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	03/24/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 2/9/23. This visit included a PSR to a State Residential Licensure Survey. This visit was in conjunction with a PSR to the Investigation of Complaint IN00401247 completed 2/9/23. Complaint IN00401247 - Corrected. Survey dates: March 22, 23, 24, 2023. Facility number: 000180 Provider number: 155282 AIM number 100274190 Census Bed Type: SNF/NF: 53 Residential: 19 Total: 72 Census Payor Type: Medicare: 8 Medicaid: 26 Other: 19 Total: 53 These deficiencies reflect State Findings cited in accordance with 410IAC16.2-3.1. Qualilty review completed on April 4, 2023.	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.	
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			

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

Edwin Onwukegwu | Administrator | 04/13/2023

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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	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 4 of 7 residents reviewed for a late-onset diagnosis of schizophrenia. Residents given a diagnosis of schizophrenia/schizoaffective disorder after the age of 65 did not have supporting documentation in the medical record to substantiate that diagnosis as per the plan of correction. (Resident K, Resident J, Resident 17, Resident 41) Findings include: 1. On 3/22/23 at 11:34 A.M., Resident K's clinical record was reviewed. Resident K was 77 years old when admitted to the facility on 10/8/19. Resident K's diagnosis included, but were not limited to, schizoaffective disorder, diagnosed 2/26/21. The most recent quarterly MDS (minimum data set) Assessment, dated 1/16/23, indicated Resident K had schizoaffective disorder and received antipsychotic medication for 7 of 7 days during the look back period. Current physician's orders included, but were not limited to: Zyprexa (an antipsychotic medication) 2.5mg (milligram) tablet by mouth two times a day related to schizoaffective disorder, dated 11/29/22. Monitor resident for verbal/physical aggression twice a day related to schizoaffective disorder, started 2/24/23. Care plans related to antipsychotic use and/or the	F 0658	A. Immediate actions taken for those residents identified: Facility audited residents (K, J, 17, and 41) with diagnosis of Schizophrenia/schizoaffective, facility consulted with the psych Nurse Practitioner who, after review of the resident's medical record, clarified diagnosis, changed active schizophrenia to history of Schizophrenia and added dementia with behavior to all affected residents. Targeted behaviors for residents K, J, 17 and 41 have been identified and added to the Care Plan and MAR/TAR for monitoring. B. How the facility identified other residents: All residents with schizophrenia have the potential to be affected by the alleged deficiency. No other residents currently have a diagnosis of active schizophrenia. Other residents on psychotropic medications were reviewed for targeted behaviors on care plan and MAR/TAR. C. Measures put into places/System Changes: Admitting or new diagnosis will be reviewed in Daily Clinical Meeting. Those with schizophrenia diagnosis after age 65 will be reviewed for supporting documentation, identification of targeted behaviors on TAR and	04/13/2023

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	diagnosis of schizoaffective disorder were not updated as per the POC (plan of correction), dated 3/14/23. A copy of Resident K's TAR for March 2023 was received on 3/23/23 at 8:20 A.M, and indicated aggressive behavior was not monitored on the following days: 3/2/23 (PM) 3/21/23 (PM) 3/22/23 (PM) 2. On 3/22/23 at 11:52 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 diagnosis included, but were not limited to, schizoaffective disorder, diagnosed 5/24/22. The most recent quarterly MDS Assessment, dated 1/10/23, indicated Resident J had schizoaffective disorder and received antipsychotic medication for 7 of 7 days during the look back period. Current physician's orders included, but were not limited to: Seroquel (an antipsychotic medication) 75mg by mouth one time a day related to schizoaffective disorder, dated 6/21/22. Monitor resident for hallucinations two times a day related to schizoaffective disorder, dated 2/24/23. Care plans related to antipsychotic use and/or the diagnosis of schizoaffective disorder were not updated as per the POC (plan of correction), dated 3/14/23.		Care Plan. 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. Facility nursing leadership will review every new admission in Daily Clinical Meeting, within 72hrs of admit for appropriate diagnosis, target behavior monitoring and Care Planning. If they admit with a diagnosis of schizophrenia, they will be reviewed by the physician/Psych NP to determine if the diagnosis is appropriate or not. If inappropriate, diagnosis will be corrected. Nursing staff were re-educated on documentation completion r/t Behavior Monitoring. D. How the corrective actions will be monitored: This process, including schizophrenia dx, identification of target behaviors monitored on TAR and Care planned will be overseen and audited by the DON/designee weekly x 1 months, bi-weekly x 2 months and then monthly x 6/till compliance is met 100% and maintained. These changes will be discussed and reviewed during Monthly QAPI x6months/till compliance is met. POC Completion Date: 4/13/2023.	

