited to what appear to the caregiver to be bruises, red areas, open areas, scratches, abrasions ...Note: Only licensed nurses can assess the skin. If the caregiver is not a nurse and they observe a change in the resident's skin, the caregiver will notify the nurse immediately so that the nurse can perform a skin assessment and notify the physician/family as appropriate and also obtain any needed orders for treatment. Appropriate documentation and care planning will be completed as per policy...Showers/baths will be offered to residents at a minimum of 2 times weekly and as needed to promote good general hygiene unless the resident has another preference [Ex. A request of daily showers]. 2. Resident preference will be honored as much as possible to include the day and the time of day...3. Nurses will do skin assessments at least weekly [or as indicated] ...4. Other times that the resident will have a skin assessment will be upon admission, readmission, after a fall or an injury, upon discovery [by a caregiver] of a skin change, prior to discharge or as indicated with a condition			

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	change. 5. The caregiver completing the bath/shower will indicate on the [Shower Sheet] any observations that they have made...this will be given to the nurse in charge...." This Federal tag relates to Complaints IN00349638 and IN00350319. 3.1-38(a)(3)			
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 provide nursing services in accordance with professional standards of practice, and ensure a resident received medications and treatments per physician's orders, resulting in 3 hospital visits, for 1 of 1 resident reviewed for provision of care (Resident C). Findings include: A confidential interview conducted during the survey indicated, a resident and the resident representative had made multiple complaints to facility staff regarding not receiving medications as ordered resulting in missed medications, not receiving treatments as ordered resulting in trips to the hospital, not receiving showers as requested resulting in fungal infections, and poor	F 0684	Resident C is no longer a Resident of the facility. Residents who reside in the facility have the potential to be affected by this finding. A 30 day look back audit of the new admissions conducted to verify all medication were transcribed and available. Facility skin sweep completed, care plans reviewed an updated with skin alterations. Nursing Staff were in-serviced by the DON, May 5 & 20, 2021, including a review of Medication Administration and reordering procedures.	05/23/2021

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	housekeeping conditions. The complaints were not followed up or resolved. Upon admission to the facility, the resident had problems getting the correct medications. The resident had been on maintenance antipsychotic medications for a long period of time, and due to facility error, the resident had missed getting his medications. It took over a month and a trip to the hospital before the resident got his medications straightened out. The resident had complained he was not getting the correct medications after admission, and it took the guardian getting involved for the facility to complete an audit. According to the resident, he was missing at least 3 medications and getting 2 extras. The resident had incontinence of bladder and would get sore in the groin. Antifungal treatments were either not available or not applied to the skin as ordered and showers were not given resulting in the resident having skin breakdown that was not treated. There was an episode where the resident reported he had soiled himself and asked to be cleaned up, but 30 hours later had still had no bath or antifungal cream to relieve pain and itching to the groin. The resident had to call an ambulance and go to ER due to pain and open sores on his groin and back where he had scratched so they were bleeding, all due to no medication. The resident representative overheard staff "chiding" the resident for requesting a shower, and they put him off with statements of "we will see if we can get to it", but staff just did not give him a shower. Grievance Logs, dated December 2020 - March 2021 indicated there was no documentation of grievances or concerns from Resident C or a representative. Resident C's record was reviewed on 4/19/21 at 1:12 p.m. Diagnoses on Resident C's profile		The DON/Designee will conduct audits of 3 residents skin assessments and care plans and all new admissions, to ensure residents medications are transcribed, residents receiving meds and treatments as per physician order. These audits will be weekly x 4 weeks, then bi-weekly x 2 months, then monthly x 2 months. Afterwards, random monitoring will continue ongoing. Further, admission orders, re-admission orders and new orders, (or any orders received since the prior CQI meeting), will be reviewed daily at the morning CQI meetings, to ensure the orders have been carried forward to the MARS/TARS per policy. This will continue to be an ongoing part of the daily CQI meeting agenda. Any concerns will be addressed if found. The results of the audits of the MARS/TARS as well as the orders reviews at the CQI meetings will be presented to the QAPI committee at the monthly QAPI meetings. Any concerns will have been addressed. Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the administrator until resolved.	

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	included, but were not limited to, schizophrenia, dementia, chronic obstructive pulmonary disease, abdominal aortic aneurysm, mild protein-calorie malnutrition, cognitive communication deficit, hypertension, repeated falls, gastro-esophageal reflux disorder, and benign prostatic hyperplasia. The Admission MDS (Minimum Data Set) assessment, completed on 12/29/20, assessed Resident C as having a BIMS (Brief Interview for Mental Status) score of 14 indicated cognitively intact. Indicated the resident preferences for routine and activities, it was very important for the resident to choose between a tub bath, shower, bed bath, or sponge bath. Assessed the resident as requiring extensive assistance with one-person physical assist for walking in room, dressing, toilet use, and personal hygiene. Occasionally incontinent of bladder, frequently incontinent of bowel. No pressure ulcers, wounds or skin problems, and no skin treatments. A Discharge Summary for Resident C from a local hospital, dated 12/22/20, indicated orders on the discharge summary not found in the resident's admission orders to the nursing facility or being documented as administered on the Medication Administration Record (MAR) included, a. Haldol (antipsychotic) 50 mg (milligrams) IM (intramuscular), last dose 11/30/20, next dose due on 12/28/20. b. Nystatin ointment (antifungal used to treat or prevent infections caused by fungus or yeast), apply to affected area twice a day. c. Gluco-msm-collagen-C-Mn-hrb21-500-333-5mg (collagen + vitamin c dietary supplement) capsule, take by mouth. A Physician's order for Resident C, dated 12/22/20, indicated Vitamin A&D Ointment (used			

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	to treat minor skin irritations and decreased itching) apply to dry skin topically every 8 hours as needed for dry skin. Treatment Administration Records (TAR's) for Resident C, dated 12/22/20 - 3/31/21, indicated the records lacked documentation A&D Ointment was every administered. A Drug Regimen Review for Resident C, dated 12/23/20, the Assistant Director of Nursing (ADON) indicated no medication issues found upon admission. A Care Plan for Resident C, dated 12/23/20, indicated the resident required staff assistance with ADL's (activities of daily living) due to poor activity endurance. The goal was for the resident to perform ADLs with one assist by discharge to home. Interventions included staff assistance with transfers, toileting, eating, bed mobility, and oral care as needed. Set up and assist with shower 2 times a week and as needed. A late entry Drug Regimen Review for Resident C created by Licensed Practical Nurse (LPN) 20 on 12/27/20 at 11:50 a.m., indicated on 12/26/20 no drug issues noted at this time. A Telehealth visit report for Resident C, dated 1/13/21, indicated multiple medication orders were potentially duplicated by other orders on the chart. A Care Plan for Resident C, dated 1/15/21, indicated the resident was at risk for skin breakdown related to impaired mobility and incontinence. The goal was for the resident to have no skin breakdown. Interventions included notifying the physician and family of change in			

