STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155282	A. BUILDING 00 B. WING	02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOOD SAMARITAN SOCIETY NORTHWOOD RETIREMENT CO	2515 NEWTON ST JASPER, IN 47547

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaint IN00398107. This visit included a State Residential Licensure Survey. This visit was in conjunction with Complaint IN00401247 and Complaint IN00400564. Complaint IN00398107 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00401247 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880. Complaint IN00400564 - Unsubstantiated due to lack of evidence. Survey dates: January 30, February 1, 2, 3, 6, 7, 8, 9, 2023. Facility number: 000180 Provider number: 155282 AIM number: 100274190 Census Bed Type: SNF/NF: 55 Residential: 22 Total: 77 Census Payor Type: Medicare: 11 Medicaid: 29 Other: 15 Total: 55 These deficiencies reflect State Findings cited in	F 0000	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Edwin Onwukegwu	Administrator	03/16/2023

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

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	accordance with 410 IAC 16.2-3.1. Quality review completed on February 16, 2023.			
F 0658 SS=E Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on interview and record review, the facility failed to ensure acceptable standards of care for 3 of 4 residents reviewed for medication administration and 4 of 24 residents reviewed during record review. Residents were diagnosed with schizophrenia/schizoaffective disorder after the age of 65 without documentation found within the medical record to substantiate that diagnosis. (Resident J, Resident K, Resident 41, Resident 12, Resident 2, Resident 33, Resident 17) Findings include: 1. On 2/2/23 at 11:00 A.M., Resident J's clinical record was reviewed. Resident J was 86 years old when admitted to the facility on 5/25/21. Resident J's diagnoses included, but were not limited to, schizoaffective disorder, diagnosed 5/24/22. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 10/19/22, indicated the Resident J had schizoaffective disorder and received antipyschotic medication on a routine basis. Current physician's orders included, but were not	F 0658	A. Immediate actions taken for those residents identified: Audited residents (J, K, 41, 12, 2, 33, 17) with diagnosis of Schizophrenia/schizoaffective to ensure appropriate supporting documentation is obtained. All documentations to target behaviors were added on the TAR so that nursing is observing and documenting targeted behaviors. Residents care plans were updated to indicate specific target behaviors that support medication usage. B. How the facility identified other residents: All residents have the potential to be affected by the alleged deficiency, hence residents with diagnosis of schizophrenia charts were audited, reviewed, updated accordingly and completed. C. Measures put into places/System Changes: During the morning clinical meeting, IDT will discuss any new admission with diagnosis of	03/14/2023

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	limited to, Seroquel (antipyschotic medication) 25 mg (milligram) tablet, give 75 mg by mouth one time a day related to schizoaffective disorder, dated 6/21/22. Resident J's assessments, behavior monitoring, and documentation of diagnosis criteria for schizoaffective disorder was requested but not received. 2. On 2/2/23 at 10:00 A.M., Resident K's clinical record was reviewed. Resident K was 77 years old when admitted to the facility on 10/19/19. Resident K's diagnoses included, but were not limited to, schizoaffective disorder, diagnosed 2/24/21. The most recent quarterly MDS Assessment, dated 10/24/22, indicated the Resident K had schizoaffective disorder and received antipyschotic medication on a routine basis. Current physician's orders included, but were not limited to, Zyprexa (antipyschotic medication) 2.5 mg tablet, give 2.5 mg by mouth two times a day related to schizoaffective disorder, dated 11/29/22. Resident K's assessments, behavior monitoring, and documentation of diagnosis criteria for schizoaffective disorder was requested but not received. 3. On 2/2/23 at 11:21 A.M., Resident 41's clinical record was reviewed. Resident 41 was 70 years old when admitted to the facility on 1/6/22. Resident 41's diagnoses included, but were not		Schizophrenia to ensure supporting documentation is in place. This will be added to our morning meeting agenda. IDT to discuss routinely any outstanding resident care plan to ensure compliance. MDS Nurse will be responsible for adding target behaviors to TAR and initial Care Plan, check for supporting documentation and if not present, request from MD) for residents admitted with schizophrenia dx or psychotropic medications. D. How the corrective actions will be monitored: The DON or designee will oversee this process and will monitor weekly x6months/till resolve. Findings will be taken to QAPI for 6months/till resolve for review and revision as warranted. E. POC Completion Date: 3/14/2023.	

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	limited to, schizoaffective disorder, diagnosed 4/28/22. The most recent significant change MDS Assessment, dated 11/29/22, indicated the Resident 41 had schizoaffective disorder. Current physician's orders included, but were not limited to, Ativan (antianxiety medication) 0.5 mg tablet, give 1 tablet by mouth in the evening for schizoaffective disorder, dated 1/24/23. Ativan (antianxiety medication) 1 mg tablet, give 1 mg by mouth one time a day for schizoaffective disorder, dated 1/13/23. Lamictal (anticonvulsant medication) 25 mg tablet, give 25 mg by mouth one time a day for depression related to schizoaffective disorder, dated 9/20/22. Resident 41's assessments, behavior monitoring, and documentation of diagnosis criteria for schizoaffective disorder was requested but not received.4. During record review on 2/1/23 at 2:48 P.M., Resident 12 was 77 years old when admitted to the facility on 3/12/18. Resident 12's diagnosis included, but was not limited to, schizoaffective disorder, diagnosed 3/26/21. Resident 12's most recent significant change MDS, dated 12/5/22, indicated Resident 12 had schizophrenia and received antipsychotics on a routine basis. Resident 12's current physician orders included, but were not limited to, Zyprexa (antipsychotic			

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	medication) 5 milligrams (mg) by mouth two times a day for a diagnosis of schizoaffective disorder. Resident 12's assessments, behavior monitoring, and documentation of diagnosis criteria for schizoaffective disorder was requested, but not received. 5. During record review on 2/3/23 at 1:59 P.M., Resident 2 was 90 years old when admitted to the facility on 12/30/20. Resident 2's diagnosis included, but was not limited to, schizoaffective disorder, diagnosed 7/28/22. Resident 2's most recent significant change MDS, dated 12/23/22, indicated Resident 2 had schizophrenia and received antipsychotics on a routine basis. Resident 2's current physician orders included, but were not limited to Namenda (antipsychotic medication) 10 mg by mouth in the evening related to unspecified dementia without behavioral disturbance and Seroquel (antipsychotic medication) 25 mg by mouth two times a day for mood and behaviors. Resident 2's assessments, behavior monitoring, and documentation of diagnosis criteria for schizoaffective disorder was requested, but not received. 6. During record review on 2/3/23 at 10:49 A.M., Resident 33 was 89 years old when admitted to the facility on 10/25/20. Resident 33's diagnosis included, but was not limited to, schizoaffective disorder, diagnosed			

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	5/25/21. Resident 33's most recent significant change MDS, dated 12/2/22, indicated Resident 33 had schizophrenia and received antipsychotics on a routine basis. Resident 33's current physician orders included, but were not limited to Quetiapine (antipsychotic medication) 12.5 mg by mouth two times a day related to schizoaffective disorder. Resident 33's assessments, behavior monitoring, and documentation of diagnosis criteria for schizoaffective disorder was requested, but not received. 7. On 2/7/23 at 2:49 P.M., Resident 17's clinical record was reviewed. Resident 17 was 67 years old when admitted to the facility on 1/18/21. Resident 17's diagnoses included, but were not limited to, schizoaffective disorder, dated 5/24/22, not noted in chart as present on admission. Current physician orders include, but are not limited to, Abilify Tablet 5 mg po once a day for schizoaffective disorder (dated 6/21/22), and Lamictal tablet 25 mg by mouth 2 times a day for schizoaffective disorder, bipolar type (dated 10/7/22). The most current annual MDS (Minimum Data Set) Assessment indicated resident had mild cognitive impairment and required set up and assistance with bed mobility, transfers, eating, toileting, and assistance with part of bathing activity. During interview with resident on 01/30/23 at 10:50 A.M., resident mumbled and was very difficult to			

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	understand. During an interview with Resident 17's brother on 02/01/23 at 10:09 A.M., his brother indicated the resident sleeps a lot. During an interview on 02/06/23 at 1:44 P.M., the Director of Nursing indicated she was unsure of what the schizoaffective diagnoses were based off of due to the residents being in the facility prior to her employment. During an interview on 2/7/23 at 9:22 A.M., the DON indicated there was not a policy for the criteria used to diagnose a resident with schizophrenia/schizoaffective disorder. A current Psychotropic Medications policy, dated 12/9/22, was provided by the Administrator on 2/6/23 at 11:22 A.M., and indicated " ... each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: ... without adequate indications for its use ... " 3.1-35(g)(1)			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record	F 0689	Immediate actions taken for those	03/14/2023

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	review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 2 of 2 residents reviewed for accidents. Care plan interventions were not followed or updated after falls, and one random observation of a treatment cart containing prescription medication was observed left unlocked and unattended. This deficient practice resulted in Resident 44 having 9 falls in 11 months resulting in three fractures. (Resident 44, Resident 28, Treatment Cart) Findings include: 1. During an interview on 2/1/23 at 9:21 A.M., CNA (Certified Nurse Aide) 73 indicated Resident 44 "falls a lot". Resident's bed was observed in low position against the wall, with padded mat rolled up and stacked against the head of the bed. Resident was out of her room. On 2/2/23, Resident 44's clinical record was reviewed. Diagnoses included, but were not limited to, fracture of unspecified part of neck of right femur, type 2 diabetes, cognitive communication deficit, unspecified abnormalities of gait and mobility, and vascular dementia. The most recent significant change MDS (Minimum Data Set) assessment, dated 12/27/22, indicated resident has severe cognitive impairment and requires extensive assistance with bed mobility, transfers, toileting, limited assistance with eating, and is totally dependent for bathing. Resident is frequently incontinent of bowel and bladder but is not on a toileting plan. Care plan included, but were not limited to, the following: Resident is at risk for falls related to impaired mobility, weakness, dementia, decreased safety		residents identified: Facility reviewed resident 44, 28, and Treatment Cart. Will ensure that each resident receives supervision and assistive devices to prevent accidents. Resident 44 re-evaluated for a Reacher use, IDT determines that resident no longer have the cognitive ability of a Reacher use, hence this was discontinued from resident's care plan. Resident 28 fall intervention and care plan has been appropriately updated. B. How the facility identified other residents: All residents have the potential to be affected by the alleged deficiency, hence a comprehensive audit will be completed identifying all at risk resident for falls and needed intervention put in place. C. Measures put into places/System Changes: All falls will be reviewed by the IDT no later than the next business day post fall to ensure all appropriate interventions have been put in place, appropriate documentation and ensure that the care plan is followed. Nursing staff will be re-trained on fall care plan review and update post fall. Care plans for all falls will be	

