STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155704	A. BUILDING 00 B. WING	07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WALDRON REHABILITATION AND HEALTHCARE CENTER	505 N MAIN ST WALDRON, IN 46182

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 10, 11, 12, 13, 14, & 17, 2023 Facility number: 000423 Provider number: 155704 AIM number: 100290450 Census Bed Type: SNF/NF: 59 Total: 59 Census Payor Type: Medicare: 6 Medicaid: 45 Other: 8 Total: 59 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 26, 2023	F 0000	Please accept this plan of correction as the facility's credible allegation of compliance. The facility respectfully requests consideration for paper compliance.	
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.	F 0557	**F 557 D Respect, Dignity/Right to have Personal Property**	08/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shannon Terrell	Nurse Consultant	08/14/2023

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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	Based on observation, interview, and record review, the facility failed to cover a foley catheter drainage bag, to provide dignity for a resident with a foley catheter for 1 of 4 residents reviewed for catheters. (Resident 8) Findings include: On 7/10/23 at 1:15 p.m., Resident 8's foley catheter drainage bag was observed hung on the open side of the bed and was uncovered. Resident 8's record was reviewed on 7/11/23 at 3:03 p.m. The record indicated resident 8 had diagnoses that included, but were not limited to, chronic kidney disease stage 3, history of urinary tract infections, kidney cyst, chronic obstructive pulmonary disease, paraplegia, neuromuscular dysfunction of the bladder, and difficulty swallowing. A Significant Change Minimum Data Set assessment, dated 5/13/23, indicated Resident 8 was cognitively intact, has had no dehydration, had an indwelling catheter, had a urinary tract infection, required extensive assistance of 2 for activities of daily living, and had limitation in range of motion in lower extremities. 07/17/23 12:58 PM., the DON said she is responsible to ensure a catheter bag is covered, said the nurses and CNA's are also, but staff should say something to her if a catheter bag is not covered. A policy for "Catheter Policy and Procedure" was provided by the Corporate Nurse Consultant, on 7/17/23 at 1:10 p.m. The policy included, but was not limited to, "Purpose: To establish guidelines to reduce the risk of or prevent infections in		**1)Immediate actions taken for those residents identified:** ·Residents #8 no longer resides within facility. **2)How the facility identified other residents:** ·Audit completed on identified residents with catheters to ensure dignity/privacy bags were in place. **3)Measures put into place/ System changes:** ·DON/Designee will observe through rounding 3 times weekly to ensure dignity bags are in place. In addition, charge nurses will be responsible to make routine walking rounds of unit during tour of duty to monitor for dignity. ·Any identified issues will be immediately corrected upon discovery. ·Nursing staff educated on resident rights/dignity relative to catheters. **4)How the corrective actions will be monitored:** ·A catheter observation audit will be completed 3x weekly by the DON or other designee. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. ·The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	residents with an indwelling catheter. Guidelines...7. May place drainage bag and excess tubing in a secondary vinyl bag or other similar device to prevent primary contact with floor or other surfaces...." 3.1-3(v)(1)			
F 0558 SS=E Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record review the facility failed to provide fresh water and failed to keep water within reach for 10 of 10 residents reviewed for hydration (Resident 21, Resident 39, Resident 48, Resident 14, Resident 41, Resident 51, Resident 7, Resident 8, Resident 50 and Resident 26). Findings include: 1.) During an observation and interview with Resident 21's family member on 7/10/23 at 2:13 p.m., the resident had a styrofoam cup on his bedside table with warm fluid in it, the cup was dated 7/9/23 third shift. Resident 21's family member indicated the resident frequently did not have fresh water and it was important for him to receive fresh water. The family member indicated the family often had to go get the resident fresh water when they visited daily. Review of the record of Resident 21 on 7/17/23 at 12:15 p.m., indicated the resident's diagnoses	F 0558	**F- 558 Reasonable Accommodations Needs/Preferences** 1. **Immediate actions taken for those residents identified:** ·Fresh water was provided for residents #21, #39,#48, #14,#41, #51, #7, #50, and #26. ·Resident #8 no longer resides in the facility. 2. **How the facility identified other residents:** ·All residents are at risk to be affected. ·An audit was conducted to determine that water is accessible to facility residents, any areas of concern were immediately addressed. **3. Measures put into place/ System changes:** ·Staff educated on components of F558 Reasonable	08/15/2023

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	included, but were not limited to, Alzheimer's disease, anxiety, dementia, major depressive disorder and constipation. 2.) During an observation on 7/10/23 at 2:28 p.m., Resident 39 was laying in bed with her eyes closed, the resident had warm styrofoam cup of water on her bedside table, dated 7/8/23 12:00 a.m., third shift. Review of the record of Resident 39 on 7/14/23 at 12:20 p.m., indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, dementia, delusional disorders, chronic kidney disease, anxiety, osteoarthritis, hypertension and osteoporosis. 3.) During an observation on 7/10/23 at 2:30 p.m., Resident 48 had a styrofoam cup on her bedside table, dated 7/9/23 at 11:19 p.m. During an interview with Resident 48's family member on 7/11/23 at 1:19 p.m., indicated the resident did not always have fresh water available. Review of the record of Resident 48 on 7/14/23 at 10:40 a.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, pulmonary fibrosis, acute and chronic respiratory failure, peripheral vascular disease, dementia, psychotic disturbance, anxiety and hypertension. 4..) During an observation on 7/10/23 at 2:33 p.m., Resident 14 had a styrofoam cup on the bedside table, dated 7/9/23 third shift. Review of the record of Resident 14 on 7/17/23 at 11:10 a.m., indicated the resident's diagnoses		Accommodations Needs/Preferences, including availability and access to water/hydration. ·Fresh ice water will be passed by nursing staff each shift and provided upon request. ·Department managers during routine angel rounding will audit the availability of hydration/water during routine rounding. ·The Evening manager on duty will audit hydration/water availability with immediate correction of identified issues. 4. **How the corrective actions will be monitored:** ·The responsible party for this plan of correction is the Director of Nursing /designee who will audit availability of hydration/ water during routine rounding. ·Concerns will be corrected when identified and reviewed during daily morning meetings as well as reviewed monthly during Quality Assurance Meeting. ·Audits will continue daily on random shifts for 6 months and or until 100% compliance is achieved for 3 consecutive months. ·The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	included, but were not limited to, pulmonary fibrosis, diabetes mellitus, dementia, anxiety, hypokalemia, hypertension, osteoporosis and constipation. 5.) During an observation on 7/10/23 at 2:34 p.m., Resident 41 had a styrofoam cup on her bedside table, dated 7/9/23 third shift. Review of the record of Resident 41 on 7/12/23 at 11:50 a.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, diabetes, dementia, osteoarthritis, hypertension and major depression. 6.) During an observation on 7/10/23 at 2:36 p.m., Resident 51 had a styrofoam cup on his bedside table, dated 7/9/23 third shift. Review of the record of Resident 51 on 7/13/23 at 12:40 p.m., indicated the resident's diagnoses included, but were not limited to, unsteady on feet, weakness, diabetes, hypertension, anxiety, major depressive disorder, dementia , psychotic disturbance, arthritis and Parkinson's disease. 7. On 7/12/23, at 11:37 a.m., Resident 7 was observed in bed, his call light was on the bed rail on his left side, and too far to the head of the bed to reach. When asked Resident 7 if he needed something, he shook his head yes. At 11:40 a.m., CNA 5 entered the room and said the call light is usually placed where he can reach it and pointed to his American flag hanging on the wall beside his bed. She pinned the call light to the bottom of the flag and said they were going to get him up for lunch. Resident 7's record was reviewed on 7/13/23 at 3:10 p.m. The record indicated Resident 7 had diagnoses that included, but were not limited to,			

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	difficulty speaking after a stroke, type two diabetes mellitus, right sided weakness, expressive language disorder, dementia with behavioral disturbance, schizophrenia, anxiety and depression. An Annual Minimum Data Set, dated 9/4/22, indicated Resident 7 was moderately cognitively impaired in cognitive skills for daily decision making, sometimes makes self understood, usually understands others, required extensive assist of 2 for bed mobility and most activities of daily living, and had limitation in range of motion on one side of upper and lower extremely. On 7/17/23 at 9:20 a.m., the Director of Nursing indicated they place the call light where he wants it, and said his care plan has been updated. She said if they don't place it where he wants it he will unclip it and throw it. 07/17/23 09:30 AM Resident 7 was observed in bed, and when asked where he preferred his call light to be placed, he grasped the call light, that was clipped on a blanket across his chest, unclipped it with his left hand, and placed it further down on his bed. The call light had been placed where he could reach it, and move it. A care plan, last revised on 7/12/23, indicated Resident 7 prefers his call light hooked to the assist bar on the far side of the bed, but an observation of the call light placed there indicated he cannot reach it with his left hand. Resident 7 was observed to be unable to reach it. An intervention was to "Attempt to place call light in the appropriate place for resident to reach it when up out of bed." A policy for "Call Light" was provided by the			