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	condition, observe for signs or symptoms of skin breakdown, observe vital signs as indicated, and skin assessment per facility protocol and as needed. A Care Plan for Resident C, dated 1/15/21, indicated the resident had a diagnosis of Schizophrenia. The goal was for the resident to be monitored for signs or symptoms of schizophrenia. Interventions included an AIMS upon admission and quarterly thereafter, physician notified of any delusions, hallucinations, increased paranoia, and changes in behavior, and psych evals as needed. The Care Plan lacked documentation of Haldol use, or monitoring of side effects for antipsychotic drug use. A Psychiatry Initial Consult for Resident C, dated 1/21/21, indicated resident with diagnosis of schizophrenia, on no medications at this time. A Progress Note for Resident C, dated 1/29/21, indicated the nurse spoke with the resident's psychiatrist at a local practice. The physician indicated she had been following the resident for 15 years for schizophrenia. He has been on Haldol injections every 4 weeks for several years. This was not communicated to our facility upon discharge from the hospital. Since he did not receive his injection that was due 3 weeks ago, she didn't feel it was necessary to start the injections back. She would be requesting a new order for Haldol 2 mg by mouth every bedtime. A Psychology Progress report for Resident C, dated 2/16/21, indicated staff report the resident was discontinued from prior antipsychotic Haldol due to it not having been administered post			

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	hospitalization. The resident reported some pain issues related to back as well as groin discomfort due to itching. He cited a desire for more frequent showers to alleviate the itching. He was very talkative, but per discussion with facility staff, may have some confabulations or delusional thought content. Patient was not currently prescribed antipsychotic medication but has a history of taking Haldol and a prior Schizophrenia diagnosis. A Progress Note for Resident C, dated 2/19/21 at 2:12 a.m., indicated the resident called 911 for emergency transport, patient with complaints of shortness of breath. The EMT (emergency medical technician) and nurse instructed patient to wear oxygen to facility breathing. Patient insistent on going to ED (emergency department) and was transported to a local hospital. A hospital Facility Report for Resident C, dated 2/22/21, indicated inguinal (groin) rash, and back pruritis (an uncomfortable, irritating sensation that causes an urge to scratch). Patient with an inguinal rash that had reportedly not been treated at this facility. Likely representative of a fungal infection around his groin. Also reporting back pruritis. Treated with clotrimazole and hydroxyzine (an antihistamine used to treat anxiety, skin rashes, and itching) as needed. Continue clotrimazole twice daily for 14 days, last day of therapy 3/9/21. Patient has a history of schizophrenia and was using Haldol decanoate injections, however he was switched to oral Haldol 2 mg by mouth every bedtime since he was in the skilled nursing facility. A Physician's order for Resident C, dated 2/22/21, indicated Clotrimazole Cream 1 % (Lotrimin antifungal cream) apply to groin topically two			

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	times a day for 14 days for rash to groin. A Physician's order for Resident C, dated 2/22/21, indicated Haloperidol Tablet 2 MG give 1 tablet by mouth at bedtime related to schizophrenia. A Progress Note for Resident C, dated 2/22/21 at 4:17 p.m., indicated resident returned from hospital with diagnosis of exacerbation COPD. A Progress Note for Resident C, dated 2/23/1 at 10:37 a.m., indicated the resident requested his inhaler be left at bedside so he could self-administer, the nurse would call the physician later for an order. A Progress Note for Resident C, dated 2/26/21 at 4:17 a.m., indicated the patient called 911 for emergency transport to the hospital due to an itchy back. The patient stated that he was in pain and had and itchy back, when offered patient refused as needed medication and insisted on going to the ER. A Psychiatry Progress note for Resident C, dated 3/12/21, indicated medication list reflected order for Haldol 2 mg oral tablet 1 by mouth every bedtime, start date 2/22/21. A Psychology Progress note for Resident C, dated 3/16/21, indicated no documentation of new recommendations, and medication list did not reflect resident having an order for Haldol 2 mg by mouth daily. He was complaining of pain in groin area. He denied an increase in symptoms of depression or anxiety, though he was quite anxious about the issue with groin area and talking about going to the hospital. A Virtual Physician's Visit note for Resident C,			

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	dated 3/5/21 at 3:07 p.m., indicated re-admit from hospital for back itching? No new hospital notes seen. Was previously in the hospital for, no current skin breakdown or rashes. A Progress Note for Resident C, dated 3/16/21 at 7:16 p.m., the resident called 911, resident stated he wanted to go out to hospital because of a cream that was not available at this time, resident taken to local hospital. A Physician's order for Resident C, dated 3/23/21, indicated Clotrimazole Cream 1% apply to groin topically two times a day for rash to groin. A Progress Note for Resident C, dated 3/28/21 at 2:04 p.m., indicated the writer was informed the resident had called 911 related to his back and groin itching and dry mouth. Resident was not redirectable. Writer had already applied treatment per MD ordered. A Progress Note for Resident C, dated 3/28/21 at 8:53 p.m., indicated the resident returned from the hospital with new orders for Chlorhexidine 0.12% Solution (a germicidal mouthwash that reduces bacterial in the mouth) x 14 days for dry mouth. Admission/Readmission Skin Assessments and Weekly Skin Checks for Resident C, dated 12/22/20, 1/4/21, 1/13/21, 1/20/21, 1/28/21, 2/5/21, 2/12/21, 2/22/21, 3/21/21, and 3/27/21, indicated the resident had no loss of skin integrity, and no new loss of skin integrity. The resident's record lacked documentation Weekly Skin Checks had been completed 2/23/21 - 3/20/21. Shower documentation for Resident C, dated 12/22/20 - 3/31/21, indicated the resident received 17 showers to include 12/23/20, 12/29/20, 1/1/21,			

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	1/7/21, 1/12/21, 1/15/21, 1/20/21, 1/27/21, 2/2/21, 2/7/21, 2/8/21, 2/11/21, 2/15/21, 3/9/21, 3/10/21, 3/15/21, and 3/26/21. The resident had refused a bath on 2/23/21 and 2/25/21. The resident record lacked documentation to indicate he had received 2 or more showers weekly per his preference or as needed for incontinence. A Care Plan for Resident C, dated 3/3/21, indicated the resident was at risk for skin breakdown due to impaired mobility. The goal was for the resident to be free of skin breakdown. Interventions included Braden scale (measured the risk for skin breakdown) quarterly and as needed, keep clean and dry, pressure relieving mattress per facility policy, and skin assessment per facility policy. The Care Plan lacked documentation of being updated, or regarding a reoccurring fungal infection of the groin or itching of back skin with treatment orders. On 4/21/21 at 11:52 a.m., the DON indicated, new admission orders usually came from the hospital. Hospital discharge medication orders should have been the physician orders written as orders to be followed in the nursing facility. Resident C's records indicated he went from an acute care hospital to a psych hospital and then was admitted to this facility. The psych hospital orders for Haldol to be given monthly were viewed in his records. This Federal tag relates to Complaint IN00349638. 3.1-37(a) 3.1-37(b)			
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