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	awareness, history of CVA (cardiovascular accident), osteoarthritis, and osteoporosis. Interventions included, but were not limited to, the following: Encourage use of grabber or ask for assistance (revised 3/4/22) Review bowel and bladder continence status and establish and/or review toileting plan based on resident's needs (revised 10/4/22) Fall events from 2/17/22 (admission date) through 1/14/23 indicated Resident 44 experienced the following 9 (nine) falls: Fall 1 On 3/19/22 at 4:10 A.M., resident was found lying on her back in the middle of the floor in her room. Resident was confused and unable to tell staff what happened, just said, "there's a girl over there but she's gone now". Full body assessment completed. Resident was assisted into bed with the assistance of 2 staff using a lift. Neurochecks were conducted: 3/19/22 at 4:10 A.M., 4:40 A.M., 5:10 A.M., 5:40 A.M., 2:15 P.M., 8:32 P.M. 3/20/22 1:01 A.M., 1:45 P.M., 7:36 P.M. 3/21/22 2:23 A.M., 10:06 A.M. No new intervention to care plan. Fall 2 On 5/17/22 at 6:47 A.M., the resident was found on the floor of her room. Resident stated, "I was trying to go to the bathroom". and stated it hurt while her hand was resting on her left hip. Resident was oriented to person. Physician was notified and order was received to send resident to emergency room for evaluation. Resident was sent to the hospital, where she was diagnosed with a displaced intertrochanteric fracture of left femur and underwent surgery for a Gamma nail		reviewed by staff immediately when a fall happens and updated as needed. All Nursing staff who passes medication and treatments will be in-serviced on ensuring that medication/treatment carts are locked when not actively using. Current staff in charge of medication administration will receive training with a return demonstration of competencies for safe medication administration and storage. D. How the corrective actions will be monitored: The DON or designee will oversee this process and will monitor weekly x4, monthlyx6 months/till resolve. Findings will be taken to QAPI for 6months/till resolve for review and revision as warranted. E. POC Completion Date: 3/14/2023.	

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	fixation of the fracture. She was discharged from the hospital back to the facility on 5/20/22 at 12:51 P.M. One new intervention was added to care plan:ensure that resident is wearing appropriate footwear (fully-enclosed slip-resistant shoes, footwear color contrast with floor) when mobilizing in wheelchair (revised 5/19/22). No documentation neurochecks was found. Fall 3 On 6/22/22 at 9:45 P.M., Resident 44 had an unwitnessed fall; staff member observed resident on floor lying prone on her left side. Hematoma noted on forehead and bruise on left arm. Vital signs were assessed. Resident was oriented to person. Resident was assisted to bed with assistance of 2 staff. Physician was notified, no new orders. Neurochecks were conducted: 6/22/22 9:45 P.M. 6/23/22 10:45 A.M., 4:15 P.M. 6/24/22 2:30 A.M., 9:55 A.M., 5:00 P.M. 6/25/22 midnight, 8:56 A.M., 4:31 P.M. 6/26 at 9:46 A.M., 9:46 P.M. No new interventions to care plan. Fall 4 On 7/5/22 at 2:20 P.M., Resident 44's motion sensor alarmed, and resident was found lying on left side on the floor, talking about a man and a baby. Resident complained of pain in left shoulder. Resident was oriented to person and incontinent. Physician was in the building and ordered X-ray. (Results of X-ray were documented after another fall later that same night). Resident was placed back in bed using lift. Neurochecks were conducted; 7/5/22 2:20 P.M., 2:50 P.M., 3:20 P.M., 3:50 P.M., 4:20 P.M. No new interventions were added to care plan.			

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	Fall 5 On 7/5/22 at 10:35 P.M., Resident 44 was standing in the hallway outside her room. Staff attempted to assist her back to bed; however, resident fell forward, then sideways, and landed on her right side, then rolled over to her back. Resident was oriented to person. Physical assessment was done. The record lacked documentation of physician notification or x-ray results. No orders. Neurochecks were conducted: 7/5/22 10:35 P.M., 11:00 P.M., and 11:30 P.M. 7/6/22 midnight, 12:30 A.M., 8:00 A.M., 3:34 P.M. 7/7/22 5:11 A.M., 1:15 P.M., 7:00 P.M. 7/8/22 1:12 P.M., 8:27 P.M. Resident had previous non-displaced fx [fracture] of left clavicle from previous fall earlier in day. Resident was assisted back to bed by nursing staff with lift. No new interventions were added to care plan. A new order for occupational therapy was initiated on 7/26/22; a new order for physical therapy was initiated on 7/27/22. Fall 6 On 8/30/22 at 12:45 A.M. CNA heard thud and entered Resident 44's room. Resident was found resident sitting between the headboard of the bed and wall of the closet, upper back/head/neck against the wall and lower back and buttocks flat against the floor, knees folded up and feet flat on the floor. Head struck wall and left crater in plaster on the wall. Resident did not land on floor mat. Red spot on scalp where head struck the wall. Resident was oriented to person and incontinent. The record lacked record of MD notification following fall. Resident was sent to emergency room due to potential for head injury. Neurochecks conducted prior to hospital visit: 8/30/22 12:45 A.M.,1:15 A.M. Resident was transferred via ambulance to emergency room due to potential head injury.			

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	Resident had physical assessment by physician, urinalysis, CT scan of the head and cervical spine, X-ray and CT scan of lumbar spine, all of which showed no acute fractures. Resident was discharged from the emergency room at 4:53 A.M. Neurochecks were conducted after return to the nursing home: 8/30/22 10:45 A.M. 8/31/22 1:16 A.M. No new interventions were added to the care plan. Fall 7 On 10/20/22 at 4:30 A.M., Resident 44 had an unwitnessed fall. A staff member found the resident lying on her right side on the floor pad next to bed. Resident was assisted back to bed with assistance of 2 staff. Bruising was noted on right arm, vital signs were within normal limits. Resident was oriented to person and incontinent. Resident was assisted back to bed with assistance of 2 staff. Neuro checks were conducted: 10/20/22 4:30 A.M. and 12:09 P.M. 10/21/22 3:40 A.M., 4:10 A.M., 4:40 A.M., 7:00 P.M. 10/22/22 3:00 A.M., 11:00 A.M. No new interventions were added to care plan. Fall 8 On 12/10/22 at 6:00 A.M., Resident 44 was found by a CNA on the floor beside her bed. Bed was in low position and floor mat in place. Resident denied pain or discomfort, no signs or symptoms of pain noted. Resident was transferred to a wheelchair and was assessed for injuries. Resident was confused. Neuro checks were conducted: 12/10/22 6:00 A.M., 6:30 A.M., 7:00 A.M., 7:30 A.M., 8:00 A.M., 2:00 P.M. 12/12/22 12:31 A.M., 8:31 A.M. A new order for occupational therapy and			

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	physical therapy were put into place the day prior to the fall, on 12/9/22. No new interventions were added to resident's care plan. Fall 9 Progess notes indicated that Resident 44 fell on 1/14/23. At that time, she was given pain medication and assisted back to to bed. Resident 44 continued to complain of pain and an X-Ray was ordered on 1/16/23. The resident was sent to the hospital on 1/16/23, where she was found to have a fracture of unspecified part of neck of right femur, which was surgically repaired at the hospital. Documentation of neuro checks were requested from DON (Director of Nursing) and not received. No new interventions were added to care plan. During an interview on 2/3/23 at 1:47 P.M., the SSD (Social Services Director) indicated no knowledge of what staff were doing to keep Resident 44 from falling. She described the resident as very impulsive and capable of things you wouldn't think she would be capable of. During an interview on 2/3/23 at 1:39 P.M. with the DON (Director of Nursing), she indicated no knowledge of what staff were doing to keep Resident 44 from falling. She pulled up the resident's care plan on the computer and indicated that the interventions were going well until the incident on 12/10/22. During an observation of Resident 44's room on 2/6/23 at 2:12 P.M. with CNA 6, no grabber was observed in the room. At that time, CNA 6 indicated she was not sure Resident 44 would know how to use a grabber.			