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	Corporate Nurse Consultant, on 7/17/23 at 1:10 p.m. The policy included, but was not limited to, "4. Call lights will be kept within the resident's reach when in room. 8. On 7/10/23 at 1:26 p.m., Resident 8 was observed in bed, and his call light was out of his reach, it was on the right side of his bed and placed where he couldn't reach it. Housekeeper 4 was passing laundry and came over to place the call light where he could reach it. He had no water or fluids to drink at his bedside. On 7/13/23 at 9:12 a.m., no fluids were observed at his bedside. Resident 8's record was reviewed on 7/11/23 at 3:03 p.m. The record indicated resident 8 had diagnoses that included, but were not limited to, chronic kidney disease stage 3, history of urinary tract infections, kidney cyst, chronic obstructive pulmonary disease, paraplegia, neuromuscular dysfunction of the bladder, and difficulty swallowing. A Significant Change Minimum Data Set assessment, dated 5/13/23, indicated Resident 8 was cognitively intact, has had no dehydration, had an indwelling catheter, had a urinary tract infection, required extensive assistance of 2 for activities of daily living, and had limitation in range of motion in lower extremities. A care plan, last revised on 5/15/23, indicated Resident 8 had altered nutrition and hydration and was on hospice care. Interventions included, but were not limited to, would be offered snacks and fluids on a regular schedule and as needed. 9. The clinical record for Resident 50 was reviewed on			

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	7/14/2023 at 2:59 p.m. The medical diagnoses included abnormal electrolytes, weakness, and metabolic encephalopathy. A Quarterly Minimum Date Set Assessment, dated 4/13/2023, indicated resident 50 was cognitively intact. During an observation on 7/10/2023 at 11:32 a.m. Resident 50 was laying in her bed with no fluids in her room at this time. During an interview and observation on 7/11/2023 at 11:06 a.m. Resident 50 had no fluids in her bedroom. She was laying in bed at this time. Resident 50 stated that the staff do not pass fluids very often, less than daily, and that she would like to have more water at her beside to help with her "urinary infections". 10. The clinical record for Resident 26 was reviewed on 7/17/2023 at 11:30 a.m. The medical diagnoses included abnormal electrolytes and kidney failure. A Quarterly Minimum Data Set Assessment, dated for 5/12/2023, indicated that Resident 26 was cognitively intact. During an observation and interview with Resident 26 on 7/11/2023 at 11:10 a.m. he had an empty water cup that was labeled "7/6". Resident 26 stated the staff do not pass fresh water to his room because it is too far down the hall, so he will fill his cup up out of the tap. He stated he wished he had ice available for his room. During an observation on 7/11/2023 at 2:35 p.m. the empty cup labeled "7/6" remained in Resident 26's room with no additional fluids available.			

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	During an interview with the Administrator on 7/14/23 at 3:00 p.m. indicated that ice water should be passed every shift. A policy entitled, "Hydration Policy", was provided by the Nurse Consultant on 7/17/2023 at 1:10 p.m. The policy indicated, " ...Nursing will make fresh water available at the bedside ..." 3.1-3(v)(1)			
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.			

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	(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on interview and record review, the facility failed to have documentation that a Notice of Medicare Non-Coverage (NOMNOC) or Advanced Beneficiary Notice (ABN) was provided to Resident 50 for 1 of 3 residents reviewed for beneficiary notices. Findings include: The clinical record for Resident 50 was reviewed on 7/14/2023 at 2:59 p.m. The medical diagnoses	F 0582	F582D NOMNOC 1. **Corrective action for the residents affected by the alleged deficient practice:** Res 108 NOMNC was reviewed. No negative outcome was identified by the alleged deficient practice. **2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice:** All Medicare	08/15/2023

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	included abnormal electrolytes, weakness, and metabolic encephalopathy. A Quarterly Minimum Date Set (MDS) Assessment, dated 4/13/2023, indicated resident 50 was cognitively intact. A completed Beneficiary Protection Notification Review was provided by the facility on 7/14/2023 at 2:05 p.m. by the Executive Director that indicated Resident 50 had a Medicare Part A stay from 3/31/2023 through 5/26/2023 with no supporting documentation, such as a NOMNOC or ABN. During an interview on 07/17/23 at 12:06 p.m. the Executive Director verified the facility could not find any supporting documentation of ABN or NOMNOC for Resident 50. A policy entitled, "SNF NOTICE FOR MEDICARE/MEDICARE ADVANTAGE/Medicaid MCO ADMISSIONS", was provided by the Executive Director on 7/17/2023 at 12:10 p.m. The policy indicated " ...Notification Process ...[Notice] will be given no later than 48 hours before the last Medicare covered day with them ...After signature of making the Phone call gives a copy to the MDS and the original to the Financial Coordinator ..." 3.1-12(a)(15)		residents have the potential to be affected. An audit was completed on all current residents on Medicare. No other residents were identified.**3.** **Measures/Systemic changes put in place to assure the alleged practice does not re occur:** The interdisciplinary care plan team will be in- serviced by the DON/SSD/Designee on the policy and procedure of NOMNC. **4. Corrective actions will be monitored to ensure the alleged practice will not re occur:** The SSD/Designee will audit 3 Residents weekly for 6 months and or until 100% compliance has been met for 3 consecutive months, at which time QA committee may determine to adjust monitoring schedule. Any issues will be presented to QA monthly for reviews/recommendations.	
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving			

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	treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on interview, observation, and record review, the facility failed to promote a clean homelike environment for 1 of 4 residents	F 0584	**F 584D** **Safe/Clean/Comfortable/Homelike Environment**	08/15/2023

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	155704	A. BUILDING 00 B. WING	07/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WALDRON REHABILITATION AND HEALTHCARE CENTER	505 N MAIN ST WALDRON, IN 46182

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	reviewed for room cleanliness. (Resident 210) Findings include: The clinical record for Resident 210 was reviewed on 7/17/2023 at 11:45 a.m. The medical diagnoses included muscle wasting and lymphedema. An Admission Minimum Data Set Assessment, dated for 6/17/2023, indicated Resident 210 was mildly cognitively impaired. Resident 210 needed extensive assistance of two or more staff for transferring and toileting activities of daily living. During an observation and interview with Resident 210 on 7/10/2023 at 11:55 a.m. he was sitting in his recliner at that time, eating his lunch. He had a bedside commode with no lid immediately next to him that had dried feces on it. He indicated he wished the staff would clean the besdide commode better after it was used. During an observation on 7/12/2023 at 4:30 p.m. the bedside commode was sitting in his room next to his dining table and continued to have the dried fecal matter on it. A policy entitled, "Safe Environment", was provided by the Nurse Consultant on 7/14/2023 at 2:45 p.m. The policy indicated, " ...The facility will provide a safe, functional, sanitary, and comfortable environment for residents ..." 3.1-19(f)(5)		**1)Immediate actions taken for those residents identified:** ·The soiled commode identified in room 210 was cleaned. **2)How the facility identified other residents:** ·A facility audit was conducted for those residents that currently utilize a bedside commode. ·Those identified were cleaned. **3)Measures put into place/ System changes:** Education provided to nursing staff on the requirements of F584 and the provision of a safe, clean, homelike environment. Department managers participate in routine angel rounds and will participate in monitoring that resident rooms are safe and sanitary. **4)How the corrective actions will be monitored:** · The responsible party for this plan of correction is the Director of Nursing/designee who will audit 2 times weekly for concerns related to bedside commode cleanliness. · The results of these audits will be reviewed in QAPI monthly for 6 months and or until 100% compliance is achieved for 3 consecutive months. · The QA Committee will then identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 0585 SS=D Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable			

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	expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the			

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	pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on interview, observation, and record review, the facility failed to timely complete a grievance for missing items reported verbally to a staff member for 1 of 2 residents reviewed for missing items. (Resident 46) Findings include: The clinical record for Resident 46 was reviewed on 7/14/2023 at 1:45 p.m. The medical diagnoses included cerebral infarct. An Annual Minimum Data Set Assessment, dated for 4/8/2023, indicated Resident 46 was cognitively intact. During an interview and observation on 7/10/2023 at 12:03 p.m. Resident 46 had indicated she had a pair of pink checkered shorts missing as well as	F 0585	**F 585 Grievances** **1.) Immediate action taken for those residents identified:** ·Interviews were conducted with resident #46, to identify missing items. A grievance form was completed. ·Follow up to grievance with resident #46 to determine satisfaction with outcome. **2.) How the facility identified other residents:** **All residents are at risk to be affected by the deficient practice.** ·Interviews were conducted with facility residents to identify grievances or concerns. ·Any concerns voiced were placed on a grievance form and	08/15/2023

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	two blankets that she had told multiple staff members, including direct care staff and the laundry staff, of over the last few weeks. During this interview, Housekeeper 4 came in with Resident 46's pink shorts and stated she was still looking for the blankets. Resident 46 reiterated the description of the blankets to Housekeeper 4 and Housekeeper 4 said she would keep an eye out for them. During an interview with Social Services Director on 7/11/2023 at 1:45 p.m. she verified she did not have a grievance for Resident 46's missing items, but she would go talk to Resident 46 and file a grievance for her. During an interview with Social Services Director on 7/11/2023 at 2:35 p.m. she confirmed staff should fill out grievance forms for missing items when they are reported to them. She provided the completed grievance form for Resident 46's missing items, dated 7/11/2023. 3.1-7(a)(2)		followed up within 72. ·A resident council meeting was held to determine if there were any concerns that had not been addressed. ·Identified issues were immediately addressed. **3.) Measures put into place/ Systemic changes:** ·Facility Staff were educated on the Grievance Policy. ·Concerns/grievances will be reviewed during scheduled departmental meetings to determine if prompt actions were taken regarding any grievance. ·Any issues identified will be immediately reviewed per Executive Director/designee. ·Bi-monthly resident council meetings times 3 months to ensure timely follow up is occurring and residents express satisfaction with outcomes. ·Grievances will be recorded on facility grievance forms and indicate the steps taken to resolve the issues, signatures of the department managers responsible for follow up, and Executive Directors signature and date verifying completion. **4.) How the corrective actions will be monitored:** ·Executive Director or designee will audit resident council notes and grievance forms weekly assure verification of resident concerns and grievance follow through.	

