STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155104	A. BUILDING 00 B. WING	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE CENTER	1201 W BUENA VISTA RD EVANSVILLE, IN 47710

(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: March 11, 12, 13, 14, 15, 18, 19, 2024. Facility number: 000043 Provider number: 155104 AIM number: 100290960 Census Bed Type: SNF/NF: 128 Total: 128 Census Payor Type: Medicare: 13 Medicaid: 90 Other: 25 Total: 128 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 28, 2024.	F 0000	*Submission of the plan of correction is not an admission of guilt by the facility related to the alleged deficiencies noted in the 2567. The facility would like to formally request paper compliance.*	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview and record review, the facility failed to ensure the MDS (Minimum Data Set) Assessment was completed accurately for 1 of 1 resident reviewed for elopement and 1 of 5 residents reviewed for falls. (Resident 117, Resident 115)	F 0641	*Submission of the plan of correction is not an admission of guilt by the facility related to the alleged deficiencies noted in the 2567. The facility would like to formally request paper*	04/08/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Adam Strickland	HFA	04/12/2024

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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	Findings include: 1. On 3/15/24 at 9:30 A.M., Resident 117's clinical record was reviewed. Diagnosis included, but was not limited to, dementia. The most recently Quarterly MDS Assessment, dated 12/29/23, indicated Resident 117 had severely impaired cognition and did not use a wander/elopement alarm during the 7-day look back period. Physician orders included, but were not limited to: Secure Care bracelet applied to right ankle. Check placement per nursing measure. Expiration: May 2024, dated 3/15/24. Secure Care bracelet applied to ankle. Check placement per nursing measure every shift for Elopement Prevention, starting 8/23/2023 and discontinued on 3/15/24. The December 2023 TAR (treatment administration record) indicated Resident 117's Secure Care bracelet was applied and checked three times daily in December except on 12/17/23 during the evening shift. A current behaviors care plan, dated 8/23/23, indicated Resident 117 required a Secure Care device due to wandering and exit seeking behaviors. On 3/15/24 at 12:15 P.M., Resident 117 was observed sitting in a recliner with a Secure Care bracelet on her right ankle. On 3/18/24 at 9:35 A.M., MDS Coordinator 9 indicated that wander/elopement alarm should be marked on the 12/29/23 MDS Assessment, and		*compliance.* F 641 Accuracy of Assessments ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** MDS has audited and modified resident 117's elopement/secure care alarm MDS assessment. MDS has audited and modified resident 115's fall/chair alarm MDS assessment. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** All residents have the potential to be affected by the alleged deficient practice and through audits/assessments, alterations in processes and in servicing the facility will ensure correct actions will be taken to accurately assess/code elopement and fall MDS assessments for all residents. ***What measures will be put into place and what systematic changes will be made to ensure the deficient practice does not recur;*** MDS will be in-serviced on accurate completion of elopement	

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	that it was a coding error. 2. On 3/13/24 at 2:50 P.M., Resident 115's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and history of falling. The most recent Quarterly MDS Assessment, dated 2/22/24, indicated Resident 115 had severe cognitive impairment, used a bed alarm daily, and did not use a chair alarm. Physician orders included, but were not limited to: Nursing to check placement and functioning of bed/chair alarm every shift for resident safety, dated 12/29/23. The February 2024 MAR indicated the placement and functioning of the bed/chair alarm was checked three times daily in February. A current falls care plan, revised 11/30/23, included an intervention "bed/chair alarm", dated 10/13/23. On 3/11/24 at 11:58 A.M., Resident 115 was observed sitting in a wheelchair in the dining room of the Wellsprings Unit with a chair alarm in place. On 3/19/24 at 9:21 A.M., MDS Coordinator 7 indicated the chair alarm was coded wrong on the 2/22/24 Quarterly MDS Assessment and should have been checked. At that time, she indicated that the facility followed the RAI (Resident Assessment Instrument) User Manual. The RAI User Manual indicated "Chair alarm includes devices such as a sensor pad placed on the chair or wheelchair or a device that clips to the resident's clothing ... Wander/elopement alarm		and fall MDS assessments. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;*** MDS/Designee(s) will monitor 3 random residents for accurate elopement and fall MDS assessments daily x 5 days a week for 4 weeks, then 3 x a week for 4 weeks, then weekly with results of compliance being forwarded to QA committee monthly x4 months and quarterly thereafter for review and further suggestions/comments. ***By what date the systematic changes for each deficiency will be completed;*** Completion Date 4-8-2024	