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	2. On 2/1/23 at 2:01 P.M., Resident 28's clinical record was reviewed. Diagnosis included, but were not limited to, Alzheimer's, dementia, anxiety, and depression. The most recent significant change MDS (minimum data set) Assessment, dated 12/4/22, indicated Resident 28 had a severe cognitive impairment, required extensive assistance of 1 (one) staff for eating, and extensive assistance of 2 (two) staff for bed mobility, transfers, and toileting. The MDS indicated Resident 28 had 2 (two) or more falls since admission or prior assessment with no injury. Care plans included, but were not limited to the following: Risk for falls related to confusion and history of falls, dated and last revised 10/24/22. Resident has had an actual fall with no injuries related to history of falls and poor balance, dated 11/8/22, and last revised 11/9/22. Interventions included, but were not limited to: Ensure resident is wearing appropriate footwear when ambulating or mobilizing in wheelchair (revised 11/9/22), dycem in wheelchair (revised 11/9/22). Fall Events from 10/21/22 (admission date) through 1/22/23, indicated Resident 28 experienced the following 8 (eight) falls: Fall 1 10/22/22 12:30 P.M. Resident was attempting to get out of a recliner in the dining room, lost balance and fell on her bottom. A CNA (certified nursing aide) witnessed the fall, but was not able to get to the resident in time to prevent the fall. The nurse was not on the floor at the time of the fall. The record lacked documentation of whether the resident hit her head or not. Neuro checks were not initiated at the time of the fall. Resident 28 had neuro checks performed on 10/23/22 at 3:09			

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	P.M., and again on 10/24/22 at 5:43 P.M. A falls care plan was not in place at the time of the fall. Fall 2 10/24/22 7:05 P.M. Resident fell into a heater getting up out of her chair and landed on knees. A CNA witnessed the fall and indicated resident did not hit her head. A risk for falls care plan was initiated that day. Fall 3 10/25/22 7:50 P.M. Resident observed sitting on the floor in front of recliner. Fall was unwitnessed. Neuro checks were initiated and completed at the following times: 10/25/22 7:50 P.M., 8:20 P.M., 9:20 P.M., 9:50 P.M. 10/26/22 3:00 A.M., 9:30 A.M. 10/27/22 1:00 P.M., 8:00 P.M. 10/28/22 3:00 A.M, 9:48 A.M. The risk for falls care plan lacked an updated intervention following fall. Fall 4 11/7/22 6:33 P.M. Resident slipped out of wheelchair while staff assisting to the bathroom. The record lacked documentation of whether the resident hit her head or not. A neuro check was completed 10/7/22 at 6:41 P.M. The clinical record lacked documentation of any other neuro checks following fall. A care plan for falls was initiated 11/8/22 that included, but was not limited to an intervention for dycem to be placed in the wheelchair. Fall 5 11/12/22 6:15 P.M. Resident was found sitting in the floor next to wheelchair in the dining room. The falls note indicated "It looks like the resident slipped out of her chair" Neuro checks were initiated and completed at the following times:			

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	11/12/22 6:15 P.M., 6:45 P.M. 11/13/22 1:35 A.M., 12:30 P.M., 5:01 P.M. 11/14/22 6:00 A.M. 11/15/22 1:20 A.M., 9:00 A.M., 6:00 P.M. The falls care plan lacked an updated intervention following fall. Fall 6 11/18/22 10:30 A.M. While in therapy, resident fell forward out of wheelchair, and landed on the floor hitting the right side of her head. Neuro checks performed after the fall revealed uneven pupils and nonreactive to light. Resident was sent to the ER (emergency room), and discharged same day at 3:48 P.M. Scans performed at the hospital revealed no injury. Neuro checks after the fall were completed at the following times: 11/18/22 10:30 A.M., 4:15 P.M. 11/19/22 9:07 A.M. 11/20/22 12:15 A.M., 9:56 A.M. 11/21/22 12:12 A.M., 10:04 A.M., 5:32 P.M. The falls care plan lacked an updated intervention following fall. Fall 7 12/21/22 4:40 P.M. Resident found sitting on the dining room floor in front of wheelchair. Resident indicated at that time she had to go to the bathroom. Neuro checks were initiated and completed at the following times: 12/21/22 4:40 P.M., 5:40 P.M., 6:10 P.M. 12/22/22 6:32 A.M. The falls care plan lacked an updated intervention following fall. Fall 8 1/22/23 7:24 P.M. Resident found lying on the floor in the hallway. Resident was sitting on buttocks up against the hallway double doors. Resident had no walker nearby. Neuro checks			

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	were initiated and completed at the following times: 1/22/23 7:24 P.M., 7:54 P.M., 8:24 P.M., 8:54 P.M., 9:24 P.M. 1/23/23 4:51 A.M., 1:17 P.M. 1/24/23 2:21 A.M., 10:30 A.M. 1/25/23 4:30 A.M., 10:28 A.M. An IDT (Interdisciplinary Team) note, dated 1/23/23 indicated the fall was reviewed and new intervention was to keep walker within reach. The falls care plan lacked an updated intervention following fall. On 2/2/23 at 9:03 A.M., Resident 28 was observed sitting at the dining room table in a wheelchair. Resident 28 had nonskid socks on that were upside down with the slick portion of the sock on the bottom on the feet. On 2/2/23 at 1:54 P.M., CNA 3 and RN (registered nurse) 5 were observed to assist Resident 28 from a wheelchair to the recliner. After transferring, the wheelchair was observed with no dycem. At that time, RN 5 indicated she was unaware of Resident 28 having dycem in her wheelchair, and that it wouldn't help the resident if it was in the wheelchair. On 2/3/23 at 10:46 A.M., Resident 28 was observed sitting in the common area in a recliner with her feet up. A walker was not in reach, and her wheelchair was observed across the room at the opening of the hallway across from the shower room. On 2/3/23 at 11:48 A.M., CNA 7 and CNA 9 were observed to transfer Resident 28 from a recliner to a wheelchair. There was no dycem observed in the wheelchair. Resident 28's socks were observed twisted with the slick side down during			

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	the transfer. On 2/6/23 at 9:11 A.M., Resident 28 was observed sitting at a table in the dining room. A walker was not observed within reach of the resident. 3. On 2/7/23 from 1:41 P.M. until 2:35 P.M., a treatment cart was observed sitting in the hallway just before the 200 Hall across from the nurses station. During that time, the following was observed: LPN (Licensed Practical Nurse) 25 walked past the treatment cart and into the nurses station Resident 25 was observed sitting in a wheelchair by the nurses station with no other staff present by the treatment cart CNA 27 walked past the treatment cart and onto the 200 Hall LPN 25 walked past the treatment cart and onto the 200 Hall to the medication cart 2 (two) doors down Housekeeper 64 walked past the treatment cart CNA 27 walked past the treatment cart leaving the 200 Hall The activities director was observed to push Resident 44 past the treatment cart and onto the 200 Hall, then was observed walking past the treatment cart to leave the 200 Hall Housekeeper 64 and Housekeeper 71 walked past the treatment cart The staffing coordinator walked past the treatment cart entering the 200 Hall and again leaving the 200 Hall Resident 17 walked past the treatment cart using a walker Resident 35 wheeled self past the treatment cart in a wheelchair CNA 27 walked past the treatment cart On 2/7/23 at 2:35 P.M., the treatment cart was observed with RN (Registered Nurse) 55. The			

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	treatment cart contained the following: Dressings (for treatments), plastic vials of normal saline, swabs, bandages, alcohol pads, fingernail clippers, 2 (two) lotion bottles with prescription labels on them with resident information, and 21 containers of creams all with prescription labels on them with resident information. At that time, RN 55 indicated the treatment cart was supposed to be locked at all times when not in use. During an interview on 2/6/23 at 12:54 P.M., the Administrator indicated the policy of the facility was to follow interventions listed in the resident care plan, and the staff was expected to do so. On 2/6/23 at 11:28 A.M., a current Falls Resource policy, dated 3/30/22, was provided and indicated "Fall reduction efforts include: ... implement interventions to reduce falls. Education regarding: ... Safe and proper use of any assistive device (wheelchair, walker, etc.)" The policy indicated after a fall, complete neuro checks, and to check the care plan to determine if the cause of the fall was addressed and if not effective, revise the care plan with a new goal. On 2/7/23 at 3:27 P.M., a current Medications: Acquisition Receiving Dispensing and Storage policy, dated 2/8/22, was provided and indicated "Medications will be stored in a locked medication cart, drawer or cupboard" At that time, the Administrator indicated the policy was for medication carts as well as treatment carts. 3.1-45(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that			

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	resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, interview, and record review, the facility failed to ensure that appropriate treatment and services were provided to for an incontinent resident in 1 of 2 residents reviewed for UTI (urinary tract infections). A resident with a UTI was observed incontinent of urine, and was not cleaned appropriately.	F 0690	A. Immediate actions taken for those residents identified: Facility ensured that (resident B) was immediately provided appropriate incontinent care and cleaned properly. B. How the facility identified other	03/14/2023

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	(Resident B) Finding includes: On 2/1/23 at 1:46 P.M., Resident B's clinical record was reviewed. Diagnosis included, but were not limited to, urinary tract infection, Alzheimer's disease, and dementia. The most recent significant change MDS (minimum data set) Assessment, dated 12/10/22, indicated Resident B had a significant cognitive impairment, displayed no behaviors, and required extensive assistance of 2 (two) staff for toileting. The MDS indicated Resident B was frequently incontinent of bowel and bladder, and was not on a toileting program. Current physician orders included, but were not limited to, the following orders: Keflex (an antibiotic) 500 mg (milligrams) ordered twice a day for 7 (seven) days for UTI, started 1/25/23 Current care plans included, but were not limited to the following: Resident has a need for antibiotic therapy related to bacteria present in urine, revised 1/27/23. Interventions included, but were not limited to requires (assistance, supervision, reminders) with hand washing after being toileting and before and after meals, and encourage fluid intake, both revised 1/27/23. Resident has an ADL (activities of daily living) self care performance deficit related to legal blindness, dementia, Alzheimer's disease, and impaired mobility, revised 12/10/22. Interventions included, but were not limited to resident requires extensive assist of one staff with toileting, revised 5/3/21. Progress notes included, but were not limited to		residents: Incontinent residents have the potential to be affected by the alleged deficiency, hence all residents who need assistance with toileting or those wearing incontinent supplies will have toileting offered to them throughout the day especially after meals. C. Measures put into places/System Changes: Current direct care staff will be re-educated on incontinent care and resident cleaning and will prove competency with a return demonstration using a checklist. D. How the corrective actions will be monitored: DON or designee and will conduct incontinent care for proper care audit weekly x4, monthly x6 months/till resolve. Findings will be taken to QAPI for 6months/till resolve for review and revision as warranted. E.POC Completion Date: 3/14/2023.	