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	A copy of Resident J's TAR for March 2023 was received on 3/23/23 at 8:20 A.M, and indicated the behavior of hallucinations were not monitored on the following days: 3/2/23 (PM) 3/15/23 (PM) 3/21/23 (PM) 3/22/23 (PM) 3. On 3/22/23 at 11:57 A.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 diagnosis included, but were not limited to, schizoaffective disorder, diagnosed 5/24/22. The most recent quarterly MDS Assessment, dated 12/12/22, indicated Resident 17 had schizoaffective disorder and received antipsychotic medication for 7 of 7 days during the look back period. Current physician's orders included, but were not limited to: Abilify (an antipsychotic medication) 5mg by mouth one time a day related to schizoaffective disorder, dated 6/21/22. Monitor resident for aggression twice a day related to schizoaffective disorder, started 2/28/23. Care plans related to antipsychotic use and/or the diagnosis of schizoaffective disorder were not updated as per the POC (plan of correction), dated 3/14/23. A copy of Resident 17's TAR for March 2023 was received on 3/23/23 at 8:20 A.M, and indicated			

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	aggressive behavior was not monitored on the following days: 3/2/23 (PM) 3/21/23 (PM) 3/22/23 (PM) 4. On 3/22/23 at 12:02 P.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 diagnosis included, but were not limited to, schizoaffective disorder, diagnosed 6/21/22. The most recent quarterly MDS Assessment, dated 2/27/23, indicated Resident 41 had schizoaffective disorder and received antipsychotic medication for 7 of 7 days during the look back period. Current physician's orders included, but were not limited to: Seroquel 12.5mg by mouth at bedtime related to schizoaffective disorder, start medication on 2/9/23. Current physician orders were not updated to reflect behavior monitoring related to schizoaffective disorder as per the POC, dated 3/14/23. Care plans related to antipsychotic use and/or the diagnosis of schizoaffective disorder were not updated as per the POC, dated 3/14/23. During an interview on 3/23/23 at 10:00 A.M., RN 5 indicated there was some misunderstanding about what needed to be done for the POC related to schizophrenia/schizoaffective diagnoses, and care plans were still being updated with behaviors			

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	for those residents, as they had not all been completed yet. She indicated all orders should have been updated and they were still working on those updates. She indicated education to staff was being given as situations arise, but had not been given to all staff. On 3/23/23 at 11:30 A.M., a current Psychotropic Medications policy, revised 12/9/22, indicated "Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: ... without adequate monitoring ... without adequate indications for its use ... Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record" This deficiency was cited on 2/9/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-35(g)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to ensure the residents received the necessary respiratory care and	F 0695	**A. Immediate actions taken for those residents identified: Facility immediately ensure**	04/13/2023