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			·The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. ·The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to assist dependent residents with Activities of Daily living (ADL) for 3 of 6 residents reviewed for ADL assistance (Resident 21, Resident 51 and Resident 27) Findings include: 1.) During an observation on 7/10/23 at 11:46 a.m., Resident 21 was walking down the hallway with a walker. The resident's hair was disheveled and uncombed and there was a black substance underneath the resident's finger nails. During an observation and interview with Resident 21's family member indicated the family visited the resident daily and most the time the family had to change his incontinent brief because it wilt be full of bowel movement and soiled. The resident member indicated the facility did not comb his hair or clean his dentures. Observation at this time Resident 21 had a strong urine smell,	F 0677	**F 677 D ADL Care Provided for Dependent Residents** **1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Residents # 21, #51, and #27 were reviewed related to preference/choice for ADL care. · Residents will receive shower/bed bath and shampoos per plan of care and preferences. · Shower sheets updated to reflect the provision of ADL care. **2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** · Any residents residing in	08/15/2023

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	dirty dentures, hair uncombed and disheveled and black substance underneath his fingernails. The family member indicated he often smelled strong of urine. Review of the record of Resident 21 on 7/17/23 at 12:15 p.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, anxiety, dementia, major depressive disorder and constipation. The Quarterly Minimum Data Set (MDS) assessment for Resident 21, dated 5/7/23, indicated the resident was severely impaired for daily decision making. The resident required extensive assistance of one person for personal hygiene. The resident was occasionally incontinent of urine. 2.) During an observation on 7/10/23 at 12:11 p.m., Resident 51 hair was disheveled and uncombed. During an observation on 7/11/23 at 10:58 a.m., Resident 51 was sitting in the dining room his hair was disheveled and uncombed. During an observation on 7/13/23 at 1:14 p.m., Resident 51 hair was disheveled and uncombed. Review of the record of Resident 51 on 7/13/23 at 12:40 p.m., indicated the resident's diagnoses included, but were not limited to, unsteady on feet, weakness, diabetes, hypertension, anxiety, major depressive disorder, dementia , psychotic disturbance, arthritis and Parkinson's disease. The Quarterly Minimum Data Set (MDS) assessment for Resident 51,dated 5/19/23, indicated the resident was severely impaired for daily decision making. The resident required		the facility have the potential to be affected. · The Nursing managers/SSD/Designee will review those residents identified as dependent to validate preferences with ADL care. · Non interview able residents shower preferences will be discussed with family/responsible party. **3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** · In-service education will be provided to nursing staff members to include: Personal Bathing preferences, C.N.A documentation, the completion of a shower sheet for those residents that refuse care. ADON will retrieve shower sheets for review and validation. · CNAs will document using POC for the provision of ADL care during their shift and or prior to completing shift. · Care Plans will reflect specific ADL preferences. **4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** · DON/Designee to audit 3 times weekly the provision of ADL care for dependent residents.	

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	extensive assistance of one person for personal hygiene. 3. The clinical record for Resident 27 was reviewed on 7/13/2023 at 3:00 p.m. The medical diagnoses of polyosteoarthritis and epilepsy. An Annual Minimum Data Set Assessment, dated for 6/17/2023, indicated that Resident 27 was cognitively intact, did not reject care, needed physical assistance of two or more staff with bathing, and it was somewhat important for Resident 27 to choose his type of bathing. A preference assessment, dated for 12/27/2023, indicated that it was very important for Resident 27 to choose his type of bathing. A care plan, dated for 6/21/2023, indicated that Resident 27 was scheduled for showers on Wednesday and Saturdays. During an interview with Resident 27 on 7/10/2023 at 12:30 p.m. he indicated he prefers to have showers and for the last week he has been getting showers twice a week. He stated in the last month, he had not been receiving his showers consistently because they "do not have enough help" so the staff would give him a bed bath to save on time. He stated he does not feel bed baths get him clean enough, so he prefers showers. Review of his shower documentation indicated that bed baths were provided on 6/21/2023, 6/28/2023, and 7/1/2023 in place of showers. During a confidential interview completed with a staff member during the survey they indicated that they were not able to provide showers as per their assignment sheets because there wasn't enough time during the shift. They would try to provide at least a bed bath, but that doesn't		· Any concerns or issues identified will be addressed to appropriate staff. · The DON will report the results of audit at the QAPI Committee Monthly times 6 months or until 100% compliance is met for 3 months. The QAPI committee will then determine if compliance is achieved or if ongoing monitoring is required.	

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	happen all the time either. A policy entitled, "Bath/Shower Schedule", was provided by the Nurse Consultant on 7/14/2023 at 2:30 p.m. The policy indicated, " ...Certified Nursing Assistants give bath or shower as scheduled, per resident preference ..." 3.1-38(a)(3)(A) 3.1-38(a)(3)(B) 3.1-38(a)(3)(D)			
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, interview and record review the facility failed to provide an ongoing activity program for the memory care unit for 4 of 4 residents reviewed for activities (Resident 48, Resident 42, Resident 51 and Resident 157). Findings include: During an observation of the memory care unit on 7/10/23 at 11:46 a.m., residents sitting in the dining room, living room, resident rooms and residents wandering up and down the hallway going in and out of other resident rooms. There were no activities occurring on the memory care unit.	F 0679	**F-679 E Activities Meet the Interest/Needs of Each Resident** =”” b=””> **b=””>** **1. Immediate actions taken for those residents identified:** Residents #48, #42, #51, #157 and #21 were assessed and care plans reviewed and revised specifically related to individualized interventions that supports their choice in activities 2. How facility identified other residents.	08/15/2023

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	The activity calendar, dated July 2023, provided by the Administrator on 7/17/23 at 12:05 p.m., indicated there was an activity of "makin/bakin" scheduled for 11:00 a.m. During an observation on the memory care unit on 7/10/23 at 2:04 p.m., there were no activities occurring on the memory care unit. The activity calendar, dated July 2023, provided by the Administrator on 7/17/23 at 12:05 p.m., indicated there was an activity of "models" scheduled for 1:30 p.m. During an observation and interview with CNA 10 on 7/10/23 at 2:47 p.m., there were no activities occurring on the memory care unit. CNA 10 indicated the memory care unit did not have activities. During an observation of the memory care unit on 7/11/23 at 10:58 a.m., residents sitting in the dining room, living room, resident rooms and residents wandering up and down the hallway going in and out of other resident rooms. There were no activities occurring on the memory care unit. The activity calendar, dated July 2023, provided by the Administrator on 7/17/23 at 12:05 p.m., indicated there was an activity of "going on a picnic" scheduled for 10:30 a.m. During an interview with the Executive Director on 7/12/23 at 11:14 a.m., indicated there were 17 residents residing on the memory care unit. 1.) During an observation on 7/10/23 at 12:52 p.m., Resident 48 was sitting at the locked exit door of the memory care unit crying and attempting to		All residents residing in the memory care unit have the potential to be affected by the deficient practice. An audit of all residents residing on the memory care unit was completed by social services and activities department. The plan of care was reviewed and updated to ensure individualized activity program interventions and to ensure preferences are included in plan of care. 3. Measures put into place/System changes Education provided to facility staff on the circadian rhythms, dementia care, dementia behavior redirection. Residents assessed for activity preferences and care plans updated to reflect. Social services completed psychosocial assessments of each memory care resident. The facility has employed an activity director and memory care coordinator to assist in ensuring the programming and specialized dementia care for the unit. New activity calendars have been posted in resident rooms and on the unit. ="" p=""> **4. How the corrective actions will be monitored:** The responsible party for this plan of correction is the Executive	