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	the following: 1/9/23 4:06 A.M. "Resident at this time yelled out. When CNA and this nurse entered residents room resident was noted to be standing in middle of room with a large puddle of urine beneath her and brief down around ankles. Residents bed was also wet ... Resident was also toileted prior to the incontinent episode ..." 1/21/23 11:32 A.M. "Noted irritability this shift" 1/22/23 1:52 P.M. "Restlessness ... N.O. [new order] for UA [urinalysis], C/S [culture and sensitivity] if indicated" A lab form for a urinalysis and c/s indicated specimen collected 1/24/23. The labs indicated a urinary tract infection. On 2/2/23 at 10:32 A.M., CNA (Certified Nurse Aide) 88 was observed to assist Resident B with incontinence care and a shower. CNA 88 assisted Resident B to the shower room already wearing a pair of gloves. CNA 88 pulled the resident's pants and brief down around her ankles, and assisted her to sit on the toilet. After toileting, CNA 88 wiped the resident with 3 (three) wipes, pulled up the resident's brief and pants, put a new pair of gloves on, then walked with the resident to the shower area. CNA 88 turned on the water, pulled Resident B's pants and brief down, and assisted the resident to sit on a shower chair. CNA 88 removed the resident's slippers, touching the bottoms of the slippers. CNA 88 then closed the curtains, and removed the resident's socks, pants, and brief. CNA 88 then removed all other clothing from Resident B. CNA 88 used a key to unlock a cabinet, and obtained washcloths and soap from the cabinet. CNA 88 began to rinse and wash the resident. Without changing her gloves, CNA 88 handed Resident B a washcloth with soap and indicated to her she could wash her own "private			

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	area". Resident B could not perform the task, so CNA 88 washed her area for her. CNA finished washing the resident, rinsed the soap off, dried, and clothed the resident. CNA 88 then combed Resident B's hair, and looked under her fingernails before taking her gloves off. At that time, CNA 88 indicated Resident B would hold her urine until staff took her to the bathroom. On 2/3/23 at 11:40 A.M., during a lunch observation, Resident B was observed lying in a recliner across from the nurses station. CNA 9 assisted Resident B out of the recliner and into a chair at one of the dining room tables. At 11:45 A.M., RN 5 served Resident B with her lunch tray. Resident B was not offered hand hygiene before eating. On 2/6/23 from 9:08 A.M. until 9:30 A.M., Resident B was observed sitting in a chair at a table in the dining room. At 9:30 A.M., Resident B stood up and began walking toward the nurses station. RN (Registered Nurse) 55 took the resident by the hand, and guided her to the recliner in front of the nurses station. At that time, the front of Resident B's pants were visibly wet. RN 55 assisted Resident B into the recliner, and while assisting the resident to scoot back in the recliner, noticed the wet spot. RN 55 indicated to CNA 35 she would need assistance to change Resident B when she returned from leaving the unit. CNA 35 then removed the food cart from the unit, and returned at 9:36 A.M. CNA 35 walked past Resident B, then down the hall. At 9:40 A.M., CNA 23 approached Resident B and indicated to her that she would assist with taking her to the bathroom. CNA 23 and CNA 35 assisted the resident to her room. At that time, the back of Resident B's pants were visibly wet. CNA 23 nor CNA 35 washed their hands or used hand			

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	sanitizer before putting on gloves to assist Resident B with toileting. During an interview on 2/3/23 at 1:48 P.M., RN 5 indicated Resident B would touch her own private areas quite frequently, but that information was not documented in the chart. RN 5 indicated that information was only passed on through shift report. She further indicated Resident B would have urinary frequency and urgency when experiencing UTIs. On 2/6/23 AT 11:28 a.m., a current Perineal Care policy, dated 8/24/22, was provided and indicated the purpose was to "prevent infection and odors the he perineal area" The policy indicated staff should perform hand hygiene prior to performing perineal care with residents. 3.1-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to ensure the residents received the necessary respiratory care and services in accordance with the professional standards of practice for 2 of 2 residents reviewed for respiratory care. The facility failed to follow	F 0695	**A. Immediate actions taken for those residents identified:** **Facility immediately ensure that residents (29, and 303) are receiving oxygenation per**	03/14/2023

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	physician oxygenation orders and have an oxygen use care plan. (Resident 29, Resident 303) Finding include: 1. On 2/2/23 at 1:16 P.M., Resident 29 was observed sitting in a recliner in their room with their eyes closed wearing oxygen per nasal cannula with the machine set at 3 LPM (liters per minute). On 2/3/23 at 8:41 A.M., Resident 29 was observed sitting in a recliner in their room with eyes closed, head tilted to the right wearing oxygen per nasal cannula with the machine set at 3 LPM and humidification bottle empty. On 2/3/23 at 1:46 P.M., Resident 29 was observed sitting in a recliner in their room with eyes closed wearing oxygen per nasal cannula with the machine set at 3 LPM and humidification bottle empty. On 2/1/23 at 2:27 P.M., Resident 29's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety disorder, chronic respiratory failure with hypoxia, and personal history of COVID-19. The most recent quarterly MDS (Minimum Data Set) Assessment dated 12/2/22, indicated Resident 29 was cognitively intact, required limited assistance of one for bed mobility and transferring, supervision with setup only for eating, extensive assistance of one for toilet use, and on oxygen. Current physician's orders included, but were not limited to, the following: Oxygen 2 LPM per nasal cannula via O2 (oxygen)		**physician order and Care plan for oxygen use completed.** **B. How the facility identified other residents:** **Residents with respiratory care needs have the potential to be affected by the alleged deficiency, hence all resident on oxygen will be audited to ensure that all are receiving oxygenation per physician order and also care planned.** **C. Measures put into places/System Changes:** **Oxygen tubing and water will continue to be replaced weekly and labeled. Nursing staff will be re-educated regarding adding oxygen tubing and water change to the MAR with new admissions and/or orders and expectation to sign when completed weekly on the MAR. DNS/Designee during admit check list audit to ensure that residents with oxygen have all the oxygen order protocols.** **D. How the corrective actions will be monitored:** **DNS/designee will audit 5 residents with oxygen weekly x4weeks and then bi-monthly x 6months/till resolve for**	

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	concentrator and/or tank at bed time for SOA (shortness of air) related to chronic respiratory failure with hypoxia, dated 3/23/22. Change O2 tubing (and humidification bottle if indicated) weekly on Sunday night shift, dated 10/9/22. A current care plan for oxygen therapy, initiated 3/24/22, included, but was not limited to the following intervention: Oxygen therapy as ordered. On 2/3/23 at 1:49 P.M., Resident 29 was observed with oxygen on at 3 LPM per nasal cannula and the humidification bottle was empty. At that time, LPN 37 indicated Resident 29's oxygen order was for 2 LPM "all the time". She further indicated the humidification bottle was changed weekly on Sunday night shift or when empty. LPN 37 indicated since the bottle was empty, she would replace it.. 2. On 2/1/23 at 10:44 A.M., Resident 303 was observed sitting in a recliner in their room wearing oxygen per nasal cannula with the machine set at 2.5 LPM and humidification bottle was dated 1/27/23. The oxygen tubing was not hooked to the machine but was lying on floor under the recliner. On 2/2/23 at 1:10 P.M., Resident 303 was observed sitting in recliner with O2 on at 2.5 LPM per nasal cannula. On 2/3/23 at 2:44 P.M., Resident 303 was observed in their room sitting in a recliner with O2 on at 2.5 LPM per nasal cannula, and humidification bottle was almost empty. On 2/6/23 at 9:07 A.M., Resident 303 was		**administration per order and documentation on the MAR.** Findings will be taken to QAPI for 6months/till resolve for review and revision as warranted. **E.POC Completion Date: 3/14/2023.**	

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	observed in their room sitting in a recliner with O2 on at 2 LPM per nasal cannula, humidification bottle was full dated 2/6/23. On 2/2/23 at 8:48 A.M., Resident 303's clinical records were reviewed. Resident 303 was admitted on 1/3/23. Diagnosis included, but were not limited to, mechanical complication of coronary artery bypass graft, acute systolic heart failure, cardiomyopathy and Type 2 diabetes. The most recent admission MDS (Minimum Data Set) Assessment, dated 1/3/23, indicated Resident 303 required extensive assistance of two for bed mobility, transfers and toilet use and was moderately impaired. The most current physician's orders included, but was not limited to, the following: O2 NC 1-5 LPM as needed to keep sats (saturations) above 89%. Please titrate level as tolerated, ordered 1/31/23. The resident's clinical record lacked a current care plan for oxygen use. A current non dated Oxygen Administration Therapy policy provided by the Administrator on 2/6/23 at 12:53 P.M. indicated "verify the physician order...fill humidifier bottle, if ordered, with distilled water and keep filled adequately at all times" A current Physician/Practitioner Orders policy, dated 12/2/21, provided by the Administrator on 2/6/23 at 11:28 A.M., lacked information for following the physician's order but indicated the purpose of the policy was "to provide individualized care to each resident by obtaining appropriate, accurate, and timely			

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	physician/practitioner orders" During an interview on 2/6/23 at 12:54 P.M., the Administrator indicated there was not a policy for following the plan of care, but it was the policy of the facility to follow physician orders, and that was the expectation of staff. 3.1-47(a)(6)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse			

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	staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure completed staffing sheets were posted daily for 6 of 6 days during the survey. Findings include: On 1/30/23 at 1:17 P.M., a staffing sheet was observed to be posted in the front lobby of the facility. The staffing sheet indicated the date, total census, number of staff and total hours for the following disciplines: Registered Nurse (RN), Licensed Practical Nurse (LPN), Qualified Medication Aide (QMA), and Certified Nursing Assistant (CNA). Specific number of staff and exact hours worked were not included in the posting. On 2/7/23 at 9:20 A.M., staff posting sheets were provided for the following dates: 1/30/23 1/31/23 2/1/23 2/2/23 2/3/23 2/4/23 2/5/23 2/6/23 2/7/23	F 0732	**A. Immediate actions taken for those residents identified:** **No specific residents were identified. Facility corrected the daily staffing sheets to include date, total census, number of staff (CNA, QMA, LPN, and RN), and exact hours worked.** **B. How the facility identified other residents:** **All residents have the potential to be affected by the alleged deficiency.** **C. Measures put into places/System Changes:** **New staff posting sheet created to show date, census, number of staff, total census, hours worked and total hours. Staffing sheets will be posted in the front lobby daily.** **D. How the corrective actions will be monitored:**	03/14/2023