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	services in accordance with the professional standards of practice for 2 of 3 residents reviewed for respiratory care. The facility failed to follow physician oxygenation orders and have an oxygen use care plan as indicated in the plan of correction (POC). (Resident 29, Resident 16) Findings include: 1. On 3/22/23 at 2:35 P.M., observed Resident 29 sitting in his recliner with O2 (oxygen) on at 2 liters per nasal cannula. The O2 tubing and humidification bottle were dated 3/22/23. At that time, an interview with RN 9 indicated the order for Resident 29's oxygen was O2 at 2 liters per nasal cannula at bedtime. When asked if Resident 29 normally wears his oxygen all the time, RN 9 indicated I would have to ask LPN 64. LPN 64 indicated she would go find an answer for me. LPN 64 did not return. On 3/22/23 at 11:32 A.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 12/29/22, 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 (liters per minute) per nasal cannula via O2 concentrator and/or tank at bed time for SOA (shortness of air) related to chronic		**that residents (29 and 16) are receiving oxygenation per physician order and residents care plans.** **B. How the facility identified other residents:** **All residents with respiratory care needs have the potential to be affected by the alleged deficiency, hence all resident on oxygen were audited to ensure that all are receiving oxygenation per physician order and also care planned.** **C. Measures put into places/System Changes:** **All nurses re-educated on ensuring that physician order on oxygen use as well as resident's care plan are adequately followed. All new oxygen orders and care plans will be reviewed by nurse leadership next business day to ensure orders have all needed components** **D. How the corrective actions will be monitored.** **The nurse leadership will make daily rounds and as needed rounds to ensure oxygen is being delivered as ordered. This process will be overseen by DON/designee by**	

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	respiratory failure witty hypoxia, dated 3/23/22. Change O2 tubing and label and humidification bottle weekly on NOC (night) shift every night shift every Tuesday for O2 tubing. Please sign and date all O2 tubing and humidification bottles, dated 3/6/23. A current care plan for oxygen therapy, initiated 3/24/22, included, but was not limited to the following intervention: Oxygen therapy as ordered. During an interview on 3/23/23 at 10:38 A.M., RN 5 indicated the POC was not followed as nurses were not making sure the order for the oxygen was correct. She indicated the nurses didn't change the order because they were not aware that the resident was putting on the oxygen himself. RN 5 indicated she had been aware that he had done that since he had been here. 2. On 3/22/23 at 2:37 P.M., Resident 16 was observed lying in bed with eyes closed and head of bed elevated with O2 on at 2 liters per nasal cannula. The oxygen tubing and humidification bottle were dated 3/22/23. O2 sat this am at 6:04 A.M. was 98% and at 8:22 A.M. was 97% on O2 at 2l per nasal cannula. The clinical record lacked documentation of an O2 sat below 90% on room air. On 3/22/23 at 11:40 A.M., Resident 16's medical records were reviewed. Diagnosis included, but was not limited to diabetes mellitus type 2, systolic heart failure, and unspecified asthma. The most recent quarterly MDS (minimum data set) assessment, dated 2/13/23, indicated Resident 16 was mildly impaired and required extensive assistance of two people for bed mobility,		**auditing all residents utilizing oxygen, to ensure that physician order for oxygen use and care plans are being followed weekly x4, bi-monthly x 2 and monthly x 6. The audit reports will be reviewed during monthly QAPI for 6months/till compliance is met 100% and maintained.** **E.POC Completion Date: 4/13/2023.**	

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	transfer, and toilet use. The MDS assessment indicated oxygen was not in use while a resident. The most current physician orders included, but were not limited to the following: Check O2 sat (saturation) if O2 sat is < 90% may place on O2 with N/C (nasal cannula) to maintain sats above 90. May titrate, dated 11/22/22 Change O2 tubing and label and humidification bottle weekly on NOC shift, dated 3/7/23 The clinical records lacked a care plan for oxygen. During an interview on 3/22/23 at 3:40 P.M., LPN 7 indicated she was not aware of an O2 order to wear the O2 routinely. She indicated the only order she could find was to check O2 sat and titrate O2 if sat is < 90%. She indicated the resident is on hospice and she would place a call to the hospice nurse to get clarification on the order. During an interview on 3/22/23 at 3:50 P.M., LPN 7 indicated the hospice nurse said oxygen use was for comfort and she is aware that Resident 16 takes it off and puts it on because sometimes it bothers her. LPN 7 indicated the order for checking O2 sats and putting on O2 for sats less than 90% needs to come out because that's an old order since November. During an interview on 3/23/23 at 10:38 A.M., RN 5 indicated the POC was not followed as the hospice nurse did not communicate with the staff nurse to change the O2 order when Resident 16 started using it daily as a comfort measure and a care plan should have been written at that time. On 3/23/23 at 9:59 A.M., a current Oxygen Administration policy, revised 6/29/22, indicated			