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	leave the unit when staff opened the door. The resident was screaming "I want to go out there" "I want to go home". There were no activities occurring on the memory care unit. The activity calendar, dated July 2023, provided by the Administrator on 7/17/23 at 12:05 p.m., indicated there was an activity of "nails and tales" scheduled for 1:00 p.m. During an observation on 7/10/23 at 2:38 p.m., Resident 48 was in the dining room asking staff to take her out in the main part of the building. There were no activities occurring on the memory care unit. During an observation on 7/11/23 at 2:40 p.m.., Resident 48 was sitting in the dining room with no residents or staff. Resident 48 grabbed the facility laptop computer that was sitting on a desk in the dining room and threw it on the floor. The resident was crying and yelling "I quit this job, I don't want to work here anymore". There were no activities occurring on the memory care unit. The activity calendar, dated July 2023, provided by the Administrator on 7/17/23 at 12:05 p.m., indicated there was an activity of "frog darts" scheduled for 2:00 p.m. Review of the record of Resident 48 on 7/14/23 at 10:40 a.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, pulmonary fibrosis, acute and chronic respiratory failure, peripheral vascular disease, dementia, psychotic disturbance, anxiety and hypertension. The plan of care for Resident 48, dated 4/27/23, indicated the resident liked group activities like		Director/ designee. Scheduled activities will be reviewed during morning meetings. Audits will be conducted 3 times weekly to determine activities are scheduled 7 days a week. Evening activities are scheduled at least 2 days weekly. Outdoor activities are scheduled monthly. Residents who refuse to attend activities are provided alternate programs. Audits will be reviewed monthly during Quality Assurance and will continue for 6 months or until 95% compliance is achieved for 3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WALDRON REHABILITATION AND HEALTHCARE CENTER	505 N MAIN ST WALDRON, IN 46182

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	bingo, coffee time, exercises, daily chronicle, games, parties, music, live entertainment and arts/crafts. The interventions included, but were not limited to, encourage and support the development of a new skill, interest or hobby, invite/encourage/escort this resident to group activities of choice, provide any needed supplies and assistance for activities. The Annual Minimum Data Set (MDS) for Resident 48, dated 5/12/23, indicated the resident was severely cognitively impaired for daily decision making. It was somewhat important for the resident to listen to music, do things with groups of people, attend her favorite activity and attend religious services, it was very important to the resident to be around animals and go outside for fresh air. 2.) During an observation on 7/10/23 at 12:55 p.m., Resident 42 was laying on the couch in the living room. There were no activities occurring on the memory care unit. During an observation on 7/11/23 at 11:00 a.m., Resident 42 was laying on the couch in the living room. There were no activities occurring on the memory care unit. The activity calendar, dated July 2023, provided by the Administrator on 7/17/23 at 12:05 p.m., indicated there was an activity of "cookbook" scheduled for 11:00 a.m. Review of the record of Resident 42 on 7/12/23 at 1:45 p.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, cerebrovascular disease, major depression disorder, bipolar disorder and osteoporosis.			

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The activity care plan for Resident 42, dated 3/2/23, the resident was dependent on staff for emotional, intellectual, physical, and social stimulation. The resident liked individual activities , listening to music, singing, dancing, watching TV, attending to her baby doll and stuffed animals. The interventions included, but were not limited to, staff to converse with the resident while providing care, invite and lead the resident to scheduled activities and the resident needs set up for independent activities if having behaviors.

The Annual Minimum Data Set (MDS) assessment for Resident 42, dated 7/1/23, indicated the resident was severely impaired for daily decision making. It was somewhat important for the resident to have books, newspapers, magazines and attend religious services. It was very important for her to listen to music, be around animals, keep up with the news, do things in groups of people, do her favorite activity and go outside to get fresh air.

3.) During an observation on 7/10/23 at 12:53 p.m., Resident 51 was sitting in his recliner in his room. There were no activities occurring on the memory care unit.

During an observation on 7/11/23 at 10:58 a.m., Resident 51 was sitting in the dining room at a table by himself, with 5 other residents in the dining room. There were no activities occurring on the memory care unit.

Review of the record of Resident 51 on 7/13/23 at 12:40 p.m., indicated the resident's diagnoses included, but were not limited to, unsteady on feet, weakness, diabetes, hypertension, anxiety, major depressive disorder, dementia , psychotic

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	disturbance, arthritis and Parkinson's disease. The Admission Minimum Data Set (MDS) for Resident 51, dated 4/20/23, indicated the resident was severely impaired for daily decision making. It was somewhat important for the resident to have books, newspapers and magazines. It was very important for the resident to listen to music, be around animals, keep up the news and do his favorite activities. The plan of care for Resident 51, dated 6/21/23, indicated the resident had impaired activity and recreational pursuits related to physical and cognitive impairments. The resident would like to do most group activities if he was invited and transported to them. The interventions included, but were not limited to, assist the resident and introduce him to fellow residents, escort to and from activities, encourage /invite participation in activities of interest, models and projects, cooking, gardening, movies, music, parties, pets, care games and daily chronicle. 4.) During an observation on 7/10/23 at 12:54 p.m., Resident 157 was wandering the memory care unit. There were no activities occurring on the memory care unit. During an observation on 7/11/23 at 10:55 a.m., Resident 157 was wandering the memory care unit. There were no activities occurring on the memory care unit. During an interview with Resident 157's family member on 7/11/23 at 11:16 a.m., indicated they visited the resident daily and had never seen activities occurring on the memory care unit. The family member indicated the resident liked jokes, loved going outside, always had a garden, loved			

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	music and use to play the guitar. Review of the record of Resident 157 on 7/17/23 at 12:30 p.m., indicated the resident's diagnoses included, but were not limited to, dementia with behavioral disturbance, chronic obstructive pulmonary disease, psychosis and hypertension. The plan of care for Resident 157, dated 6/6/23, indicated the resident was at risk for altered activity patterns/pursuits related to the resident was dependent on staff for activities, cognitive stimulation, and social interaction. The resident needed socialization, displays cognitive deficits, encourage to engage in programming. The resident resides on a secured unit. The Admission Minimum Data Set (MDS) for Resident 157, dated 6/13/23, indicated the resident was severely impaired for daily decision making. It was very important for the resident to listen to music, do his favorite activity and go outside to get fresh air, somewhat important to be around animals and do things in groups of people. During an interview with Confidential Staff 12, indicated the memory care unit did not have activities. During an interview with Confidential Staff 13, indicated the memory care unit did not have activities. During an interview with Confidential Staff 14, indicated the memory care unit did not have activities. During an interview with Confidential Staff 16, indicated the memory care unit did not have activities.			

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	During an interview with Confidential Staff 18, indicated the memory care unit did not have activities. During an interview with the Activity Aide on 7/17/23 at 11:05 a.m., indicated the facility did not have an Activity Director. There were three Activity Aides, one was full time and the other two were part time. There was no Activity Aide assigned to the memory care unit. The activity policy provided by the Executive Director on 7/13/23 at 8:30 a.m., indicated the it was the policy of the facility to specify the responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring all staff, across all shifts and departments, understand the principles for each resident; and that the care and services provided were person centered, and honor and support each resident's preferences, choices, values and beliefs. The facility would provide an ongoing program to support residents in their choice of activities. 3.1-33(a)			
F 0689 SS=E 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			

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	to prevent accidents. Based on observation, interview and record review the facility failed to implement fall interventions and failed to keep walk ways free of clutter for 4 of 7 residents reviewed for falls (Resident 51, Resident 50, Resident 19 and Resident 20). Findings include: 1.) Review of the record of Resident 51 on 7/13/23 at 12:40 p.m., indicated the resident's diagnoses included, but were not limited to, unsteady on feet, weakness, diabetes, hypertension, anxiety, major depressive disorder, dementia , psychotic disturbance, arthritis and Parkinson's disease. The plan of care for Resident 51, dated 4/14/23, indicated the resident was at risk for falls and injury and has had an actual falls relate to dementia, history of falls, Parkinson's disease, poor safety awareness, unsteady gait, visual impairment and weakness. The interventions included, but were not limited to, bright colored tape on call light, non-skid footwear, urinal within reach, soft touch call light and bedside commode beside bed. The Quarterly Minimum Data Set (MDS) assessment for Resident 51,dated 5/19/23, indicated the resident was severely impaired for daily decision making. The resident was admitted to the facility on 4/7/23. The fall risk assessment for Resident 51, dated 6/8/23, indicated the resident was at risk for falls. The incident audit report for Resident 51, dated 4/27/23, indicated the resident had a fall in his room with no injury. The resident had on improper	F 0689	**F 689 E Free of Accidents/Hazards/Supervision/ Devices** **1.) What corrective actions will be accomplished for those residents found to have been affected by the practice?** Residents #51, #50, #20and #19 were assessed and care plan interventions updated. Rooms were cleaned of clutter to ensure walkways were clear. **2.) How will other residents having the potential to be affected by the same practice and what corrective action will be taken:** Any resident has the potential to be affected. An audit was conducted to determine that resident's environment remains free of hazards and walkways are free of clutter. **3.) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur.** ·Care Plans will be reviewed to determine interventions are appropriate for these residents identified to be at risk for falls. · The DON or designee will audit 3 residents weekly to determine compliance with the fall prevention Identified issues will be addressed through re-education. ·Staff educated in components	08/15/2023