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	§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 follow up was completed to include neurological (neuro) checks, 72 hour follow up documentation, interventions were initiated, and care plans were updated for 5 of 6 residents reviewed for falls (Residents C, N, P, R, and K). Findings include: 1. Resident C's record was reviewed on 4/19/21 at 1:12 p.m. Diagnoses on Resident C's profile included, but were not limited to, schizophrenia, dementia, cognitive communication deficit, and repeated falls. A Progress Note for Resident C, dated 12/22/2020 at 4:33 p.m., indicated the resident arrived at the facility from a local hospital. The resident was alert to self and appeared slightly anxious and confused. A late entry SBAR (Situation, Background, Assessment, Recommendation) Summary for Providers note for Resident C, created by the ADON (Assistant Director of Nursing) on 1/13/21 at 3:09 p.m., indicated, on 12/27/20 at 12:03 a.m., the resident fell. A Progress Note for Resident C, dated 12/27/20 at 1:49 a.m., indicated the resident was found in his	F 0689	Residents C, N, P, R and K had no negative outcomes related to neuro checks not having been done per policy. Residents who reside in the facility have the potential to be affected by this finding. A 30 day look back on falls was conducted to insure Fall Assessments were current, care plans were current and accurate. Any concerns would have been addressed. Nursing staff was in-serviced by the DON, May 5 & 20, 2021, including a review of Fall Follow-Up Policy and post fall protocol. Falls are reviewed at the daily CQI meeting as part of the agenda, and this practice will continue for all falls. The DON and /or designee will conduct fall audits weekly for 4 weeks, then bi-weekly for 2 months, then monthly for 2 months. Afterwards, random audits will continue ongoing. Any concerns will be addressed if found.	05/23/2021

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	bathroom sitting on the floor near the toilet bowl. The resident indicated he was trying to get back to his chair when it moved back, and he slipped to the floor. An assessment was done with no visible injuries noted, vital signs within normal limits, no pain, and neuro checks started. A Progress Note for Resident C, dated 12/27/20 at 11:07 p.m., indicated fall follow up with neuro checks continues as ordered. A late entry Interdisciplinary Team Progress Note for Resident C, created by the ADON on 3/12/21, indicated on 12/28/20 at 10:46 a.m., the resident had an unwitnessed fall on 12/27/20. The resident was found on the floor in his bathroom. The resident stated after urinating, he attempted to transfer back to his wheelchair and his wheelchair rolled backwards and he fell landed on his bottom. Immediate intervention added was to remind the resident to lock his wheelchair prior to transfers. A late entry Progress Note for Resident C created by the DON (Director of Nursing), on 3/29/21, indicated on 12/28/20 at 12:14 p.m., fall follow up with neuros continues as ordered. No adverse reaction noted. Vital signs within normal limits and recorded in PCC (Point Click Care electronic medical record system). No complaints of pain, physician and responsible party made aware. A late entry Progress Note for Resident C created by the DON on 3/29/21 at 10:40 a.m., indicated on 12/29/20 at 12:23 p.m., fall follow up with neuros continues as ordered. No adverse reaction noted. Vital signs within normal limits and recorded in PCC. No complaints of pain. Physician and responsible party made aware. Resident C's record lacked documentation of the		The results of the falls audits will be presented to the QAPI committee at the monthly QAPI meetings. Any concerns will have been addressed. Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the administrator until resolution.	

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	physician being notified of the fall on 12/27/20 in a timely manner, lacked documentation all follow up assessments and neuro checks being completed for 72 hours post fall. 2. Resident N's record was reviewed on 4/19/21 at 2:57 p.m. Diagnoses on Resident N's profile included, but were not limited to, schizoaffective disorder, bipolar type, contracture of ankle and foot, dependence on wheelchair, Alzheimer's disease with late onset, and lack of coordination. A SBAR Summary for Providers note for Resident N, dated 3/2/21 at 2:54 a.m., indicated the resident fell. A Progress Note for Resident N, dated 3/2/21 at 3:01 a.m., indicated the patient was found on floor at bedside during rounds. The patient denied pain, was free from visible injuries, and 72 hour fall follow up was initiated. All responsible patients notified. A Progress Note for Resident N, dated 3/2/21 at 12:12 p.m., indicated resident was found on the floor beside her bed early this morning by staff during rounds. Vital signs stable and neuro checks initiated. The resident was asking for her bracelets and headband when staff approached her and as staff was placing her back in bed. Resident usually wears her bracelets and headband while in bed. Immediate intervention was to ensure resident had bracelets and headband on while in bed and if not, keep those items within reach while in bed. Resident N's record lacked documentation of follow up assessments and neuro checks being completed for 72 hours post fall.			

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	A Fall Assessment for Resident N, dated 3/2/21, indicated no history of falls in the past 3 months. Score of 12 indicated high risk for falls. On 4/22/21 at 11:12 a.m., the MDS (Minimum Data Set) Coordinator indicated, Resident N's medical record lacked documentation to reflect fall follow up had been completed, or neuro checks had been completed per the policy. 3. Resident P's record was reviewed on 4/22/21 at 10:07 a.m. Diagnoses on Resident P's profile included but were not limited to schizophrenia. A Progress Note for Resident P, dated 12/1/20 at 5:59 p.m., indicated the resident arrived at the facility from a local hospital. The resident seemed confused made attempts to get out of bed and had to be redirected. A Progress Note for Resident P, dated 12/2/20 at 10:09 a.m., indicated the resident fell from the bed this shift, no injuries noted. A SBAR Summary for Providers note for Resident P, dated 12/2/20 at 12:00 p.m., indicated the resident fell. Vital signs stable, neuro checks started and within normal limits. Will continue neuro and vital sign checks. A Progress Note for Resident P, dated 12/2/20 at 1:27 p.m., indicated the resident was alert, he was found on the floor beside the bed, and stated he fell out of the bed. Resident denied hitting his head. A Progress Note for Resident P, dated 12/2/20 at 11:22 p.m., indicated resident remained on fall follow up with neuro checks. No adverse reaction noted at this time.			

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	A late entry Interdisciplinary Team Progress Note for Resident P created by the DON on 12/4/20 at 1:41 p.m., indicated on 12/3/20 at 9:34 a.m., fall follow up. Resident had a fall on 12/2, discovered lying on the side of his bed on his left side, no visible injury upon assessment, vitals within normal limits, denies pain or discomfort, writer, responsible party, and MD made aware, no new orders received. Bed in lowest position and floor mat placed beside bed as immediate intervention A Progress Note for Resident P, dated 12/3/20 at 9:03 p.m., indicated family/responsible party were notified of present condition. A Progress Note for Resident P, dated 12/14/20 at 6:47 a.m., indicated, Resident was found sitting on the floor with his buttocks against the floor. Assessment done, resident said he did not hit his head. A Progress Note for Resident P, dated 12/14/20 at 10:03 a.m., indicated the resident was found on floor next to his bathroom door. When interviewing resident, he stated he was trying to get to the bathroom by himself. Immediate intervention would be to toilet resident before and after meals to prevent resident from attempting to toilet himself A late entry SBAR Summary for Providers note for Resident P, created by the ADON on 12/18/20 at 3:58 p.m., indicated on 12/14/21 at 3:58 p.m. the resident fell. A SBAR Summary for Providers note for Resident P, dated 12/22/20 at 3:44 a.m., indicated the resident had elevated blood pressure, and large raised area to middle of head following an			