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	Each staff posting sheet indicated the date, total census, number of staff and total hours for the following disciplines: Registered Nurse (RN), Licensed Practical Nurse (LPN), Qualified Medication Aide (QMA), and Certified Nursing Aide (CNA). Specific number of staff and exact hours worked were not included in the posting. During an interview on 2/7/23 at 9:20 A.M., the Director of Nursing (DON) indicated she was unsure if the actual hours needed to be posted on the posted nurse staffing sheet. On 2/7/23 at 10:45 A.M., a current Nursing Staff Daily Posting Requirements policy, revised 4/25/22 was provided and indicated "...total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff member directly responsible for resident care per shift..."		**Administrator/designee will audit for staffing sheet posting 5x/week for 1 month, then 3x/week for 6months/till resolve. Findings** will be taken to QAPI for 6months/till resolve for review and revision as warranted. **E.POC Completion Date: 3/14/2023.**	
F 0849 SS=D Bldg. 00	483.70(o)(1)-(4) Hospice Services §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet			

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	the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of			

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	services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the			

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	hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care			

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	specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.			
	Based on interview and record review, the facility failed to ensure a communication process with hospice personnel was developed and implemented, including how the communication will be documented between the LTC (long term care) facility and the hospice provider, and to ensure that the needs of the resident were addressed for 1 of 1 residents reviewed for hospice. The clinical record of Resident 41 lacked	F 0849	A. Immediate actions taken for those residents identified: Facility contacted hospice regarding Resident 41 communication and documentation binder. All documentation for residents was received and a binder for daily visits was created.	03/14/2023

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	documentation of ongoing communication between facility staff and hospice staff. (Resident 41) Findings include: On 2/2/23 at 11:21 A.M., Resident 41's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, dementia without behaviors, and cerebral ischemia. The most current significant change MDS (Minimum Data Set) Assessment, dated 11/29/22, indicated the resident was severely cognitively impaired and an extensive assist of 2 (two) staff for bed mobility and transfers. Current physician's orders included, but were not limited to, admitted to (hospice company) with diagnosis of cerebral ischemia on 11/29/22, dated 12/6/22. The current care plans lacked a care plan for hospice care. Progress notes included the following: 11/29/22 2:28 P.M., resident was with (hospice company) admission nurse 11/29/22 5:10 P.M., resident currently receiving (hospice company) care 11/30/22 8:00 P.M., resident fell out of recliner in common area (not documented that Hospice Nurse was notified) 12/1/22 care plan conference held (Hospice Nurse not listed in attendance) 1/8/23 resident fell in dining room, Hospice Nurse notified. 1/12/23 resident agitated and physically aggressive towards staff, Hospice Nurse made		B. How the facility identified other residents: All hospice residents have the potential to be affected by the alleged deficiency, hence hospice visit, and documentations audit was completed for all hospice residents to ensure that there is proper communication and documentation. C. Measures put into places/System Changes: A binder for each resident receiving Hospice care will be placed at the nurse's station on the unit that the resident resides in by HIM. The charge nurse will meet with the Hospice nurse providing care to the resident prior to him/her exiting the facility and the charge nurse will document the visit from Hospice services in PCC. The Hospice visit note will be printed and placed in binder on the unit by Health Information Management (HIM). Nurses will be educated on these processes/expectations by DNS/designee. D. How the corrective actions will be monitored: DON or designee will audit Hospice binders and PCC documentation weekly x 6months/till resolved for visit notes. Findings will be taken to QAPI for 6months/till resolved for review and revision as warranted. E.POC Completion Date: 3/14/2023.	

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	aware 1/19/23 6:54 P.M., resident fell in dining area, Hospice Nurse notified 1/19/23 7:06 P.M., hospice nurse called indicating she will come to evaluate resident after fall 1/24/23 family called asking about ativan dosage...hospice nurse also spoke with family about starting new PRN (as needed) ativan dose 2/6/23 3:08 P.M., nurse called (hospice company) for refill The clinical record lacked further documentation of any other hospice communication. Documentation from (hospice company) on Resident 41 was available after DON (Director of Nursing) contacted them to send records over during the survey process. There was not a system in place to communicate routinely between hospice and the facility. During an interview on 2/3/23 at 2:53 P.M., LPN (Licensed Practical Nurse) 84 indicated that a hospice nurse and aide come a couple times a week to see the resident. They indicated they think when the hospice nurse is here, the hospice nurse would verbally report to the nurse on the hall and the facility nurse should document the information in the resident's electronic health record. During an interview on 2/3/23 at 3:28 P.M., the Hospice Nurse indicated they talk to the nurse while they are at the facility. The hospice nurse would notify the physician's office and update them on resident's condition and get any new orders. They would verbally notify the facility with any new orders and would notify the pharmacy if needed. They further indicated that all facilities have access to the (hospice company) electronic medical record.			

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	During an interview on 2/3/23 at 4:00 P.M., the DON indicated the hospice notes were sent to the facility after the resident was seen and scanned into the resident's chart. She was not sure of access to (hospice company's) electronic record because she would usually call them if she needed anything. During an interview on 2/6/23 9:04 A.M., LPN (Licensed Practical Nurse) 14 indicated the facility nurse and the hospice nurse would verbally discuss new orders, refills, a decline or improvement in the resident and the facility nurse would usually put in some sort of note indicating what was discussed. They further indicated that they did not have access to the (hospice company) electronic record but management might. During an interview on 2/6/23 at 1:05 P.M., the Administrator indicated the facility does not have a policy about documenting hospice care because it's the same as documenting for any other resident, but that facility nurses should be documenting all conversation with the hospice nurse in the facility's electronic record under progress notes. He further indicated they do not have access to (hospice company's) electronic record because they will call them if they need something. During an interview on 2/7/23 at 10:58 A.M., the Hospice Aide indicated she documents in (hospice company's) electronic record, but not in the facility's electronic record. She further indicated if she has a new finding, she will verbally notify the facility nurse and the Hospice Nurse and it would be up to them to document the finding.			

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	During an interview on 2/7/23 at 3:06 P.M., the DON indicated that residents on hospice services should have a hospice care plan in their electronic clinical record. A current Hospice policy, dated 1/16/23, was provided by the Administrator on 2/3/23 at 1:40 P.M., and indicated " 9. A coordinated comprehensive plan of care shall be jointly developed by the location and hospice ... 10. The hospice information/documentation should be integrated into the electronic medical record (EMR) or AL [assisted living] medical record. Hospice documentation received from the hospice agency will be scanned and retrieved in Resident Spaces or placed in the AL resident's medical record in a timely manner. 11. Progress notes related to hospice services for nursing or social work may be completed in (EMR name) using the PN - Hospice or as an interdisciplinary [IDP]progress note in the resident's chart. 12 ... a. When hospice employees provide activities of daily living (ADL) care, it will be documented on hospice forms and scanned into Resident Spaces or copied and placed in the resident's medical record in a timely manner ... 15. When a Medicare/Medicaid certified location is the hospice resident's residence ... the resident must ... have a care plan and be provided with services required under the plan of care ... "			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of			

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	communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.			

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	(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to properly prevent and/or contain COVID-19 during 1 random observation of staff entering a COVID-19 positive resident room, 3 of 5 resident observed for care, and 1 of 4 residents observed for medication administration. Gloves were not changed from dirty to clean tasks, hands were not washed appropriately, staff was not appropriately wearing a face mask, staff did not sanitize hands prior to providing incontinence care, and staff did not sanitize hands prior to handling medications. (Resident B, Resident G, Resident K, Resident M, Resident J)	F 0880	A. Immediate actions taken for those residents identified: Facility training on gloves use: All staff were trained on proper hand hygiene practices and appropriate glove use. Each staff demonstrated competency at the conclusion of the training. Proof of education/training completion with staff with sign-in sheet. Increased audit/monitoring of hand hygiene compliance and PPE usage Facility training on N95 and PPE use: All staff were trained on proper N95 and PPE use. Each staff demonstrated competency at	03/14/2023

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	Findings include: 1. On 2/2/23 at 10:32 A.M., CNA (Certified Nurse Aide) 88 was observed to assist Resident B with incontinence care and a shower. CNA 88 assisted Resident B to the shower room already wearing a pair of gloves. CNA 88 pulled the resident's pants and brief down around her ankles, and assisted her to sit on the toilet. After toileting, CNA 88 wiped the resident with 3 (three) wipes, pulled up the resident's brief and pants, put a new pair of gloves on, then walked with the resident to the shower area. CNA 88 turned on the water, pulled Resident B's pants and brief down, and assisted the resident to sit on a shower chair. CNA 88 removed the resident's slippers, touching the bottoms of the slippers. CNA 88 then closed the curtains, and removed the resident's socks, pants, and brief. CNA 88 then removed all other clothing from Resident B. CNA 88 used a key to unlock a cabinet, and obtained washcloths and soap from the cabinet. CNA 88 began to rinse and wash the resident. Without changing her gloves, CNA 88 handed Resident B a washcloth with soap and indicated to her she could wash her own "private area". Resident B could not perform the task, so CNA 88 washed her area for her. CNA finished washing the resident, rinsed the soap off, dried, and clothed the resident. CNA 88 then combed Resident B's hair, and looked under her fingernails before taking her gloves off. On 2/6/23 at 9:40 A.M., CNA 23 and CNA 35 assisted Resident B to her bathroom. CNA 23 nor CNA 35 washed their hands or used hand sanitizer before putting on gloves to assist Resident B with toileting. After assisting Resident B with toileting, CNA 23 washed her hands with a 9 (nine) second lather with soap, and CNA 35 washed her hands without lathering the		the conclusion of the training. Proof of education/training completion with staff sign-in sheet. Increased audit/monitoring of N95 and PPE usage compliance. Facility will ensure that residents (B, G, K, M, and J) are all receiving care from staff practicing safe nursing care with minimum or no risk of cross-infection. B. How the facility identified other residents: All residents have the potential to be affected by the alleged deficiency. C. Measures put into places/System Changes: The facility IP nurse received additional re-education on IP control and practices from the IP consultant. All pertinent staff in-service on handwashing, glove change, hand sanitizing, masking and medication handling. D. How the corrective actions will be monitored: Infection control nurse or designee will audit 5 occurrences hand hygiene including gloving weekly x6 months/till resolve for proper procedure. IP nurse/designee will audit 5 med passes/week x6 months/ till resolve for proper medication handling. Findings will be taken to QAPI for 6 months/till resolve for review and revision as warranted. E.POC Completion Date: 3/14/2023.	