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	footwear. The incident audit report for Resident 51, dated 5/20/23, indicated the resident had an unwitnessed fall in his room. The resident had an injury post incident of a bruise to the scalp of his head (5/29/23). The incident audit report for Resident 51, dated 5/24/23, indicated the resident had an unwitnessed fall in his room. The resident had no injuries. The incident audit report for Resident 51, dated 5/28/23, indicated the resident had an unwitnessed fall in his room. The resident had slight raise on right side of forehead. The incident audit report for Resident 51, dated 6/8/23, indicated the resident had a witnessed fall in his room. The resident acquired a 12 centimeter (cm) by 8 cm abrasion on the right side of his back and shoulder. The incident audit report for Resident 51, dated 7/4/23, indicated the resident unwitnessed fall in his room. The resident had no injuries. During an observation on 7/13/23 at 12:57 p.m., Resident 51 was laying in bed awake. The resident did not have a soft touch call light pad, no colored bright colored tape on the call light, no socks on, no urinal within reach and no bedside commode beside his bed. During an interview with LPN 4 on 7/13/23 at 1:14 p.m., verified Resident 51 did not have a soft touch call light pad, no colored bright colored tape on the call light, no socks on, no urinal within reach and no bedside commode beside his bed.		of F689 and the prevention of Accidents and Hazards/ Supervision, to include intervention implementation and care plan updating. ·The Director of Nursing/designee/ administrator will monitor for clear and clutter free pathways through direct observation during routine facility rounding. ·Identified concerns will be addressed with 1-1 education and corrected upon discovery. ·Nursing staff will be educated on fall prevention upon hire and at least annually and prn. **4.) How the corrective actions will be monitored to ensure the practice will not recur and what quality assurance program will be put into place.** ·The DON or designee will audit 3 residents weekly to determine compliance with the fall interventions and prevention. ·Observations will include clutter free pathways. Identified issues will be addressed immediately and through re-education. ·The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months or until an average of 90% compliance or greater is achieved x3 consecutive months. ·The QA Committee will identify any trends or patterns and make recommendations to revise the	

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	LPN 4 looked in the resident's room and bathroom for his urinal and was unable to locate it. During an interview with the Director Of Nursing (DON) on 7/13/23 at 1:25 p.m. indicated herself and the memory care staff were responsible to ensure Resident 51's fall interventions were in place. 2. The clinical record for Resident 19 was reviewed on 7/13/2023 at 10:35 a.m. The medical diagnoses include muscle wasting and spondylosis. A Quarterly Minimum Data Set Assessment, dated for 4/1/2023, indicated that Resident 19 was cognitively intact, needed assistance of one staff to transfer and walk, and utilized a walker and wheelchair. A fall care plan for Resident 19, dated 5/30/2023, indicated to keep her environment free of clutter. A fall risk assessment, dated 7/2/2023, indicated Resident 19 was at risk for falling. During an interview and observation on 7/10/2023, Resident 19 had a large box at the end of her bed on the floor that had multiple items in it including a large piece of foam used for a bed extension. She indicated they had placed that box there over the weekend and she is not sure what it is for. During an observation on 7/11/2023 at 11:01 a.m. the large box remained at the foot of the bed upon the floor. 3. The clinical record for Resident 20 was reviewed on 7/13/2023 at 10:25 a.m. The medical diagnoses included emphysema and heart failure. An Admission Minimum Data Set Assessment,		plan of correction as indicated.	

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	dated for 6/9/2023, indicated that Resident 20 was cognitively intact. A fall care plan for Resident 20, dated for 7/6/2023, indicated she was risk for falls due to weakness and impaired mobility. A fall risk assessment, dated for 4/10/2023, indicated Resident 20 was at risk for falls. During an interview and observation on 7/10/2023 at 12:08 p.m. Resident 20 indicated she had trouble walking with her rollator in her room due to the clutter in her room and that she was not able to get in and out of the bathroom because of a large box at the end of her roommate's, Resident 19, bed. She further indicated in the bathroom there was a clutter on the floor as well and some of her personal items sitting on the floor by her bed. A large box was noted at the end of the roommate's bed. In the bathroom were two packs of briefs sitting on the floor in front of the toilet, a bedpan in a plastic bag, and a trash can in the walkway. During an interview and observation on 7/11/2023 at 2:22 p.m. the box remained at the end of her roommate's bed and the multiple items in the bathroom remained on the floor. Resident 20 indicated staff will "kick the box" under the bed so she can walk through, but they have to pull it back out when they take care of her roommate. She stated she is afraid she is going to trip and fall over all the stuff on the floor. During an interview with CNA 1 at 7/11/2023 at 2:27 p.m. she indicated she believed hospice had placed all the extra items in a box for Resident 19 and left them at the end of her bed. She was not sure where else they could store them.			

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	4. The clinical record for Resident 50 was reviewed on 7/14/2023 at 2:59 p.m. The medical diagnoses included abnormal electrolytes, weakness, and metabolic encephalopathy. A Quarterly Minimum Date Set Assessment, dated 4/13/2023, indicated resident 50 was cognitively intact and used an indwelling urinary catheter. A fall care plan, dated 4/6/2023, indicated for Resident 50 to have a mat at bedside. A fall risk assessment, dated 5/3/2023, indicated Resident 50 was at risk for falling. During an observation on 7/12/2023 at 1:20 p.m. Resident 50 was in bed at this time without her fall mat in place. During an observation on 7/12/2023 at 4:05 p.m. Resident 50 was in bed at this time without her fall mat in place. A policy entitled, "Falls and Fall Risk", was provided by the Nurse Consultant on 7/17/2023 at 1:10 p.m. The policy indicated, " ...The fall related care plan will address both prevention of falls as well as the application specific interventions in response to an occurrence of a fall ..." 3.1-45(a)(1) 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and			

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	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 and record review, the facility failed to ensure the urinary catheter drainage bag was free of contact with the floor for 1 of 3 residents reviewed for urinary catheter. (Resident 50) Findings include:	F 0690	**F-Tag 690** **1) Immediate actions taken for those residents identified:** · Resident # 50 catheter tubing secured to ensure correct placement off the floor. **2) How the facility identified other residents:** · Visual observation audit	08/15/2023

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	The clinical record for Resident 50 was reviewed on 7/14/2023 at 2:59 p.m. The medical diagnoses included abnormal electrolytes, weakness, and metabolic encephalopathy. A Quarterly Minimum Date Set Assessment, dated 4/13/2023, indicated resident 50 was cognitively intact and used an indwelling urinary catheter. During an interview and observation on 7/11/2023 at 11:06 a.m. Resident 50 was in bed at this time with her urinary catheter drainage bag off to the left side of the bed. The drainage bag had been placed in a urinary hat that was tipped over and causing the bag to be laying on the floor with a moderate amount of dark urine in the collection system. During an observation on 7/12/2023 at 3:30 p.m. Resident 50 was laying in bed with her urinary catheter bag hanging off the right side of her bed. Her bed was placed so the right side of her bed was contacting the wall. The bed was in the lowest position with the urinary catheter collection bag contacting the wall and flooring. A policy entitled "Catheter Policy and Procedure", was provided by the Executive Director on 7/14/2023 at 11:30 a.m. The policy indicated, " ...place drainage bag and excess tubing in a secondary vinyl back or other similar device to prevent primary contact with the floor or other surfaces ..." 3.1-41(a)(2)		conducted of those residents with catheters to ensure tubing was off the floor. Any resident that has a catheter has the potential to be affected. **3) Measures put into place/ System changes:** · The nursing staff, which includes licensed nurses, QMA's and C.N. A's were educated on catheter care and tubing placement. · The IDT team will observe correct catheter and tubing placement during scheduled Angel Rounding. Identified areas will be corrected immediately. **4) How the corrective actions will be monitored:** · The Director of Nursing / designee will be the responsible party for this plan of correction. · Audits will be conducted 3 times weekly to include all shifts for catheter tubing placement. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. · The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning			

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	§ 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 oxygen tubing was dated for 2 of 3 residents reviewed for oxygen therapy. (Resident 210 and Resident 20) Findings include: 1. The clinical record for Resident 210 was reviewed on 7/17/2023 at 11:45 a.m. The medical diagnoses included muscle wasting and obstructive sleep apnea. An Admission Minimum Data Set Assessment, dated for 6/17/2023, indicated Resident 210 was mildly cognitively impaired. Resident 210 utilized oxygen therapy and BiPAP/CPAP. During an observation and interview with Resident 210 on 7/10/2023 at 11:55 a.m. he was sitting in his recliner at this time, eating his lunch. He had an oxygen cannula in place connected to an oxygen concentrator. No date was on the tube or the storage bag for his nasal cannula. Resident 210 was not sure when the tubing was last changed. During an observation on 7/11/2023 at 2:55 p.m. Resident 210 continued to use his nasal cannula with no date indicated on either the tubing or	F 0695	**F 695D Respiratory, Tracheostomy, Care and Suctioning** **1.) Corrective actions accomplished for those residents found to be affected by the alleged practice:** · Resident #210 no longer resides in the facility. Resident #20 tubing was changed and dated. **2.) Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:**· All residents using oxygen had the potential to be affected by this alleged practice.· Audit conducted for those residents using oxygen to determine tubing had been changed and dated accordingly. **3.) Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:**· Education provided on changing and dating oxygen tubing weekly. · An audit conducted on those residents with	08/15/2023

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	155704	A. BUILDING 00 B. WING	07/17/2023