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	unwitnessed fall. Recommendation to send to ER for evaluation. A Progress Note for Resident P, dated 12/22/20 at 3:57 a.m., indicated during rounds patient found on floor at bedside with large knot on forehead. Patient stated he fell while trying to urinate in urinal. EMS (Emergency Medical Services) called to transport to a local hospital for evaluation and treatment. A Progress Note for Resident P, dated 12/22/20 at 6:50 a.m., indicated the resident returned from the hospital with a diagnosis of subdural hematoma. The patient refused all treatment while in ED. The ER physician recommended the patient being placed on hospice care. A late entry Interdisciplinary Team Progress Note for Resident P created by the DON on 3/15/21 at 9:50 a.m., indicated on 12/23/20 at 9:45 a.m., the resident had a fall, he was discovered lying on the floor next to his bed, stated he fell while attempting to use his urinal. No visible injury discovered during assessment, vitals within normal limits. Staff would be to encourage resident to use urinal in a sitting position as immediate intervention. A Progress Note for Resident P, dated 12/29/20 at 6:30 a.m., indicated resident noted to be sitting on his buttocks on the floor with his back against the bed legs stretched out. A late entry Interdisciplinary Team Progress Note for Resident P created by the ADON on 3/12/21 at 9:57 a.m., indicated on 12/29/20 at 9:54 a.m., the resident had an unwitnessed fall. He was found on the floor next to his bed. When asked, resident stated he was reaching for his urinal and slipped out of bed. Immediate intervention would be to			

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	keep urinal within reach while in bed. A Progress Note for Resident P, dated 12/31/20 at 2:40 p.m., indicated resident observed in a sitting position leaning against dresser at foot of bed, wheelchair also at bottom of bed. A late entry Interdisciplinary Team Progress Note for Resident P created by the ADON on 3/12/21 at 10:01 a.m., indicated on 1/1/21 at 9:59 a.m., resident had an unwitnessed fall 12/31/20. He was found on the floor by his bed. Immediate intervention was for a fall mat to be placed beside bed when resident was in bed. A Progress Note for Resident P, dated 1/11/21 at 10:04 a.m., indicated the resident was removing his tray from room with no wheelchair or rollator and his legs buckled and the fell to the floor landing on his left side. The fall was witnessed by staff member, resident did not hit head. An Interdisciplinary Team Progress Note for Resident P, dated 1/19/21 at 9:25 a.m., indicated the resident had a fall, discovered sitting on the floor with his back against his bed, resident noted to have no socks on, resident stated he thinks he "slid", no visible injury upon assessment, vitals within normal limits. Staff will encourage resident to wear non-skid socks while in bed to prevent sliding as an immediate intervention. Resident P's record lacked documentation of the physician being notified of the multiple falls in a timely manner, lacked documentation all follow up assessments and neuro checks being completed for 72 hours post fall, and care plans being updated post fall versus after the resident died on 1/27/21.			

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	Initial and Post Fall Risk Assessments were completed on 12/1/20, 12/2/20, 12/14/20, 12/22/20, 12/29/20, and 1/17/21, all indicated the resident scored as a high risk for falls. A Care Plan for Resident P, dated 12/28/20, indicated the resident was at risk for falls due to history of recent falls. The goal was for the resident to have no injuries due to falls. The goal dated 12/28/20 was for the resident to have no injury due to falls. Fall care interventions were added and documented as follows: 12/28/20 attempt to keep areas free of clutter, 12/28/20 bed in low position, 1/7/21 encourage patient to sit in wheelchair and not ambulate behind wheelchair and push it, 3/15/21 encourage resident to sit while using urinal, 1/19/21 encourage resident to wear non- skid socks while in bed, 3/15/21 fall mat bedside bed, 12/28/20 fall mat beside bed, bed against the wall on one side, 12/28/20 keep call light in reach, 12/29/20 keep items of daily use within his reach, 3/15/21 keep urinal within reach of resident, 12/28/20 notify and update MD as needed, and 3/15/21 toilet resident before and after meals. On 4/22/21 at 11:00 a.m., the Administrator (ADM) indicated, as she was new to the facility, she could not answer as to why the previous DON and ADON had charted fall follow up assessments, SBAR assessments to the physician in resident charts 3-4 months after the incidents or added care plans after residents had discharged or died. 4. Resident R's record was reviewed on 4/22/21 at 11:50 a.m. Diagnoses on Resident R's profile included, but were not limited to, dementia, unsteadiness on feet, and traumatic stress disorder.			

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	A Progress Note for Resident R, dated 4/1/21 at 9:42 a.m., indicated resident was found on the floor after an unwitnessed fall. Vital signs, neuro and skin assessments completed and within normal limits. Staff stated resident had gotten out of bed and did not have shoes or antiskid socks on. Immediate intervention will be for staff to ensure resident has shoes or non-skid socks on when out of bed. A SBAR Summary for Providers note for Resident R, dated 4/1/21 at 2:30 a.m., indicated resident fell. Recommendation order for back x-ray to rule out injury. Resident R's record lacked documentation of follow up assessments and neuro checks being completed for 72 hours post fall. 5. Resident K's record was reviewed on 4/21/21 at 10:00 a.m. Diagnoses on Resident K's profile included, but were not limited to, cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, difficulty walking, vascular dementia, and repeated falls. A Progress Note for Resident K, dated 3/2/21 at 12:21 p.m., indicated the resident was found on the floor in front of his Broda (a tilt-in-space chair for positioning) chair. Resident K's record lacked documentation of follow up assessments and neuro checks being completed for 72 hours post fall. On 4/21/21 at 12:00 p.m., the DON indicated, fall follow up included completion of an incident report, assessment of the resident to include vital			

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	signs, skin assessment as needed, and neuro checks if the resident hit their head or if the fall was unwitnessed. Follow up documentation was to be completed in the progress notes for at least 72 hours unless there was an injury to be monitored longer. Care Plans post fall were to be updated by the MDS nurse. On 4/20/21 at 1:10 p.m., the Administrator provided an Incident/Accidents/Falls policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, "It is the policy of the facility to ensure that any incident/accident to include falls is reported immediately to the nurse or appropriate person designated to be in charge ...1. If a resident is involved in an incident/accident an immediate assessment of the resident will be completed by the nurse ...2. In case of a fall, the resident will have a head-to-toe assessment to include a pain assessment and assessment as to any change in their ROM ability/function ...3. The nurse responsible for the oversight and care of the resident will complete an incident/accident report ...4. The nurse will notify the resident's attending physician/Nurse Practitioner, DON, Administrator, and the resident's responsible party. The physician will be notified of any changes in condition related to the fall that have been identified ...The resident's responsible party will be kept informed of any orders received or interventions put into place ...6. The incident/accident report will be completed as soon as information is obtained. The report should be finished as much as possible before the nurse ends the shift ...7. The occurrence will be documented [usually in the Risk Management section of PCC]. The progress note within the resident's medical record is to be included. Documentation in the Medical Record should			