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	soap in her hands. 2. During an observation on 2/6/23 at 2:53 P.M., CNA 39 provided incontinence care for Resident G. CNA 39 cleaned resident and failed to change gloves after opening a drawer, grabbing a remote, and removing resident's blankets. CNA 39 then provided incontinence care and failed to change gloves from dirty to clean tasks. After incontinence care was provided, CNA 39 placed a clean brief and removed gloves. CNA 39 failed to sanitize hands with hand sanitizer before Resident G's blankets were pulled up and the bed was lowered. CNA 39 then disposed of the soiled brief and lathered her hands for 1 (one) second. During an interview on 2/7/22 at 11:45 A.M, the Infection Preventionist (IP) indicated staff should obtain clean gloves before touching the resident and sanitize hands and change gloves after performing incontinence care. At that time, she indicated staff should lather for 45 seconds with soap when washing hands. 3. On 2/2/23 at 8:04 A.M., QMA (Qualified Medication Aide) 65 was observed preparing medications for Resident J and failed to sanitize their hands prior to preparing the medications. They then proceeded to hold back capsules with a finger in the medication cup as they were pouring other pills into the bag to crush them. They touched the inside of the bag with fingers to open it and dump the crushed pills back out. 4. On 2/2/23 at 8:14 A.M., QMA 65 was observed preparing medications for Resident K and failed to sanitize their hands prior to preparing the medications. They then held the the medication with their fingers inside the medication cup and in the water cup. During an interview on 2/7/23 at 3:07 P.M., the			

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	DON (Director of Nursing) indicated staff should either sanitize or wash their hands before and after administrating medications. 5. On 2/1/23 at 9:07 A.M., CNA (certified nurses aide) 7 was observed entering Resident M's room. A cart was observed outside the door that contained PPE (personal protective equipment) and signs were observed on the door that indicated the resident was on contact isolation and droplet precautions. CNA 7 was observed putting on gown, eye protection, and gloves. Already wearing a surgical mask, CNA 7 placed an N95 mask over the surgical mask before entering the room. The N95 mask did not snuggly fit on her face. On 2/1/23 at 9:17 A.M., CNA 7 was observed putting on gown, eye protection, gloves and N95 mask over surgical mask before entering Resident M's room. The N95 mask did not fit snuggly on her face. On 2/3/23 at 9:19 A.M., Resident M's clinical record was reviewed. Diagnosis included, but was not limited to, COVID-19. Current physician's orders included, but not limited to, resident on isolation due to respiratory infection. Droplet precautions ordered 1/24/23. During an interview on 2/7/23 at 11:45 A.M., Infection Preventionist indicated for contact and droplet isolation staff would be expected to wear a faceshield or goggles, N95 mask, gown and gloves. She indicated staff could wear an N95 mask on over a surgical mask and go in a Covid positive room, but they would need to change the surgical mask after they left the contaminated room.			

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	On 2/6/23 at 1:45 P.M., a current Personal Protective Equipment policy, dated 10/21/22, was provided by the Administrator, but lacked information on applying an N95 mask over a surgical mask, and indicated the center will provide at no cost to the employee, the following appropriate personal protective equipment for all employees considered at risk for occupational exposure: masks. A current Oral Medication Administration policy, dated 11/4/22, was provided by the Administrator on 2/6/23 at 11:22 A.M., and indicated " ... Staff will wash their hands in accordance with infection control policy before and after assisting with medication administration ... " On 2/6/23 at 11:28 A.M., a current undated Hand Hygiene policy was provided and indicated during hand washing, the hands should be rubbed vigorously for at least 15 seconds before rinsing. The policy further indicated hand hygiene should be performed when entering a resident's room, before a clean task, after a dirty task or glove removal, and before exiting a room. This Federal tag relates to Complaint IN00401247 3.1-18(b) 3.1-18(l)			
F 0888 SS=D Bldg. 00	483.80(i)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more			

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	since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in			

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	paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests			

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	for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements			

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	of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; Based on interview and record review, the facility failed to ensure staff COVID-19 vaccination medical exemptions specified a clinically recognized contraindication for 1 of 1 staff medical exemptions reviewed. (Staff 10) Finding includes: On 2/7/23 at 10:00 A.M., Staff 10's COVID-19 medical exemption was reviewed. The medical exemption, signed 6/7/22, indicated Staff 10 should not receive the COVID-19 vaccine related to family history of Guillian Barre after vaccine. During an interview on 2/6/23 at 3:05 P.M., the Administrator indicated that unvaccinated staff testing and precautions depend on the county rates of transmission of covid. On 1/30/23 at 10:34 A.M., the county rate for COVID-19 community transmission rate was high per the CDC COVID data tracker website. During an interview on 2/7/23 at 11:15 A.M., Staff 10 indicated they have a medical exemption for the COVID-19 vaccine because they had an aunt that passed away from Guillian Barre. They further indicated they have not tested for covid for awhile and does not remember the last time that they were tested. They do not use any additional precautions due to being unvaccinated. They just wear a surgical mask. On 2/7/23 at 11:45 A.M., the Infection Preventionist indicated that corporate has to review and approve any medical exemptions. She	F 0888	A. Immediate actions taken for those residents identified: Facility will ensure that staff 10 COVID-19 vaccination medical exemption meets criteria for clinically recognized or Acceptable. B. How the facility identified other residents: All residents have the potential to be affected by the alleged deficiency. Other staff members with exemptions have been reviewed to ensure they meet the proper criteria for medical or religious approved exemption. C. Measures put into places/System Changes: Moving forward for all staff requesting medical exemptions, the facility will ensure that the exemption meets criteria prior to granting approval. Facility Infection preventionist will submit to corporate medical department for review and approval. All unvaccinated staff will be required to test weekly. All unvaccinated staff must wear a mask while in resident care areas even if community transmission rate is low. D. How the corrective actions will be monitored: This process will be overseen by the IP nurse or designee and	03/14/2023

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	further indicated if an isolated covid outbreak occurs, all staff will continue to wear surgical masks but if more develop all staff have to wear N95 masks. On 2/07/23 at 2:45 P.M., the Administrator indicated their COVID-19 staff vaccination policy does not indicate additional precautions because no additional precautions are required for unvaccinated staff. On 2/7/23 at 10:59 A.M., a current Covid-19 Health Care Staff Vaccination policy, revised 8/25/22, was provided by the Infection Preventionist and indicated "...COVID-19 vaccination shall be required for all employees unless exempt for medical or religious purposes as indicated by Sanford leadership based on CDC (Centers for Disease Control) and other applicable regulatory agencies ... employees who are unvaccinated ... with an approved medical or religious exemption may be required by Sanford to utilize mitigation strategies, which could include but are not limited to: masking and use of other PPE (personal protective equipment), adhering to physical distancing measures, reassignment of duties which limit exposure to those most at risk ... or a regular schedule of testing for unvaccinated staff" 3.1-18(b)		audited weekly x4 and bi-weekly x6 months/till resolved. Findings will be taken to QAPI for 6months/till resolved for review and revision as warranted. E.POC Completion Date: 3/14/2023.	
F 9999 Bldg. 00	1. 3.1-14 PERSONNEL (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall	F 9999	A. Immediate actions taken for those residents identified: Facility will ensure that staff (COTA 24, RN 20, Activity Assistant 18, LPN 41, CNA 3, CNA 45) all have either tuberculin	03/14/2023

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	include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. IF the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency repeat testing will depend on the risk of infection with tuberculosis. This State rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure tuberculin skin tests or risk assessments were completed for 6 of 10 employee files reviewed. (COTA 24, RN 20, Activities Assistant 18, LPN 41, CNA 3, CNA 45) Findings include: 1. On 2/6/23 at 2:00 P.M., COTA (Certified Occupational Therapist Assistant) 24's employee file was reviewed. Hire date was 3/27/19. The file lacked documentation that an annual tuberculin		skin test or annual risk assessment. B. How the facility identified other residents: All residents have the potential to be affected by the alleged deficiency. Current employee files will be reviewed to ensure all other employees have received an appropriate physical exam including TB testing upon hire and annually. C. Measures put into places/System Changes: The facility will add TB testing upon hire on the new hire check list. Facility will complete all employee annual TB risk assessment every March. Facility will add to calendar for IP nurse to complete during her monthly audit. IP nurse/designee will be re-educated on the process. D. How the corrective actions will be monitored: DNS/designee will audit new employees for 6months/till resolve for completion of physical exam and TB testing. Findings will be taken to QAPI for 6months/till resolve for review and revision as warranted. E.POC Completion Date: 3/14/2023.	

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	skin test or annual risk assessment had been completed. 2. On 2/6/23 at 2:00 P.M., RN (Registered Nurse) 20's employee file was reviewed. Hire date was 10/2/19. The file lacked documentation that an annual tuberculin skin test or annual risk assessment had been completed. 3. On 2/6/23 at 2:00 P.M., LPN (Licensed Practical Nurse) 41's employee file was reviewed. Hire date was 9/21/09. The file lacked documentation that an annual tuberculin skin test or annual risk assessment had been completed. 4. On 2/6/23 at 2:00 P.M., CNA (Certified Nursing Aide) 3's employee file was reviewed. Hire date was 8/6/18. The file lacked documentation that an annual tuberculin skin test or annual risk assessment had been completed. 5. On 2/6/23 at 2:00 P.M., CNA 45's employee file was reviewed. Hire date was 7/30/20. The file lacked documentation that an annual tuberculin skin test or annual risk assessment had been completed. 6. On 2/6/23 at 2:00 P.M., Activities Assistant 18's employee file was reviewed. Hire date was 10/11/22. The file lacked documentation that an initial tuberculin skin test or annual risk assessment had been completed. During an interview on 2/7/23 at 11:42 A.M., the Administrator indicated no other documentation of staff tuberculin skin tests or annual risk assessments could be found. He further indicated the facility had not initiated or implemented a nationally recognized standard for TB assessment or recognition.			