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	storage bag. 2. The clinical record for Resident 20 was reviewed on 7/13/2023 at 10:25 a.m. The medical diagnoses included emphysema and heart failure. An Admission Minimum Data Set Assessment, dated for 6/9/2023, indicated that Resident 20 was cognitively intact and utilized oxygen therapy. During an interview and observation on 7/10/2023 at 12:11 p.m. Resident 20 was using a nasal cannula connected to an oxygen concentrator in her room. The tubing and storage bag for her oxygen nasal cannula was not dated. Resident 20 indicated that her tubing has never been changed. She pulled the cannula out of her nose to show the plastic of the tubing was very flimsy and had obvious build up around the nose piece. During an observation on 7/11/2023 at 2:33 p.m. Resident 20 was utilizing a nasal cannula without a date on the tubing or storage bag. The tubing continued with build up around the nose piece. During an interview with CNA 1 on 7/11/2023 at 2:35 p.m. she confirmed the oxygen tubing was not dated and she would replace the nasal cannula. During an interview with the Executive Director on 7/14/23 at 3:00 p.m., indicated that oxygen tubing should be dated when it is changed. 3.1-47(a)(g)		oxygen orders to determine correct tubing dates were present.**4.) How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** · Responsible party for this plan of correction is the Director of Nursing.· Audits per Director of Nursing/Designee will be conducted weekly on those residents identified to utilize oxygen to ensure dating is correct. · Identified issues will result in further education. · Audit results will be reported, reviewed, and trended for compliance thru the Quality Assurance Committee for a minimum of 6 months and or until compliance is met at 100% for consecutive three months, at which time QA committee may determine/recommend altering plan of correction.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain			

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	management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview and record review the facility failed to assess a new onset of pain, treat a new onset of pain and failed to notify the physician of a resident experiencing an new onset of pain for 1 of 4 resident's reviewed for pain (Resident 42) Finding include: During an observation on 7/10/23 at 11:51 a.m., Resident 42 was standing in the hallway with her left hand clenched in a tight ball. CNA 6 asked the resident if she had something in her hand and attempted to open the resident's left hand, the resident yelled "that hurts", QMA 7 was standing there and indicated the resident had been "doing that for awhile" with her left hand. The resident was moaning and refused to open her left hand. During an observation on 7/11/23 at 11:09 a.m., Resident 42 was sitting in the dining room and was clenching her left hand in a tight ball, the left hand was swollen and bruised and the resident was crying. The resident was guarding her left hand with her right hand. During an observation on 7/12/23 at 2:30 p.m., Resident 42 sitting in the dining room with left hand clinched, the left hand was swollen and bruised. Review of the record of Resident 42 on 7/12/23 at 1:45 p.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, cerebrovascular	F 0697	**F 697 D Pain Management** **1) Immediate actions taken for those residents identified:**· Residents # 42 was assessed, orders reviewed, and care plan updated. · Pain medication reviewed with physician. · Order received for a “palmer guard” to her left hand. **2) How the facility identified other residents:**· Any resident that resides within the facility has the potential to be affected. · No other resident has been identified to experience new pain. · Residents are identified through admission, annually, quarterly, significant change and prn.**3) Measures put into place/ System changes:**· Educated Licensed nursing staff on components/requirements of F697 Pain management; Notification of Change/Physician Notification.· The facility will ensure that pain management is provided to residents that require such services.· Care plans will be reviewed for new admission/re-admission, annually, quarterly, with significant change and prn for pain management.**4) How the corrective actions will be monitored:**· Oversight of	08/15/2023

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	disease, major depression disorder, bipolar disorder and osteoporosis. The Annual Minimum Data Set (MDS) assessment for Resident 42, dated 7/1/23, indicated the resident was severely impaired for daily decision making. The resident had mild pain occasionally in the last five days. During an interview with the Director Of Nursing (DON) on 7/12/23 at 2:55 p.m., indicated there was no documentation of the Resident 42's left hand pain and the physician had not been notified about the new onset of left hand pain. During an interview with RN 8 on 7/12/23 at 3:09 p.m., indicated no staff had reported Resident 42's left hand pain on 7/10/23 or 7/11/23. During an interview with RN 9 on 7/12/23 at 3:00 p.m., indicated the staff had just now reported to him about Resident 42's left hand pain, bruising and swelling. RN 9 indicated he was not sure if the resident had an injury or was getting contracted. During an interview with the DON on 7/12/23 at 3:05 p.m., indicated she notified the physician of Resident 42's left hand pain and got an order to have an x-ray. The change in condition policy provided by the Executive Director (ED) on 7/14/23 at 11:30 p.m., indicate the guidelines were developed to ensure all significant changes in resident status were thoroughly assessed and physician notification was based on the assessment findings. This was to be documented in the resident resident medical record. Medical care problems were communicated to the attending physician in a timely, concise and thorough manner. The nurse should not hesitate		this plan of correction is the facility Director of Nursing/designee who will conduct audits on new admissions/readmissions to ensure pain has been assessed and managed. · New admissions will be reviewed during scheduled clinical meetings to ensure that any pain concerns have been addressed. · Identification of new pain will be determined through interview and observation of 3 residents weekly to ensure pain medication regime is effective.· Concerns identified during interviews will be reviewed during scheduled morning meetings for rapid resolution.· Results of audits will be taken to QA monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	to contact the attending physician at any time for a problem which in his or her judgment required immediate medical intervention. 3.1-37(a)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview and record review the facility failed to have adequate staffing on the memory care unit to provide care, monitor, intervene and provide services in a safe manner	F 0725	**F 725 Sufficient Nursing Staff** **1) Immediate actions taken for those residents identified:** · Staffing patterns were	08/15/2023

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	for 4 of 4 random resident observations. (Resident 151, Resident 52, Resident 48 and Resident 21). Finding include: During an observation on 7/10/23 at 12:54 p.m., Resident 151 was wandering up and down the hallway, entering other resident rooms. During an observation on 7/10/23 at 12:54 p.m., Resident 151 was wandering up and down the hallway, entering other resident rooms. During an observation on 7/11/23 at 10:58 a.m., there were 5 residents sitting in the dining room there were no staff present. Resident 52 stood up from his geriatric chair and indicated he was leaving the resident was unstable on his feet and pulling his catheter tubing as he was moving away from his geriatric chair. The resident was half way over his arm rest of the chair. Was unable to locate staff on the memory care unit, except for housekeeper 11. Housekeeper 11 indicated she was not trained to assist residents, but would try to help keep the resident from falling. Housekeeper 11 talked with the resident and moved his geriatric chair around and underneath him so he could sit down. During an observation on 7/11/23 at 2:40 p.m.., Resident 48 was sitting in the dining room with no residents or staff. Resident 48 grabbed the facility laptop computer that was sitting on a desk in the dining room and threw it on the floor. The resident was crying and yelling "I quit this job, I don't want to work here anymore". There were two people standing at the medication cart and they indicated they were from the pharmacy and did not work at the facility. Went down the hallway to		reviewed/revised to ensure appropriate staffing levels were met for the memory care unit. Residents # 51, #52, #48 and #21 were assessed and care plans reviewed and updated as needed. **2) How the facility identified other residents:** · Any resident that resides on the memory care unit had the potential to be affected, however no adverse effects were identified. **3) Measures put into place/ System changes:** · Communication devices (Walkie Talkies) have been provided to facilitate communication between memory care staff and the general population. · Education provided on operation of communication devices to facility staff. · Staffing will be reviewed daily by the Administrator/Director of Nursing and to determine appropriate staffing available to meet the needs of the residents. · Facility Managers that provide direct resident care will be placed on the daily schedule. · Provision of On-Call rotation to support staffing needs. · The manager on duty for weekend rotation will review and ensure staffing is appropriate. · If problems are noted the Administrator/On Call staff are contacted.	

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	locate staff and found Resident 21 and his family member in the supply room. Resident 21's family requested help to get her husband out of the supply room. Resident 157 came into the supply room and was standing over Resident 21 and his family member. Resident 21's family member indicated she did not know what to do, she needed help and was fearful. This surveyor was unable to locate any staff on the memory care unit and left the secured unit and went to the main part of the building and reported to the Director Of Nursing (DON) what was occurring on the memory care unit. The DON and approximately 5 other staff went to the memory care unit. Two CNA's came out of a resident's room whom they were providing incontinent care to. During an interview with the Executive Director on 7/12/23 at 11:14 a.m., indicated there were 17 residents residing on the locked memory care unit. During an interview with Confidential Staff 12, indicated the memory care unit worked with one CNA or a CNA and a QMA. There was not enough staff on the memory care unit to provide Activities Of Daily Living (ADLS) such as showers, cannot prevent residents from wandering in and out of other resident rooms, cannot manage resident behaviors, the memory care unit was unsafe for residents and their quality of care was poor related to wounds, falls and behaviors. Confidential Staff 12 indicated they had to rely on housekeeping and therapy to assist when they were on the unit. Confidential Staff 12 has had to leave the memory care unit unattended to summons for help from the main part of the building when residents were having altercations. During an interview with Confidential Staff 13,		· Education provided on the provision of toileting assistance, call light response time, ADL's, **4) How the corrective actions will be monitored:** · Daily review of staffing patterns to determine an adequate staffing pattern to meet resident needs per Administrator and Director of Nursing. · Director of Nursing/designee will randomly audit 3 times weekly to include all shifts concern related to provision of care on the memory unit, which includes monitoring, and provision of safe care. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months at which time the committee may make recommendations to revise the plan of correction.	