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	include the following: Description of the occurrence to include time and place, physical and mental status of the resident, time of physician notification and physician response/orders, time of notification to resident's family/representative ..." This Federal tag relates to Complaint IN00349638. 3.1-45(a)(1)			
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 interview, and record review, the facility failed to provide tracheostomy care as ordered by the physician for 1 of 1 residents reviewed for tracheostomy care (Resident D). Findings include: A confidential interview conducted during the survey indicated, the resident's tracheostomy (trach) had not been taken care of frequently enough to meet Resident D's needs. The resident had not been checked at least every 20 minutes as needed, and tracheostomy care had not been provided by staff following the physician's orders. Resident D's record was reviewed on 4/20/21 at	F 0695	Resident D is no longer a resident of the facility. Residents who reside in the facility who have a trach could have the potential to be affected by this finding. There are no residents who currently have a tracheostomy in place. Nursing staff were in-serviced by the DON, May 5 & 20, 2021, including a review of Trach Care Policy and documentation. Should the facility admit a resident	05/23/2021

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	11:21 a.m. Diagnoses on Resident D's profile included, but were not limited to, acute respiratory failure with hypoxia (condition in which the body or a region of the body is deprived of adequate oxygen supply), and tracheostomy status. A Physician's orders for Resident D, dated 3/30/21, indicated 5 L (liters) of oxygen per trach every shift. A Physician's order for Resident D, dated 3/29/21, indicated suction resident via trach every 2 hours as needed for excess secretions. A Physician's order for Resident D, dated 3/29/21, indicated, suction resident via trach every 2 hours as needed for excess secretions using Yankauer (oral suctioning tube) tubing. A Physician's order for Resident D, dated 3/29/21, indicated change trach collar every morning after completing trach care. A Physician's order for Resident D, dated 3/29/21, indicated provide trach care twice daily using a trach cleaning kit. Clean around trach opening and behind flange, and replace gauze with clean, sterile t-split gauze. A Progress Note for Resident D, dated 3/29/2021 at 4:30 p.m., indicated the resident arrived at the facility via stretcher and three-person transferred to bed. The resident needed total care with all ADL's (activities of daily living), she was unable to make her needs known, and she had a cuffed trach size 8.0 with 5 L of oxygen per trach with 28% humidity and had copious amounts of thin white sputum from the site. Treatment Administration Records (TAR's) for		with a tracheostomy, the following monitoring will be rolled out: DON/Designee will monitor trach care daily x 4 weeks, then bi-weekly x 2 months, then monthly x 2 months. Afterwards, random monitoring will continue ongoing. Any concerns will be addressed if found. The results of the monitoring will be presented to the QAPI committee at the monthly QAPI meeting. Any concerns will have been addressed. Any patterns will be identified.. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the administrator weekly until resolution.	

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	Resident D, dated 3/31/21 - 4/6/31, indicated the records lacked documentation the trach collar had been changed daily as ordered on 3/31/21, 4/3/21, 4/4/21, and 4/5/21. TARs for Resident D, dated 3/30/31 - 4/6/21, indicated the records lacked documentation trach care had been provided at 6:00 a.m. as ordered on 3/31/21, 4/3/21, 4/4/21, and 4/5/21. TARs for Resident D, dated 3/30/21 - 4/6/21, indicated the records lacked documentation suctioning had been performed. A late entry Progress Note for Resident D created by the Activity Director on 4/5/2021 at 8:35 a.m., and later struck out of the resident record indicated, on 4/4/21 at 12:23 p.m., a Certified Nursing Assistant (CNA) was performing care on Resident D (turning her on her side to clean her) when the resident began to make moaning sounds that quickly turned into shallow screams. Resident had a diagnosis of acute respiratory failure with hypoxia. As the CNA continued to provide care, the resident became unresponsive. Resident was a full code, the nurse was notified, and 911 was called. An ambulance came and paramedics resuscitated Resident D and she became responsive. The resident was taken to the hospital in stable condition per nurse on shift. A Progress Note for Resident D, dated 4/4/21 at 8:26 p.m., LPN 20 indicated resident was found unresponsive and sent to a local hospital via 911. The physician, Director of Nursing, and Power of Attorney were notified. No adverse reaction noted. A late entry Progress Note for Resident D created by the Assistant Director of Nursing (ADON) on			

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	4/6/21 at 1:10 p.m., indicated, on 4/4/21 at 8:51 p.m. an SBAR (Situation, Background, Assessment, Recommendation communication tool) Summary for Providers, was sent to the physician reporting the resident had experienced unresponsiveness. The communication included vital signs, oxygen level, blood sugar reading, and primary diagnoses. Indicated, resident found unresponsive by CNA during rounds. 911 called and resident transported to a local hospital. Primary Care Provider responded with feedback to send resident to the ER. A Baseline Care Plan for Resident D, dated 3/30/21, indicated, special treatment included oxygen therapy, suctioning, trach care, and monitoring. A Care Plan for Resident D, dated 4/8/21 (created 4 days after the resident's death), indicated the resident was at risk for respiratory distress due to tracheostomy and history of pneumonia. The goal was for the resident to be free of respiratory distress. Interventions included, but were not limited to, encourage head of bed up, encourage to keep airway clear, observe for signs of infection and notify the physician, suction as needed/per physician's order, and trach care per order. On 4/23/21 at 11:28 a.m., LPN 19 indicated there were no current residents with a tracheostomy. If a resident was admitted with a tracheostomy, nurses were to follow hospital orders for trach care, put the orders on the MAR (Medication Administration Record), and then sign off when care was completed daily. On 4/22/21 at 11:00 a.m., the Administrator provided a Tracheostomy Care Guidelines, undated, and indicated the guideline was the one			

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	currently being used by the facility. The guideline indicated the nurse was responsible for evaluating for proper artificial airway care. Evaluation of the artificial airway care included, but was not limited to, validating when tracheostomy care was last performed. Planning included verifying there was a physician's order to provide tracheostomy care. Recording and reporting included, "...record respiratory evaluations before and after care; type and size of tracheostomy tube; frequency and extent of care; type, amount, color, and odor of drainage; resident tolerance and understanding of procedure as applicable...." This Federal tag relates to Complaint IN00351165. 3.1-47(a)(5)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure effective pain management for a resident with severe acute and chronic pain conditions, admitted for rehabilitation, wound care and pain management, resulting in the resident calling 911 twice and leaving against medical advice for 1 of 3 residents reviewed for pain management (Resident B). Findings include: On 4/20/21 at 1:00 p.m., the closed medical record for Resident B was reviewed. The diagnoses	F 0697	Resident B is no longer a Resident of the facility. All Residents who reside in the facility have the potential to be affected by this finding. An audit was conducted to ensure Pain Assessments were current, within the last 30 days. Care plans were reviewed for accuracy as related to pain. Any concerns would have been addressed.	05/23/2021

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	included but were not limited to chronic ulcer of the skin of other sites with necrosis (death of cells in organ or tissues) of bone, and Raynaud's Syndrome (a condition where some areas of the body feel numb and cool). An admission pain assessment, dated 12/8/20, indicated Resident B should be assessed for pain. He had experienced pain almost constantly in the past 5 days. It made it hard for him to sleep at night and limited his day to activities. He rated his pain at 10/10. No non-medication interventions for pain control were identified. A history and physical assessment, dated 12/16/20, indicated Resident B had been admitted to the facility for rehab and wound management on 12/8/20, after a hospital stay for non-pressure ulcer of skin with necrosis of bone. Resident had a past medical history of Raynaud's Syndrome. The resident had a history of homelessness and had recently been hospitalized for frost bite to his hands. No additional pain assessments were found in the record. Resident B's pain score was assessed with vital signs each shift, and when pain medications were administered. A review of the physician's orders indicated Resident B was prescribed oxycodone-acetaminophen 10-325 mg., 2 tablets every 4 hours (scheduled) from 12/8/20 to 12/16/20 for pain. On 12/9/20 at 2:00 p.m., a progress note indicated " ...resident is in a lot of pain with Raynaud's disease some relief once pain medication given q [every] 4 hrs. for pain if not given timely resident begins tearing rocking and doubles over treatment		Nursing Staff were in-serviced by the DON, May 5 & 20, 2021, including a review of facility Pain Management. The DON and /or designee will conduct interviews of 3 residents on pain medication to ensure medication is managing their pain weekly for 4 weeks, then bi-weekly for 2 months, then monthly for 2 months. After that random monitoring will continue ongoing. Any concerns will be addressed if found . Results of the monitoring for pain will be presented to the QAPI committee at the monthly QAPI meetings. Any concerns will have been addressed. Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored weekly by the administrator until resolved.	