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	On 2/8/23 at 9:27 A.M., a current Tuberculosis and Employee Screening policy, dated 9/20/21, was provided and indicated "If required by state-specific regulations, a risk assessment will be conducted initially to assess the agency's risk for transmission of TB and to direct control measures to be implemented. In addition, retrospective risk assessment will be conducted by the agency each calendar year ... Employees providing services directly to clients will be screened and tested for TB prior to being exposed to clients. New employees should have a two-step tuberculin skin test (TST) conducted. Routine screening during employment will be based on an annual risk assessment, if required to be conducted or state requirements. Employee TB screening results will be kept in each employee's file" 2. 3.1-14 PERSONNEL (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This State rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure dementia training was completed for 9 of 10 employee files reviewed. (COTA 24,			

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	RN 20, Activities Assistant 18, LPN 41, CNA 3, CNA 45, EVS 94, RN 97, LPN 68) Findings include: 1. On 2/6/23 at 2:00 P.M., COTA (Certified Occupational Therapist Assistant) 24's employee file was reviewed. Hire date was 3/27/19. The file lacked documentation of required dementia inservice training. 2. On 2/6/23 at 2:00 P.M., RN (Registered Nurse) 20's employee file was reviewed. Hire date was 10/2/19. The file lacked documentation of required dementia inservice training. 3. On 2/6/23 at 2:00 P.M., LPN (Licensed Practical Nurse) 41's employee file was reviewed. Hire date was 9/21/09. The file lacked documentation of required dementia inservice training. 4. On 2/6/23 at 2:00 P.M., CNA (Certified Nursing Aide) 3's employee file was reviewed. Hire date was 8/6/18. The file lacked documentation of required dementia inservice training. 5. On 2/6/23 at 2:00 P.M., CNA 45's employee file was reviewed. Hire date was 7/30/20. The file lacked documentation of required dementia inservice training. 6. On 2/6/23 at 2:00 P.M., Activities Assistant 18's employee file was reviewed. Hire date was 10/11/22. The file lacked documentation of required dementia inservice training. 7. On 2/6/23 at 2:00 P.M., EVS (Environmental Services) 94's employee file was reviewed. Hire date was 5/25/22. The file lacked documentation of required dementia inservice training.			

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	8. On 2/6/23 at 2:00 P.M., RN 97's employee file was reviewed. Hire date was 10/11/22. The file lacked documentation of required dementia inservice training. 9. On 2/6/23 at 2:00 P.M., LPN 68's employee file was reviewed. Hire date was 12/28/22. The file lacked documentation of required dementia inservice training. During an interview on 2/7/23 at 11:42 A.M., the Administrator indicated no other documentation of dementia inservice training could be found. On 2/8/23 at 1:44 P.M., a current Memory Care Staff In-Service and Dementia Training policy, dated 4/5/22, was provided and indicated "Minimum training will include: ... Dementia management and care of the cognitively impaired" On 2/8/23 at 9:56 A.M., a current State-Specific Senior Living Information policy, dated 2/6/23, was provided and indicated "... staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia" 3. 3.1-13 Administration and management (w) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution			

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	in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. This State rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure a Dementia Disclosure Agreement was completed, and a dementia director/coordinator was named and in place during the survey period for 1 of 1 dementia unit. Finding includes: On 2/7/23 at 2:45 P.M., a current Dementia Disclosure Agreement was requested. At that time, the Administrator indicated the facility did not currently have a Dementia Disclosure Agreement in place. He further indicated the dementia unit did not currently have a dementia director/coordinator. On 2/8/23 at 9:56 A.M., a current State-Specific Senior Living Information policy, dated 2/6/23, was provided and indicated "In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit"			
R 0000 Bldg. 00				

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	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaint IN00398107. This visit was in conjunction with Complaint IN00401247 and Complaint IN00400564. Complaint IN00398107 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00401247 - Substantiated. Federal/State deficiencies related to the allegations are cited at F880. Complaint IN00400564 - Unsubstantiated due to lack of evidence. Survey dates: January 30, February 1, 2, 3, 6, 7, 8, 9, 2023. Facility number: 000180 Residential Census: 22 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 16, 2023.	R 0000	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills			

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	required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on an interview and record review, the facility failed to ensure a Cardiopulmonary Resuscitation (CPR) and First Aid (FA) certified staff member was present on all shifts for 4 of 7 days reviewed. Finding includes: On 2/8/23 at 3:00 P.M., the staffing schedules were reviewed for 1/29/23 through 2/4/23. The staffing schedule lacked a CPR certified staff member for the following date: 1/29/23 day (6:00 am- 7:00 am) The staffing schedule lacked a First Aid certified staff member for the following dates: 1/30/23 night (11:30 pm- 6:00 am) 1/31/23 night (11:30 pm- 6:00 am) 2/2/23 evening (3:30 pm- 10:00 pm) During an interview on 2/9/23 at 9:45 A.M., the Administrator indicated either a CPR or FA	R 0117	A. Immediate actions taken for those residents identified: Facility will ensure that all front line staff will be CPR and First Aide certified and will ensure that a minimum of one (1) awake staff person with current CPR and first aid certificates shall be on site at all times. B. How the facility identified other residents: No specific resident was identified. However, all residents have the potential to be affected by the alleged deficiency. C. Measures put into places/System Changes: Facility audited all front-line staff to ensure that all are CPR and first aide certified. Facility will ensure that no front line staff is allowed to work until they are CPR and first	03/14/2023

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	certified staff member needed to be in the building at all times. On 2/9/23 at 9:55 A.M., a current Cardiopulmonary Resuscitation In Senior Living Communities policy, revised 3/23/22 was provided and indicated "...The offering of CPR training is recommended for all front-line staff, as well as any staff person that has frequent contact with residents or visitors. A First Aid policy was requested and not received.		aide certified. Residential manager to double check to confirm that all new hire front line staff are CPR and first aide certified prior to scheduling staff. D. How the corrective actions will be monitored: The administrator or designee will oversee this process and will monitor weeklyx6months/till resolve. Findings will be review during QAPI meeting till compliance is met. E.POC Completion Date: 3/14/2023.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6)			

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	months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to ensure Resident Rights and Dementia inservices were completed for 5 of 5 employee files reviewed. (LPN 80, LPN 81, CNA 84, LPN 83, CNA 82). Findings include: 1. On 2/8/23 at 1:45 P.M., Licensed Practical Nurse (LPN) 80's employee file was reviewed. The file lacked any inservices related to resident rights or dementia. 2. On 2/8/23 at 2:00 P.M., LPN 81's employee file was reviewed. The file lacked any inservices related to resident rights or dementia. 3. On 2/8/23 at 2:10 P.M., Certified Nursing Aide (CNA) 84's employee file was reviewed. The file lacked any inservices related to resident rights or dementia. 4. On 2/8/23 at 2:20 P.M., LPN 83's employee file was reviewed. The file lacked any inservices related to resident rights or dementia.	R 0120	A. Immediate actions taken for those residents identifiedFacility will ensure that staff (LPN80, LPN 81, CNA 84, LPN 83, CNA 82) completes required 3hrs of Resident Dementia in-services. C. Measures put into places/System Changes: D. How the corrective actions will be monitored: E.POC Completion Date: 3/14/2023.	03/14/2023

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	5. On 2/8/23 at 2:30 P.M., CNA 82's employee file was reviewed. The file lacked any inservices related to resident rights or dementia. During an interview on 2/7/23 at 11:42 A.M., the Administrator indicated no other documentation of inservice training could be found. On 2/8/23 at 1:44 P.M., a current Memory Care Staff In-Service and Dementia Training policy, dated 4/5/22, was provided and indicated "Minimum training will include: ... Dementia management and care of the cognitively impaired" On 2/8/23 at 9:56 A.M., a current State-Specific Senior Living Information policy, dated 2/6/23, was provided and indicated "... staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia"			
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least			

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	155282	A. BUILDING 00 B. WING	02/09/2023

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	annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure initial tuberculin skin tests were completed for 5 of 5 employee files reviewed. (LPN 80, LPN 81, CNA 84, LPN 83, CNA 82). Findings include: 1. On 2/8/23 at 1:45 P.M., Licensed Practical Nurse (LPN) 80's employee file was reviewed. The file lacked documentation that a tuberculin skin test had been completed.	R 0121	A. Immediate actions taken for those residents identified: Facility will ensure that staff (LPN 80, LPN 81, CNA 84, LPN 83, CNA 82) all have either tuberculin skin test or annual risk assessment. B. How the facility identified other residents: All residents have the potential to be affected by the alleged deficiency. Current employee files	03/14/2023

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	2. On 2/8/23 at 2:00 P.M., LPN 81's employee file was reviewed. The last tuberculin skin test was completed on 5/16/19. The file lacked documentation that a tuberculin skin test had been completed after that date. 3. On 2/8/23 at 2:10 P.M., Certified Nursing Aide (CNA) 84's employee file was reviewed. The last tuberculin skin test was completed on 5/20/19. The file lacked documentation that a tuberculin skin test had been completed after that date. 4. On 2/8/23 at 2:20 P.M., LPN 83's employee file was reviewed. The last tuberculin skin test was completed on 10/6/21. The file lacked documentation that a tuberculin skin test had been completed after that date. 5. On 2/8/23 at 2:30 P.M., CNA 82's employee file was reviewed. The last tuberculin skin test was completed on 11/20/20. The file lacked documentation that a tuberculin skin test had been completed after that date. On 2/8/23 at 9:27 A.M., a current Tuberculosis and Employee Screening policy, dated 9/20/21, was provided and indicated "If required by state-specific regulations, a risk assessment will be conducted initially to assess the agency's risk for transmission of TB and to direct control measures to be implemented. In addition, retrospective risk assessment will be conducted by the agency each calendar year ... Employees providing services directly to clients will be screened and tested for TB prior to being exposed to clients. New employees should have a two-step tuberculin skin test (TST) conducted. Routine screening during employment will be based on an annual risk assessment, if required to be conducted or state requirements. Employee TB		will be reviewed to ensure all other employees have received appropriate physical exam including TB testing upon hire and annually. C. Measures put into places/System Changes: Facility will add TB testing upon hire on the new hire check list. Facility will complete all employee annual TB risk assessment every March. Facility will add to calendar for IP nurse to complete during her monthly audit. IP nurse/designee will be re-educated on the process. D. How the corrective actions will be monitored: DNS/designee will audit new employees for 6months/till resolve for completion of physical exam and TB testing. Findings will be review during QAPI meeting till compliance is met. E.POC Completion Date: 3/14/2023.	