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	indicated the memory care unit was staffed with one person most of the time, but sometimes there would be two. The Nurse that covered the unit worked out in the main part of building and only came to the memory care unit to pass medications. There was not enough staff to provide showers, monitor and intervene with behaviors. The Staff member has had to leave the memory care unit unattended to get assistance with behaviors. The Staff member has always had to use the mechanical lift by themselves which was dangerous because they are suppose to use two people. During an interview with Confidential Staff 14, indicated the memory care unit worked with one CNA or a CNA and QMA. There was not enough staff on the memory care unit and the residents were not receiving the care they deserved. The staff cannot monitor and intervene with behaviors, basic ADL's like shaving, denture care and brushing and cleaning hair. There was not enough staff to monitor residents who wander in and out of other resident rooms. The Staff member indicated falls was also a problem due to not enough staff. During an interview with Confidential Staff 15, indicated sometimes the memory care unit worked with one staff and there needs to be 3 staff on the unit due to wandering and behaviors. There was not enough staff to provide incontinent care timely and when they are providing care if a resident falls they do not even know because they are in another resident room. During an interview with Confidential Staff 16, indicated there was usually one staff on the memory care unit. The Staff member indicated Resident 52 attempts to stand up from his chair			

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	and climb out of his bed all the time and it was hard to monitor him with just one staff. There was not enough staff to provide ADL's such as showers, assist people to bed and toileting needs. There was not enough staff to monitor behaviors and wandering with just one staff. There are residents who will follow staff when they are trying to provide care and come in other resident rooms while staff is providing care because there was not anyone to distract them. During an interview with Confidential Staff 17, indicated sometimes there was only one staff on the memory care unit and that was not enough staff to provide care to the residents. During an interview with Confidential Staff 18, indicated the memory care unit worked with one or two staff. There was not enough staff to answer call lights, monitor resident, toileting needs, ADL's such as showers. Resident 52 constantly tries to stand up out of his chair and falls are a concern due to low staffing. The memory care unit was an unsafe environment for residents due to behaviors. During an interview with Housekeeper 11 on 7/13/23 at 11:20 a.m., indicated she was not allowed to assist with resident care, but on 7/11/23 it scared her when Resident 52 was climbing out of his geriatric chair she wanted to try to keep him from falling. Housekeeper 11 indicated Resident 52 did stand up a lot out of his chair, but she had never seen him climb out like he did that day. The CNA care sheet for the memory care unit provided by the Social Service Director on 7/13/23 at 1:30 p.m., indicated 7 residents required 1 staff members assistance for transfers, one resident required 2 staff members assistance for transfers			

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	and 4 residents required a mechanical lift for transfers. There were 10 residents who used a wheelchair, 1 resident who used a walker and 4 residents who ambulated independently. 3.1-17(a)			
F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to provide eight hours of RN coverage for 2 of 6 days triggered reviewed in Quarter 2 of Fiscal Year 2023 and 1 of 1 days randomly selected for Quarter 2 of Fiscal Year 2023. Findings include: A Payroll Based Journal (PBJ) report, compiled on 7/5/202, indicated no RN hours were reported for six days, including 1/22/2023 and 1/29/2023. Timecards were reviewed for 1/22/2023 and 1/29/2023 on 7/17/2023 at 11:45 a.m. to indicate no RN hours for these aforementioned day.	F 0727	**F 727** **1. Immediate actions taken for those residents identified:** No resident was identified to have been affected **2. How the facility identified other residents:** All residents are at risk to be affected by the deficient practice. **3. Measures put into place/system changes:** Staffing will be reviewed daily by the Administrator/Director of Nursing to determine appropriate	08/15/2023

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	Timecards for a randomly selected day, 1/28/2023, was reviewed by surveyor on 7/17/2023 at 11:45 a.m. to indicate only 5 hours and 9 minutes of RN coverage on that day. During an interview with the Executive Director on 7/17/2023 1:45 p.m. she indicated that there were no RN hours for 1/22/2023 and 1/29/2023. She stated the RN on call was not in the building at that time due to "kids" and she was unsure why there were incomplete RN hours on 1/28/2023, but it would have fallen under the same weekend as 1/29/2023. It was the expectation of the facility to follow the regulation of having eight hours of consecutive RN coverage daily. 3.1-17(b)(3)		staffing /RN coverage 8 hours daily/7days a week The Administrator and Director of Nursing were educated on the requirement of F727. **4. How the corrective actions will be monitored:** Daily review of staffing patterns to ensure RN coverage for 8 consecutive hours 7days each week The results of these audits will be reviewed in the monthly quality assurance meeting for 6 months or until 100% is achieved x3 consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
F 0744 SS=E Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview and record review the facility failed to implement an specialized memory care unit activity program and failed to implement individualized interventions for residents with dementia for 5 of 5 residents reviewed for dementia (Resident 48, Resident 42, Resident 51, Resident 157 and Resident 21). Findings include: During an observation of the memory care unit on	F 0744	**Immediate actions taken for those residents identified.** # 48,#42,#51,#157, and #21 were assessed and care plans reviewed and revised specifically related to individualized interventions related to activity program and resident preferences. **How facility identified other residents.** All residents who reside on the	08/15/2023

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	7/10/23 at 11:53 a.m., residents were sitting in the dining room, bedroom, living room and wandering up and down the hallway going in other resident rooms. There were no activities on the unit. There was no staff intervention. During an observation on 7/10/23 at 2:04 p.m., residents were sitting in the dining room, bedroom, living room and wandering up and down the hallway going in and out of other resident rooms. There were no activities on the unit. There were no staff intervention. During an observation on 7/10/23 at 12:51 p.m., Resident 48 was sitting was sitting at the door crying and attempting to leave the memory care unit when staff opened the door. The resident was yelling and screaming "I want to go out there" "I want to go home". The staff took the resident to her room. There were no activities occurring on the memory care unit. There was no staff intervention to attempt to calm the resident. During an observation on 7/10/23 at 2:38 p.m., Resident 48 was transferring herself from the bed to the wheelchair and wheeled herself to the dining room. Reported to CNA 10 that the resident was observed transferring herself from the bed to her wheelchair. Resident 48 was in the dining room crying and asking to go out into the main part of the building. There were no activities occurring on the memory care unit. The staff member told the resident she could not take her out in the main building and took the resident back down to her room. There was no staff intervention for Resident 48 being upset and crying. During an observation on 7/11/23 at 2:40 p.m.., Resident 48 was sitting in the dining room with no		memory care unit are at risk to be affected by the deficient practice. All residents on the memory care were audited by the social services and activities department to ensure plan of care includes individualized activity interventions specific to residents preferences and to ensure supportive memory care interventions. **Measures put into place/system changes**. Education provided on the circadian rhythms, dementia, and dementia behavior redirection was reviewed with all staff. Facility schedules routine nursing/environmental/and activity personnel to unit to promote continuity of care. Residents' activity preferences are communicated to staff who work the unit to ensure implemented as indicated in residents personalized plan of care. A new activity director and memory care coordinator have been hired to ensure ongoing delivery of memory care activity programming and ongoing psychosocial assessment to deliver care per residents' preference. The administrator, social services director, and activity director will participate in routine walking rounds during tour of duty to monitor that activity programming, supportive dementia care, and staffing on the memory care unit is appropriate. **How the corrective actions will**	

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	155704	A. BUILDING 00 B. WING	07/17/2023

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	residents or staff. Resident 48 grabbed the facility laptop computer that was sitting on a desk in the dining room and threw it on the floor. The resident was crying and yelling "I quit this job, I don't want to work here anymore". There were no activities occurring on the memory care unit. There were no staff intervention for the Resident 48 being upset. Went down the hallway to locate staff and found Resident 21 and his family member in the supply room. Resident 21's family requested help to get her husband out of the supply room. Resident 157 came into the supply room and was standing over Resident 21 and his family member. Resident 21's family member indicated she did not know what to do, she needed help and was fearful. There was no staff intervention for residents wandering. During an interview with the Executive Director on 7/12/23 at 11:14 a.m., indicated there were 17 residents residing on the locked memory care unit. 1.) Review of the record of Resident 48 on 7/14/23 at 10:40 a.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, pulmonary fibrosis, acute and chronic respiratory failure, peripheral vascular disease, dementia, psychotic disturbance, anxiety and hypertension. The plan of care for Resident 48, dated 4/27/23, indicated the resident liked group activities like bingo, coffee time, exercises, daily chronicle, games, parties, music, live entertainment and arts/crafts. The interventions included, but were not limited to, encourage and support the development of a new skill, interest or hobby, invite/encourage/escort this resident to group activities of choice, provide any needed supplies and assistance for activities.		**be monitored.** The responsible party for this plan of correction is the Administrator or other designee. An audit will be conducted 3 times per week to determine that activities are scheduled 7days per week, evening activities scheduled and provided at least 2x weekly, and outdoor/outings activities are scheduled monthly. Residents who refuse to attend activities are provided alternate programs. Audits will be reviewed monthly during quality assurance and will continue for 6 months or until 95% compliance is achieved for 3 consecutive months.	