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	done to fingers as ordered today fingers are very sensitive take 1 hr. to do treatments pain pills rx [prescription] has run out after 12 p.m. dosage [name of physician] provider notified per phone and faxed spoke with [name] customer service adon [assistant director of nursing] was notified of the above [sic]." On 12/9/20 at 5:42 p.m., a Physician Note indicated "Patient in severe pain due to Raynaud's phenomenon. Underlying etiology unknown to me as of yet. Patient is appropriately on a calcium channel blocker [heart/blood pressure medication]. His blood pressure is elevated so I will increase the Niphedipine [blood pressure medication] to BID [2 x day]. I called in Percocet 10- 2 tabs q 4 PRN [2 tablets every 4 hours as needed] to the dispensing pharmacy. If patient truly requires pain medication Q4 [every 4 hours], suggest starting Oxycontin [stronger narcotic] scheduled ...." Resident B's medical record included a care plan for wounds, dated 12/10/20 with a target date of 1/19/20. This care plan indicated: Wounds are present on bilateral hands r/t (related to) Raynaud's Disease: Right thumb, middle finger, ring finger, left thumb, index finger, and middle finger. The goal was for the wound to be decreased in size. The interventions included: diet as ordered, pressure reducing mattress/cushion in chair, skin checks weekly and prn (as needed), and treatment as ordered. On 12/10/20 at 10:00 a.m., a progress note indicated " ...requested more pain med [medication] Norco rx [hydrocodone-acetaminophen, narcotic pain medication] only 36 sent pharmacy has no other refills resident is on 2 tabs q 4 hrs [tablets every 4			

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	hours] around the clock routinely." On 12/11/20 at 12:45 p.m., a progress note indicated, "Resident has been pacing and crying sporadically x3 days concerning his 'uncontrollable pain' ...Resident states he is going to call 911 himself and go to ER [emergency room]...." On 12/14/20 at 6:23 p.m., a progress note indicated Resident B "...called 911 this morning stating he was in pain, ambulance came and resident was taken to the hospital. Once assessed, hospital sent resident back without administering pain medication to him. While back in the facility, [name] expressed his need for pain management but staff was under the impression [Name] had received meds [medication] earlier for his malady while at the hospital. Writer and Administrator met with [Name] in his room and discovered additional hospital paperwork that detailed resident had not been treated at all citing he was under the care of another physician...." On 12/16/20 the pain medication, oxycodone-acetaminophen 10-325 mg., 2 tablets were changed to PRN (as needed) every 4 hours. Resident B did not have a care plan for pain management. On 1/5/21 at 10:32 a.m., a progress note indicated "...resident is alert left for dr appoint returned in time for lunch resident is very upset due to dr stating he would need to remove a couple of fingers resident c/o [complaints of] of severe pain and medicated on a prn basis q [every] 4 hrs no s/s [signs or symptoms] of covid-19 no papers were given to this nurse escort mention she gave them to DON [Director of Nursing]."			

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	A review of Resident B's MAR (Medication Administration Record), dated 1/1/21 to 1/8/21 indicated: On 1/1/21 Resident B received 3 doses of oxycodone-acetaminophen 10-325, 12:56 a.m., 4:46 a.m., and 9:25 p.m. The pain scores were 8/10, 7/10, and 8/10. On 1/2/21 Resident B received 1 dose of oxycodone-acetaminophen 10-325 at 9:00 p.m. The pain score was 6/10. On 1/3/21 Resident B received 1 dose of oxycodone-acetaminophen 10-325 at 9:00 p.m. The pain score was 9/10. On 1/4/21 Resident B had no documentation of having received oxycodone-acetaminophen, PRN. On 1/5/21 Resident B received 2 doses of oxycodone-acetaminophen 10-325 at 3:26 p.m., and 7:40 p.m. The pain scores were 5/10 and 3/10. On 1/6/21 Resident B received 1 dose of oxycodone-acetaminophen 10-325 at 12:05 a.m. The pain score was 4/10. On 1/7/21 Resident B received 1 dose of oxycodone-acetaminophen 10-325 at 7:58 p.m. The pain score was 4/10. On 1/8/21 Resident B had no documentation of having received oxycodone-acetaminophen, PRN. On 1/8/21 at 4:06 p.m., a progress note indicated, "Spoke with [Name] NP [Nurse Practitioner] concerning resident possibly cheeking [holding in mouth] his medications. Requesting an order to crush medications. [Name] reviewed resident's orders and progress notes and concluded that he is on an abnormally high dose of narcotic pain medications for an extended period of time. Wounds to fingers improving, left hand is healed and right hand is improving significantly. [Name] gave new orders to D/C [discontinue] narcotic pain meds and start Tylenol 650 mg scheduled			

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	and Ibuprofen 800mg PRN. Resident informed of changes. He became very upset, stating it "isn't fair" and his wounds are "to the bone." Explained his wound assessment was completed yesterday and he also had an appointment with Dr. [Name] on the 5th. There are no bones or tendons exposed. He is healing well and has minimal tissue loss at this time. He then stated he is getting "out of this place" and "nobody is going to tell me I can't have my pain medications." Attempted to explain to resident we will continue to monitor his pain and asses as needed. Resident began to curse at staff, then went back to his room. On 1/8/2021 at 3:09 p.m., a progress note indicated, "Resident received new order today to d/c pain meds new order received for Tylenol or ibuprophen ordered. Res [resident] upset that pain meds d/c res left facility AMA [against medical advice] signed by resident. On 4/22/21 at 12:21 p.m., during an interview the Social Service Director (SSD) indicated Resident B had been at the facility since 12/2/20, he was a fairly young person, and was drug seeking, he had drug seeking behaviors. He signed out AMA (against medical advice), in January, because he wanted pain medication. On 4/22/21 at 11:00 a.m., the Administrator (ADM) provided a current, undated policy, titled "Management of Pain." This policy indicated, "Our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. The purpose of this policy is to accomplish that mission through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement...As part of the			

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	comprehensive approach to pain assessment and management, pain will be considered the 'fifth' vital sign at the facility...pain is defined as 'whatever the experiencing person says it is, existing whenever the experiencing person says it does." This Federal tag relates to Complaint IN00345145. 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all			