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	"Oxygen administration is carried out only with a medical provider order. A licensed nurse or other employee trained according to state regulations in the use of oxygen will be on duty and is responsible for the proper administration of oxygen to the resident ... Verify physician order" This deficiency was cited on 2/9/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-47(a)(6)			
F 9999 Bldg. 00		F 9999	Final Observation.	04/13/2023
R 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey. This visit also included a PSR to a Recertification and State Licensure Survey completed on 2/9/23. This visit was in conjunction with a PSR to the Investigation of Complaint IN00401247 completed 2/9/23. Complaint IN00401247 - Corrected. Survey dates: March 22, 23, 24, 2023. Facility number: 000180 Provider number: 155282 AIM number 100274190 Census Bed Type: SNF/NF: 53 Residential: 19	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.	

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	Total: 72 Census Payor Type: Medicare: 8 Medicaid: 26 Other: 19 Total: 53 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-5.			
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 found not labeled with the complete date in the dry storage area, refrigerator, or shelves in the kitchen area not supporting the documentation of food labeling as per plan of correction.(Kitchen) Findings includes: On 3/23/23 at 8:37 A.M. to 10:00 A.M., the following was observed in the dietary areas: Dry goods storage in basement: six (6) unopened baking soda boxes with a best buy date of 4/6/2021 box of panko that was dated but no year covered container of cinnamon with no open date present 6 (six) bags of bag of jet puffed marshmallows with expiration date of 10/20/ 2022	R 0273	A. Immediate actions taken for those residents identified: Facility immediately completed a full walk through of food storage area and entirely removed all expired foods, and unlabeled foods 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: All staff were in-serviced on proper labeling and storing of food and food products such as spices etc. On food delivery day the lead cook will ensure food is labeled properly using FIFO (first in, first out) using month/date/year. Every Friday the Lead cook will be	04/13/2023

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	6 boxes of angel cake mix with a best by date of 8/14/ 2021 flour and sugar bins not dated clear plastic container of iodized salt not dated clear container of red-looking material not dated clear container of self rising flour not dated bag of long grain rice dated 7/19/22 (no year) box of Uncle Ben rice pilaf in a plastic bag opened 12/16/22 no best buy found on box opened can of vegetable shortening not dated bottle of open balsamic vinegar, imitation vanilla and white whine vinegar not dated organic all spice opened and dated 9/10/18 ground nutmeg opened and dated 9/1/21 container of opened baking powder dated 4/19/22 small container of opened all spice and ground cloves not dated container of quick dried oats dated 3/20 (no year) bag of grits in a plastic bag dated 5/8/20 box of Sysco Spanish Rice opened not dated green covered container of chocolate chips not dated large container of olive oil opened not dated plastic container of apple cider vinegar opened not dated clear container of Karo syrup opened not dated container of refried beans dated 1/11 (no year) container of pre-dipped batter dated 1/15/20 package of opened hot dog buns not dated Observed in kitchen: container of panko not dated containers of oregano, fajita seasoning, cayenne pepper dated 1/8/20 containers of marjoram, thyme, dill weed, rosemary, basil, Italian seasoning, onion powder, garlic powder, lemon seasoning, Lawry's seasoned salt, Old Bay's seasoning not dated container of rubbed sage dated 1/23/19 .		responsible for ensuring all dry storage is checked for or disposed of any expiring foods and unlabeled foods. Every Friday the Lead Cook will ensure the cold storage including refrigerator and freezer will be cleaned and all expiring foods and unlabeled foods will be disposed of. The Assisted Living Manager will make rounds in the Kitchen twice a week to ensure that foods are labeled correctly and that expiring foods have been disposed. D. How the corrective actions will be monitored: This audit will be done weekly x4, then bi-monthly x 2 and then monthly x 6 months/till compliance is met. This will be covered in QAPI monthlyx6months/till 100% is achieved. E.POC Completion Date: 4/13/2023	