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	screening results will be kept in each employee's file"			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to ensure food was stored appropriately for 1 of 1 kitchen observations. Food containers were not labeled with the complete date in the dry storage area, refrigerator, or shelves in the kitchen area. (Kitchen) Finding includes: On 2/8/23 at 8:40 A.M., the following was observed in the kitchen: Dry storage: an opened tub of macaroni with a label dated 7/1 (no year) an opened tub of bowtie pasta with a label dated 6/6 (no year) an opened tub of rice with a label dated 4/7 (no year) an opened bag of fettuccini with no date an opened tub of spiral noodles with no date an opened tub of chocolate chips with a label dated 1/20/22 with a smaller tub of chocolate chips sitting on top of it with no date an opened box of grits with a best by date of 10/9/21, in a bag dated 5/8/20 an opened bag of whole wheat flour with no date an opened box of spanish rice with no date an opened tub of cocoa powder with a label dated 3/3 (unable to read year)	R 0273	A. Immediate actions taken for those residents identified: Facility immediately ensured that food was appropriately stored by labeling food container stored in dry storage area, refrigerator, or shelves in the kitchen area with date. B. How the facility identified other residents: No specific resident was identified. However, all residents have the potential to be affected by the alleged deficiency. C. Measures put into places/System Changes: Facility staff in-serviced on properly and appropriately storing food and ensuring that food container is properly labeled. Residential manager/supervisor will make round every morning to food store area to ensure that all food is properly stored and labeled. D. How the corrective actions will be monitored: Residential manager/designee will monitor this process weeklyx4, then every two weeks x 4, and	03/14/2023

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	an opened bag of batter mix with no date on outside bag. original bag on the inside dated 1/15/20 an opened tub of self rising flour with a label dated 7/15 (no year) an opened tub of salt with a label dated 9/22 (no year) an opened tub of red substance (unable to read label with item name or date) an opened tub of cornmeal with a label dated 6/26/20 Refrigerator: a pitcher of pink lemonade with a thick layer of visible sediment at the bottom dated 1/30 (no year) an opened tub of chicken salad with a label dated 2/2 (no year) an opened tub of dijon with a label dated 6/27 (no year) an opened gallon of milk 1/5 full with expiration date 2/7/23 a full gallon of milk with expiration date 2/7/23 In the kitchen sitting on a shelf: an opened tub of panko with a label dated 6/20 (no year) During an interview on 2/8/23 at 1:59 P.M., the Facility Manager indicated all open food in the kitchen should have been labeled with open date that included the month, day, and year. On 2/8/23 at 3:40 P.M., a current Food-Supply Storage - Food and Nutrition Services policy, dated 6/21/22, was provided and indicated "Foods that have been opened or prepared are placed in an enclosed container, dated, labeled and stored properly"		monthly 6months/till resolve. Findings will be review during QAPI meeting till compliance is met. E.POC Completion Date: 3/14/2023.	
R 0275	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency			

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Bldg. 00	(h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on observation, interview and record review, the facility failed to ensure diet orders were in place for residents, reviewed, and revised by the physician as needed for 8 of 8 residents reviewed for diet orders. (Resident 77, Resident 73, Resident 74, Resident 71, Resident 70, Resident 72). Findings include: 1. On 2/8/23 at 11:30 A.M., Resident 77's clinical record was reviewed. Diagnoses included, but were not limited to, congestive heart failure and diabetes mellitus type II. Resident 77 was admitted on 3/4/22. A health history and physician admitting orders form, dated 3/4/22, indicated the resident's diet order was Regular CCHO (consistent carbohydrates) signed by the physician. 2. On 2/8/23 at 9:20 A.M., Resident 73's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II and hypothyroidism. Resident 73 was admitted on 4/24/08. The current physician's orders lacked a diet order for the resident. 3. On 2/8/23 at 10:05 A.M., Resident 74's clinical record was reviewed. Diagnoses included, but were not limited to, hyperlipidemia and primary hypertension. Resident 74 was admitted on 12/1/20. The current physician's orders lacked a diet order	R 0275	**A. Immediate actions taken for those residents identified:** Facility immediately ensured that diet orders were reviewed, revised by the physician, and placed in residents (77, 73, 74, 71, 70, 72) charts. **B. How the facility identified other residents:** **All residents have the potential to be affected by the alleged deficiency.** **C. Measures put into places/System Changes:** **Facility staff completed audits for all residents and physician diet order obtained and placed in residents' charts. Facility admitting charge nurses will ensure that all new residents upon admission have a diet order. Nursing staff in-service on diet order completed.** **D. How the corrective actions will be monitored.** **Residential manager/designee will monitor this process monthlyx3months. Findings will be taken to QAPI for 3 months for review and revision**	03/14/2023

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	for the resident. 4. On 2/8/23 at 11:18 A.M., Resident 71's clinical record was reviewed. Diagnoses included, but were not limited to, paroxysmal atrial fibrillation, hyperlipidemia, unspecified hypercalcemia, and hypertensive heart disease with heart failure. Resident 71 was admitted on 12/1/20. The current physician's orders lacked a diet order for the resident. 5. On 2/8/23 at 1:45 P.M., Resident 70's clinical record was reviewed. Diagnoses included, but was not limited to, hypothyroidism. Resident 70 was admitted on 8/11/22. The current physician's orders lacked a diet order for the resident. On 2/8/23 at 12:15 P.M., a diabetic resident was observed eating in the dining room and indicated she does not get a special meal for her diabetes. She further indicated that if it was something that she knows she shouldn't eat, she will eat or drink a better option for her from the food she keeps in her room. 6. On 2/8/23 at 2:30 P.M., Resident 72's clinical record was reviewed. The clinical record lacked a diet order. On 2/8/23 at 10:52 A.M., the Senior Living Manager indicated none of the residents have a specific diet ordered from a physician as they do not offer special diets. She further indicated all residents receive a regular diet, regardless of their diagnoses and if the residents have special needs, the residents adjust their meals to meet their own needs.		**as warranted.** **E.POC Completion Date: 3/14/2023**	

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	A current Diet Orders policy, dated 5/9/22, provided by the Administrator on 2/8/23 at 3:40 P.M., indicated, "a physician's order must be received for all diets ... on a monthly basis, the diet roster should be compared to the physician's orders, diet tray cards, and menu extensions to monitor compliance with the physician's diet order ... "			
R 0412 Bldg. 00	410 IAC 16.2-5-12(i) Infection Control - Noncompliance (i) Persons with a documented history of a positive tuberculin skin test, adequate treatment for disease, or preventive therapy for infection shall be exempt from further skin testing. In lieu of a tuberculin skin test, these persons should have an annual risk assessment for the development of symptoms suggestive of tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss. If symptoms are present, the individual shall be evaluated immediately with a chest x-ray. Based on interview and record review, the facility failed to perform an annual TB (tuberculosis) screening or risk assessment for 4 out of 6 records reviewed for annual TB testing. (Resident 71, Resident 72, Resident 73, Resident 74) Findings include: 1. On 2/8/23 at 2:30 P.M., Resident 72's clinical record was reviewed. The clinical record lacked a TB test or screening assessment for 2022. The most recent TB test was administered on 6/28/21. 2. On 2/8/23 at 9:20 A.M., Resident 73's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus, type II and unspecified dementia. Resident 73 was admitted 4/24/08.	R 0412	A. Immediate actions taken for those residents identified: Facility will ensure that residents (71, 72, 73, 74) all have either tuberculin skin test or annual risk assessment. B. How the facility identified other residents: All residents have the potential to be affected by the alleged deficiency. Current residents' files will be reviewed to ensure all other residents have received appropriate TB testing upon admission and annual risk assessment C. Measures put into	03/14/2023

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	The most recent TB (tuberculosis screening) skin test was 5/14/21. 3. On 2/8/23 at 10:05 A.M., Resident 74's clinical record was reviewed. Diagnoses included, but were not limited to, unspecified dementia and spinal stenosis. Resident 74 was admitted on 12/1/20. The most recent TB (tuberculosis screening) skin test was 5/14/21. 4. On 2/8/23 at 11:18 A.M., Resident 71's clinical record was reviewed. Diagnoses included, but were not limited to, hypertensive heart disease with heart failure and paroxysmal atrial fibrillation. Resident 71 was admitted on 12/1/20. The most recent TB (tuberculosis screening) skin test was 5/14/21. On 2/9/23 at 8:40 A.M., a current Tuberculosis Control Plan policy, dated 4/4/22, provided by the Administrator, indicated the purpose of the policy was "to provide early identification of residents infected with Mycobacterium tuberculosis to prevent the spread of TB through appropriate screening, placement and treatment of residents with exposure to TB" On 2/9/23 at 8:40 A.M., a current Annual Tuberculosis Risk Assessment policy, dated 4/4/22, provided by the Administrator, indicated "the administrator, infection preventionist or designee would conduct an annual tuberculosis (TB) risk assessment for the location"		places/System Changes: Facility will add TB testing upon hire on the new hire check list. Facility will complete all employee annual TB risk assessment every March. Facility will add to calendar for IP nurse to complete during her monthly audit. IP nurse/designee will be re-educated on the process. D. How the corrective actions will be monitored: Residential manager/designee will audit new resident chart for 6months/till resolve for completion of new admission TB testing and annual risk assessment. Findings will be review during QAPI meeting till compliance is met. E.POC Completion Date: 3/14/2023.	