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	controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview and record review, the facility failed to ensure residents received physician prescribed medications for 1 of 1 random medication observation (Resident M). Findings include: On 4/20/21 at 9:35 a.m., during a medication pass observation, Qualified Medication Aide (QMA) 6 removed a pre-labeled cup of medications from the drawer for Resident M. The cup contained 11 pills. QMA 6 indicated Resident M was supposed to receive 14 medications but 3 were not available to administer. QMA 6 checked off all the boxes on Resident M's MAR (medication administration record), which indicated she had administered all the ordered medications (17 medications). At 9:40 a.m., during an interview QMA 6 indicated if medications were not in the cart for a resident, she would check the backup medications for any which had been delivered. If they were not there, she would order them from pharmacy by sending a message in the computer if they had not already been ordered. On 4/21/21 at 9:10 a.m., during an interview the Director of Nursing (new DON) indicated she was trying to determine which medications were not given to Resident M. The resident's zinc (a supplement) capsules should have been discontinued because they usually only gave	F 0755	Resident M currently has a supply of all ordered meds, and receives them per physician order. Residents who reside in the facility have the potential to be affected by this finding. An audit of medication was completed to ensure all medications were available to residents. Nursing Staff were in-serviced by the DON, May 5 & 20, 2021, including a review of Medication Administration and reordering procedures. The DON/Designee will audit 3 residents are receiving meds and treatments as per physician order. These audits will be weekly x 4 weeks, then bi-weekly x 2 months, then monthly x 2 months. Afterwards, random monitoring will continue ongoing. Further, admission orders, re-admission orders and new orders, (or any orders received since the prior CQI meeting), will be reviewed daily at the morning CQI meetings, to ensure the orders have been carried forward to the MARS/TARS per policy. This will	05/23/2021

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	them for 14 days, she had possibly not received her lisinopril (blood pressure medication). QMA 6 had documented all of Resident M's medications as having been given, for the past 3 days. QMA 6 did not know how to indicate on the medication administration record if a medication was not given because it was unavailable. On 4/21/21 at 2:30 p.m., during an interview the DON indicated she had done an audit of the medication cart and Resident M's medication list. When she checked the medication cart. Resident M did not have any lisinopril and she was able to verify it had been ordered, but not yet received. There was also no zinc and she had ordered it. She educated QMA 6 on not documenting medication as given, if the medication was not given, or not available to give. She wasn't sure what the 3rd medication was that QMA 6 had indicated she had not administered, as unavailable. Maybe it was Med Pass supplement. She did not know how long it took to get medication from the pharmacy, because she was new to this facility. She did not know if the doctor had been informed that the resident had not received all of her medications. A review of Resident M's medical record, on 4/21/21 at 1:30 p.m., indicated the resident's diagnoses included, but was not limited to hypertension (high blood pressure), anemia, chronic kidney disease, and history of cerebral infarction (stroke). Resident M's MAR and current physician's orders indicated the following medications were ordered for 9a.m.: Aricept 10 milligrams (mg) for depression ascorbic acid 1,000 mg (vitamin C) for immunity aspirin 81 mg for CVA (stroke) prevention		continue to be an ongoing part of the daily CQI meeting agenda. Any concerns will be addressed if found. The results of the audits of the MARS/TARS as well as the orders reviews at the CQI meetings will be presented to the QAPI committee at the monthly QAPI meetings. Ay concerns will have been addressed. Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the administrator until resolved.	

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	chlorthalidone 25 mg for HTN (blood pressure) clopidogrel bisulfate 75 mg for anticoagulant (blood thinner) fluoxetine 20 mg for depression isorbide mononitrate ER (extended release) 60 mg for CAD (coronary artery disease, heart) lisinopril 20 mg for HTN (blood pressure) niphedipine ER (extended release) 60 mg for HTN (blood pressure) pantoprazole sodium 40 mg delayed release for ulcer zinc capsule 220 mg for immunity caltrate 600+D3 600/800 mg for heart (calcium and vitamin D) carvedilol 12.5 mg for HTN (blood pressure) ferrex 150 mg capsule iron supplement Keppra 1,000 mg for seizures senna-plus 8.6-50 mg for constipation Med Pass (liquid supplement) 2.0 60 ml, 4 times a day QMA 6 had documented she administered and signed off all 17 ordered 9 a.m. medications on 4/20/21 The physician's progress notes did not indicate the physician had been notified of Resident M not receiving all of her scheduled medications. On 4/20/21 at 11:00 a.m., the DON provided a current undated policy, titled "Medication Storage in the Facility." This policy indicated "Medications and biological [sic] are stored safety [sic], securely, and promptly following the manufacturer or supplier recommendations...." This Federal tag relates to Complaint IN00345145. 3.1-25(b)(3) 3.1-25(g)(3)			

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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, and interview, the facility failed to maintain a clean and sanitary environment on 2 of 3 hallways (200 and 300) observed for cleanliness. Findings include: On 4/19/21 at 9:47 a.m. during the initial facility tour, the following was observed: a. The main dining room was observed with food and paper debris under the tables. An activity staff member was rearranging the chairs, and a resident was sitting at a table looking around. b. Room 301 was observed with a buildup of unidentified sticky substances throughout the room on the floor. The second bed in the room with no assigned resident had food crumbs on the bedding. c. Room 304 was observed with a large area of an unidentified sticky pink substance on the floor in the middle of the room. d. Room 303 was observed with food, and a buildup of unidentified dark sticky substances on the floor. e. Room 305 was observed with a large area of the floor soiled with circles of dark unidentified substances and the over-the-bed table littered with dried-up food debris. f. Room 306 observed with a buildup of unidentified dark substances around the recliner of the floor. g. Room 309 was observed with food and paper debris on the floor, 2 used blue vinyl glove under the bedside dresser, and a buildup of dark unidentified substances over a large area of the	F 0921	Based on observation, and interview, the facility failed to maintain a clean and sanitary environment on 2 of 3 hallways (200 and 300) observed for cleanliness. All Residents Rooms and the 200 and 300 Hallway which were cited were immediately cleaned. Residents who reside in the facility have the potential to be affected by this finding. All Residents Rooms and the 200 and 300 Hallway which were cited were immediately cleaned. All Housekeeping staff was in-serviced by the DON, May 5 & 20, 2021, including a review of Cleaning Policies for Resident Rooms, Hallways and Common Areas. The Housekeeping /Laundry Supervisor and /or designee will conduct audits of residents rooms and common area to ensure cleaning schedules are in compliance for 4 weeks, then bi-weekly for 2 months, then monthly for 2 months. Afterwards , random audits will continue	05/23/2021

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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
	floor. h. The tile floor in the 300 hallway was observed to be dull, heavily soiled with dirt and debris tracked in from outside, dark cake-like food smashed into the floor near the fire doors, dust bunnies along the cove base, and unidentified dark spots of spillage throughout the hallway. The floors were observed to have a substantial buildup of dirt and unidentified filth 2-3 inches wide out from the cove base in the hallway, resident rooms, and around resident doorways along the entire hallway. On 4/19/21 at 10:30 a.m., observation of floors in the common area around the main nurse's desk, main dining room, and therapy room, did not appear to have been swept or mopped recently, all heavily soiled. There was no observation of a housekeeper working in those areas thus far during the survey process. On 4/19/21 at 10:37 a.m. during observation of the 200 Hallway/Secured Memory Care Unit, the following was observed: a. Room 202 was observed with a large amount of debris on the floor to include a used surgical mask, food packets, candy wrappers, dirt, food crumbs and dust bunnies. b. Room 204 was observed to have a strong urine odor permeating out into the hallway. The floors in the room and bathroom were sticky with a substance smelling of urine, there were wheelchair tracks observed through the sticky substance in the entrance of the room, and shoes stuck to the floor when walking in the room. c. Rooms 207, 212, 210, 209, 204, 203, and 201's floors were observed to be soiled with a buildup of dark unidentified substances, debris, and/or food. d. Room 215 was observed to have a strong urine		ongoing. Any concerns will be address if found. The facility CQI team will tract/trend and address concerns to ensure compliance. Results of the audits of the Halls/resident Rooms/Common Areas will be presented to the QAPI committee at the monthly meetings. Any concerns will have been addressed. Any patterns will be identified. If needed, an Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the administrator weekly until resolved.	