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	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	container of poultry seasoning dated 3/4/16 Observed in refrigerator: container of liquid eggs opened and dated (no year) platter of tomatoes cut and covered with date of 3/19/23 bag lettuce unopened expired 3/20/23 bowl of lettuce salad dated 3/18 no year bottle of opened Worcestershire sauce dated 4/9 (no year) bottle of opened Dijon mustard dated 6/27 (no year) During an interview on 3/23/23 at 4:08 P.M., the residential manager indicated she did not look at all the areas and just picked out a few areas and marked "OK". She also indicated that the facility has a policy for left over food are to be consumed or discarded within 7 days. The in-service indicates the item will be pulled after 72 hours or 3 days. During an interview on 3/24/23 at 10:10 A.M., Cook 37 indicated the outdated food that was observed during the tour on 3/23/23, was not to be there and should have been pitched. On 3/23/23 at 11:15 A.M., a current Food-Supply Storage-Food and Nutrition Services policy, dated 6/21/2022, was provided and indicated "Foods that have been opened or prepared are placed in an enclosed container, dated, labeled, and stored properly." This deficiency was cited on 2/9/23. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on interview and record review, the facility failed to ensure that resident diet orders were reviewed and revised by the physician as the resident's condition requires for 5 of 5 residents reviewed for diet orders (Resident 70, Resident 72, Resident 73, Resident 74, Resident 77). Findings include: During an interview on 3/22/23 at 10:00 A.M., with the Director of Nursing (DON), the DON indicated that residents need to be re-assessed annually for health concerns and needs. She provided a health history and admitting order document for each of 5 residents; these documents included physician diet orders that were not transcribed to the residents' charts. During record reviews on 3/23/23 at 11:20 A.M., 5 of 5 residents reviewed for dietary orders did not have dietary orders in their electronic chart, as follows: 1. 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. The current physician's orders lacked a diet order for the resident.	R 0275	**A. Immediate actions taken for those residents identified: Facility updated residents (77, 73, 74, 70, and 72) service plan to reflect their current diet order as written by the physician, is documented in their service plan.** **B. How the facility identified other residents:** **All residents have the potential to be affected by the alleged deficiency, hence the rest of the residents diet orders were audited to ensure there are current written physician orders in the medical record, which are now reflected on their individual service plans.** **C. Measures put into places/System** All staff were in-serviced on ensuring that all residents have a current diet order from the physician, and diet orders are on the resident service plan. All new admitting residents will have a written diet order from the physician which will be on their service plan. When resident's return from doctor's appointments,	04/13/2023

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	2. 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. 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 for the resident. 4. 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. 5. Resident 72's clinical record was reviewed. The clinical record lacked a diet order. Facility Policy states that "an interdisciplinary care team will perform ongoing accurate and comprehensive assessments of the clients' needs...food and nutritional...status must be included in the assessment process. Facility policy also indicates that a Mini Level of Care Evaluation "should be completed every six months by a licensed nurse..." This policy lacked the inclusion of keeping food and nutritional status updated or revised as needed.		assisted living manager/designee will review any paper work to ensure that is no changes in current diet order. **D. How the corrective actions will be monitored:** **The Assisted Living manager will audit this weekly x4 weeks, then bi-monthly x2 months then monthly x 6 months. The audit will be review during QAPI monthly meeting x 6months/till 100% compliance is achieved.** **E.POC Completion Date: 4/13/2023**	

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	This deficiency was cited on 2/9/23. The facility failed to implement a systemic plan of correction to prevent recurrence.			