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	The Admission Minimum Data Set (MDS) assessment for Resident 48, dated 5/12/23, indicated the resident was severely impaired for daily decision making. The resident had a behavior of wandering daily. It was somewhat important to listen to music, be in groups of people, doing her favorite activities and attending religious activities, very important to be around animals and go outside and get fresh air The plan of care for Resident 48, dated 7/7/23, indicated the resident had impaired safety/injury related to secured unit for dementia for smaller environment and programming. The interventions included, but were not limited to, distract resident when wandering/insistent on leaving facility by offering pleasant diversions, structured activities, food, conversation, television, books, encourage resident to avoid secured doorways to avoid 2.) During an observation on 7/10/23 at 12:55 p.m., Resident 42 was laying on the couch in the living room. There were no activities occurring on the memory care unit. During an observation on 7/11/23 at 11:00 a.m., Resident 42 was laying on the couch in the living room. There were no activities occurring on the memory care unit. Review of the record of Resident 42 on 7/12/23 at 1:45 p.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, cerebrovascular disease, major depression disorder, bipolar disorder and osteoporosis. The activity care plan for Resident 42, dated			

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	3/2/23, the resident was dependent on staff for emotional, intellectual, physical, and social stimulation. The resident liked individual activities, listening to music, singing, dancing, watching TV, attending to her baby doll and stuffed animals. The interventions included, but were not limited to, staff to converse with the resident while providing care, invite and lead the resident to scheduled activities and the resident needs set up for independent activities if having behaviors. The Annual Minimum Data Set (MDS) assessment for Resident 42, dated 7/1/23, indicated the resident was severely impaired for daily decision making. It was somewhat important for the resident to have books, newspapers, magazines and attend religious services. It was very important for her to listen to music, be around animals, keep up with the news, do things in groups of people, do her favorite activity and go outside to get fresh air. 3.) During an observation on 7/10/23 at 12:53 p.m., Resident 51 was sitting in his recliner in his room. There were no activities occurring on the memory care unit. During an observation on 7/11/23 at 10:58 a.m., Resident 51 was sitting in the dining room at a table by himself, with 5 other residents in the dining room. There were no activities occurring on the memory care unit. Review of the record of Resident 51 on 7/13/23 at 12:40 p.m., indicated the resident's diagnoses included, but were not limited to, unsteady on feet, weakness, diabetes, hypertension, anxiety, major depressive disorder, dementia , psychotic disturbance, arthritis and Parkinson's disease.			

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	The Admission Minimum Data Set (MDS) for Resident 51, dated 4/20/23, indicated the resident was severely impaired for daily decision making. It was somewhat important for the resident to have books, newspapers and magazines. It was very important for the resident to listen to music, be around animals, keep up the news and do his favorite activities. The care plan for Resident 51, dated 4/11/23, indicated the resident had a diagnosis of dementia and required a secure unit for smaller programming/activities. The interventions included, but were not limited to, encourage to participate in activities and redirect away from unsafe areas or other resident rooms. The plan of care for Resident 51, dated 6/21/23, indicated the resident had impaired activity and recreational pursuits related to physical and cognitive impairments. The resident would attend most group activities if he was invited and transported to them. The interventions included, but were not limited to, assist the resident and introduce him to fellow residents, escort to and from activities, encourage /invite participation in activities of interest, models and projects, cooking, gardening, movies, music, parties, pets, care games and daily chronicle. 4.) During an observation on 7/10/23 at 12:54 p.m., Resident 157 was wandering the memory care unit. There were no activities occurring on the memory care unit. There was no staff intervention. During an observation on 7/11/23 at 10:55 a.m., Resident 157 was wandering the memory care unit. There were no activities occurring on the memory care unit. There was no staff intervention.			

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	During an interview with Resident 157's family member on 7/11/23 at 11:16 a.m., indicated they visited the resident daily and had never seen activities occurring on the memory care unit. The family member indicated the resident liked jokes, loved going outside, always had a garden, loved music and use to play the guitar. Review of the record of Resident 157 on 7/17/23 at 12:30 p.m., indicated the resident's diagnoses included, but were not limited to, dementia with behavioral disturbance and psychosis. The plan of care for Resident 157, dated 6/6/23, indicated the resident was at risk for altered activity patterns/pursuits related to the resident was dependent on staff for activities, cognitive stimulation, and social interaction. The resident needed socialization, displays cognitive deficits, encourage to engage in programming. The resident resides on a secured unit. The Admission Minimum Data Set (MDS) for Resident 157, dated 6/13/23, indicated the resident was severely impaired for daily decision making. It was very important for the resident to listen to music, do his favorite activity and go outside to get fresh air, somewhat important to be around animals and do things in groups of people. 5.) Review of the record of Resident 21 on 7/17/23 at 12:15 p.m., indicated the resident's diagnoses included, but were not limited to, Alzheimer's disease, anxiety, dementia and major depressive disorder. During an interview with the Activity Aide on 7/17/23 at 11:05 a.m., indicated the facility did not have an Activity Director and there was no			

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	Activity Aide assigned to the memory care unit. The Dementia unit policy provided by the Executive Director on 7/12/23 at 2:25 p.m., indicated the facility had developed specialized areas to serve those living with dementia and the associated challenges. It has been shown that individuals living with dementia benefit from specialized environments to meet their unique needs. The facility adopted dementia specific interactions and interventions to increase quality of life for the residents they serve. The Interdisciplinary Team (IDT) would assess whether the potential resident's current cognitive, medical, physical, and emotional state can be appropriately served, given current resources available, that the resident can benefit form the cognitively/socially oriented services provided on the memory care unit. The potential resident shall demonstrate that they can benefit, even passively from the specialized memory care activity programming. 3.1-37(a)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted			

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	professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident			

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	reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review, the facility failed to complete an inventory sheet and failed to have staff or resident/resident's representative sign the inventory sheet upon discharge. Findings include: On 7/14/23 at 9:38 a.m., an interview with a family member for Resident 156 was completed. The family member indicated Resident 156 had been discharged the day before, and all his things he brought here; his phone, clothes, etc., were packed in boxes by her and removed from the facility. The family member indicated she didn't fill out any kind of an inventory sheet when he was admitted, and no one filled out or had her sign one when she removed his clothing and other items from the facility. Resident 156's record was reviewed on 7/14/23 at 12:46 p.m. The record indicated Resident 156 had diagnoses that included, but were not limited to, cognitive communication deficit, cancer in the	F 0842	**F 842 D Resident Records-Identifiable Information** **1) Immediate actions taken for those residents identified:** · Resident #156 was discharged from the facility, family received residents' belongings. **2) How the facility identified other residents:** · Any resident that resides within the facility had the potential to be affected, however none were identified. **3) Measures put into place/ System changes:** · Facility wide audit conducted to identify inventory record completion. · Staff educated on completion of inventory records upon admission. **4) How the corrective actions will be monitored:** · Responsible party for this	08/15/2023

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	abdominal cavity, seizure disorder, high blood pressure, and muscle wasting. On 7/14/23 at 2:38 p.m., the Vice President of Leadership Development provided a copy of Resident 156's personal effects inventory, and indicated that was all she had, she didn't know if anything had been brought in after he was admitted. The personal effects inventory indicated there were no clothes, shoes, or furniture listed on the inventory sheet, and the only items listed were a cell phone and charger, and a walker. A policy for "Admission of Resident" was provided by the Vice President of Leadership Development on 7/14/23 at 2:45 p.m. and indicated this was the only policy they had regarding inventory sheets. The policy included, but was not limited to "Purpose: To facilitate a smooth transition into a healthcare environment...Policy...6. Take itemized inventory of resident's personal effects including items of value and complete the inventory sheet...." 3.1-50(a)		plan of correction is the Director of Nursing/designee. · New admission audits will be completed within 48 hours of admission to identify completion of inventory records. · Electronic record maintenance will be reviewed monthly during Quality Assurance Meetings until 100% compliance has been achieved for 3 months. · QA committee will make recommendations to revise the plan of correction as indicated.	
F 0851 SS=D Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff.			

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	Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing			

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	information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. Based on interview and record review, the facility failed to accurately report the RN coverage hours for 4 of 6 days triggered on a Payroll Based Journal Report for Fiscal Year 2023 Quarter 2. Findings include: A Payroll Based Journal (PBJ) report, compiled on 7/5/2023, indicated no RN hours were reported for six days, including 1/8/2023, 2/2/2023, 2/26/2023, and 3/26/2023. During an interview with the Executive Director on 7/17/2023 1:45 p.m. she indicated that a previous Director of Nursing (DON 6) had been in the building for eight consecutive hours on 1/8/2023 and the current Director of Nursing (DON) had completed the eight consecutive hours of RN coverage for 2/2/2023, 2/26/2023, and 3/26/2023. She was unsure why these hours were not captured on the PBJ report and was still waiting to hear from their reporting partners. The facility's expectation was that all nursing hours are reported accurately to the PBJ.	F 0851	F 851 D Payroll Based Journal 1) Immediate actions taken for those residents identified: · No resident was identified to have been affected. 2) How the facility identified other residents: · No resident was identified to have been affected. 3) Measures put into place/ System changes: · Staffing will be reviewed daily by the Administrator/Director of Nursing and to ensure RN coverage is available per requirement. · The provision of On-Call rotation to support RN coverage is reviewed during daily morning meetings to ensure coverage. · Facility will accurately report RN coverage hours per requirement. 4) How the corrective actions will be monitored:	08/15/2023

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			· Staffing patterns and RN coverage are reviewed daily per Executive Director/designee. · Facility will submit direct care staffing information on specified schedule per CMS but no less than frequently than quarterly. · PBJ will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. · The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	