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	155717	A. BUILDING 00 B. WING	04/23/2021

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	odor permeating out into the hallway, but unable to detect if the smell was from the floors, bedding, or resident who was wandering around his room. e. The tile floor in the 200 hallway was observed to be dull, heavily soiled with dirt and debris tracked in from outside, dust bunnies along the cove base, and unidentified dark spots of spillage throughout the hallway. The floors were observed to have a substantial buildup of dirt and unidentified filth along the cove base in the hallway, resident rooms, and around resident doorways along the entire hallway. On 4/19/21 at 10:44 a.m., Housekeeper 18 was observed sweeping in room 213, and indicated she was cross training to help in housekeeping. On 4/20/21 at 9:41 a.m., the 200 hallway was observed to be littered with food, paper, and Styrofoam debris. Room 215 was observed to have a foul urine odor permeating out into the hallway. On 4/20/21 at 9:49 a.m., the Housekeeping Supervisor was observed in room 202 demonstrating how to sweep under and around resident beds to Housekeeper 12. The Housekeeping Supervisor was observed to sweep up a dustpan heaping full of debris to include a used surgical mask, food packets, candy wrappers, dirt, food crumbs and dust bunnies. On 4/20/21 at 9:54 a.m., Housekeeper 12 indicated, the resident rooms were cleaned every day, and she thought Housekeeper 18 had swept room 202 the previous day. Housekeeper 12 indicated, the large amount of debris swept up in room 202 could be common every day if the resident dropped food at breakfast and if a family member had brought snacks.			

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	On 4/23/21 at 11:57 a.m., the floors along the 300 hallway cove base and resident doorways were observed to have been cleaned and the wax stripped off the floor approximately 2-3 inches from the walls. The Housekeeping Supervisor indicated, housekeeping staff had tried multiple cleaners, and finally were able to use degreaser and get the "nastiness" off the floor, around doorways and behind resident doors. A Room Deep Clean schedule, dated April 2021, indicated room 202 was deep cleaned 4/2/21, and rooms 204 and 215 were not documented as having been deep cleaned in April. Environmental Room Deep forms for resident room 202 indicated, the room was deep cleaned on 3/2/21 and 4/2/21. Environmental Room Deep forms for resident room 204 indicated, the room was deep cleaned on 3/4/21, and 4/4/21. Environmental Room Deep form for resident room 215 indicated, the room was deep cleaned on 3/13/21. There was lack of documentation to indicate the room had been deep cleaned in April 2021. A housekeeping schedule, dated 4/18/21 - 5/15/21, indicated on 4/18/21 there was 1 housekeeper scheduled for housekeeping, 1 for orientation, and 1 for laundry. Handwritten notes indicated, 3 housekeepers worked and 1 called off. On 4/20/21 at 10:35 a.m., the Housekeeping Supervisor indicated, there were 2 housekeepers scheduled to work daily. The one housekeeper was split to clean the 100 and 300 hallways, and			

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	one housekeeper cleaned the 200 hallway. The 2 housekeepers were responsible for cleaning every resident room to include sweeping, mopping, and dusting. Each housekeeper also deep cleaned a resident room daily, and they were responsible for cleaning all the common areas and bathrooms daily. He could not explain the reasoning for the lack of cleanliness in the facility. On 4/23/21 at 9:35 a.m., the former Housekeeping Supervisor indicated, the Environmental Room Deep Cleaning 3-page form was used by the housekeeper to document rooms that were deep cleaned daily. There was no documentation to indicate when general daily cleaning was completed. Each resident room was deep cleaned on a rotation basis, and she had provided the current Housekeeping Supervisor a copy of the calendar to use. If a resident room could not be deep cleaned as scheduled, the housekeeper would document on the Environmental Room Deep Cleaning form the reason the room was not cleaned, and the supervisor would reassign the room for another day. Some resident rooms were deemed "target rooms" which meant the resident might have had an incontinence problem and the room might have needed cleaned more often. Nursing staff had a mop bucket for instances when a resident had accidents off shift, but they were not cleaning up the floors after residents had been incontinent. The Director of Nursing (DON) should have trained the nursing staff on sanitization. The procedure would be to clean up urine or feces with a paper towel, then mop the floor. The mop water left for nursing staff had sanitizer in it. On 4/23/21 at 9:40 a.m., the Housekeeping Supervisor indicated, deep cleaning of a resident room meant cleaning of the bed, bed frame,			

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	mattress, walls, bathroom, and all surfaces. The divider curtains were taken down and washed monthly, and as needed. On 4/23/21 at 9:52 a.m., the Administrator (ADM) indicated, there had been a discussion in a morning meeting recently regarding nursing staff were to clean up urine and bowel movement (or any bodily fluids), then contact housekeeping. On 4/23/21 at 11:28 a.m., LPN 19 indicated, if a resident had a spill or bio spill such as blood, urine, or feces, nursing was supposed to clean it up using soap and water, then housekeeping was informed to go behind to clean. On 4/20/21 at 1:10 p.m., the Administrator provided a Resident Room - Clean policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, to provide a clean, attractive, and safe environment for residents, visitors, and staff. The procedure included, general inspection of the resident room and picking up loose trash, removal of general waste from the resident's room, high and low dusting, cleaning, and disinfecting the room furnishings, cleaning the phone, bedside commodes, toilet, handrails, nurse call and cord, and cleaning and restocking the bathroom. The resident's room and bathroom floors were to be cleaned with the dust mop then wet mopped. The toilet was cleaned and sanitize, and periodic cleaning of ceramic tile and grout in the bathroom. On 4/20/21 at 1:10 p.m., the Administrator provided a Public Lounges/Lobbies/Hallways-Clean policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, to provide clean, orderly, and attractive			

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	public areas for residents, visitors and staff that enhance the image of the facility. The policy indicated, clean and disinfect all handrails, doorknobs, window glass and frames, fire/smoke doors, and hardware. Remove waste by removing plastic trash liners, disposing of waste in the waste container, wiping the waste container, and relining the trash container, high and low dusting, and cleaning the floor. This Federal tag relates to Complaints IN00345543, IN00349638, and IN00350319. 3.1-19(f)(5)			