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	includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn by/attached to the resident that activate an alarm and/or alert the staff when the resident nears or exits a specific area or the building. This includes devices that are attached to the resident's assistive device (e.g., walker, wheelchair, cane) or other belongings".			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review, interview, the facility failed to ensure preventative measures were in place or orders were followed to prevent an ulcer from forming and progressing for 1 of 2 residents reviewed for facility acquired skin ulcers. (Resident 11) Findings include: On 3/14/24 at 8:26 A.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, type 2 diabetes mellitus, Alzheimer's disease, and restless leg syndrome.	F 0686	**Heritage Center** **Annual Recertification and Licensure Survey** **Plan of Correction** **3-19-2024** *Submission of the plan of correction is not an admission of guilt by the facility related to the alleged deficiencies noted in the 2567. The facility would like to formally request paper compliance.*	04/08/2024

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	The most recent Quarterly MDS Assessment, dated 2/20/24, indicated Resident 11 was cognitively intact, required extensive assistance of two staff for mobility, transfers, and toileting, and was receiving oxygen therapy. Current physician orders included, but were not limited to: Daily skin check If any new area of skin impairment found, follow altered skin integrity policy. Every day make note if new area found. Start date 1/20/24. Cleanse daily with normal saline, Betadine, and apply foam dressing every shift for left achilles pressure area. Start date 3/7/24. Assess left Achilles Pressure ulcer and dressing daily. Start date 3/8/24. Doxycycline Hyclate (antibiotic) Oral Tablet 100 MG (milligrams) Give 1 tablet by mouth two times a day for left heel wound for 7 Days. Start date 3/14/2024. Current care plans included, but were not limited to: "I have potential for altered skin/pressure injury, date initiated 3/2/21; [nursing staff provide] daily skin checks, date initiated 12/28/22." On 3/19/24 at The DON provided a treatment administration record for the following order for the month of February and March 2024: Daily skin check. If any new area of skin impairment found, follow altered skin integrity policy every day shift make note if new area found; start date 1/20/24. The following dates during February and March 2024 lacked a documentation of completion for this order: 2/9/24 2/13/24		F 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** Resident 11 received a skin assessment and Braden. Care plan, physician orders, TAR, and interventions related to pressure ulcer prevention/treatment audited, updated as needed, implemented, and staff educated to ensure appropriate/followed. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** All residents have the potential to be affected by the alleged deficient practice and through audits/assessments, alterations in processes and in servicing the facility will ensure correct actions will be taken to assess, treat and prevent pressure ulcers for all residents. All residents received skin assessment and Braden. Care plans, physician orders, TAR, CNA assignment sheets, interventions related to pressure ulcer prevention/treatment were audited, updated (as needed), implemented and staff will be educated to ensure	

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	2/16/24 2/20/24 3/8/24 A progress note on 3/6/24 at 1:47 P.M., indicated Resident 11 approached staff and requested pain medication due to pain in the left leg and and left ankle, and staff "will continue to monitor". Documentation between 3/6/24 at 1:47 P.M. to 3/7/24 4:21 P.M. lacked follow up or assessment of the area in pain indicated by Resident 11. An initial skin/wound note on 3/7/24 at 4:21 P.M. indicated an unstageable pressure area, acquired in facility, was found. Measurements included "H 4.3cm(centimeters), L 2.2cm, W 2.3cm". The wound was unable to be staged due to the amount of slough/eschar (dead/necrotic tissue) and serous exudate (drainage) present. A progress note on 3/11/24 at 6:23 P.M., indicated Resident 11 had odor and purulent (containing pus/infection) drainage coming from the pressure area on the left achilles. The physician was notified. A progress note on 3/12/24 at 10:20 A.M. indicated an order received for Keflex Oral Capsule 500 MG (antibiotic) Give 500 mg by mouth four times a day for Wound for 7 Days. A skin and wound evaluation dated 3/12/24 indicated the left achilles wound measured 3.2 cm(centimeters) in length, and 2.0 cm in width, area of 5.6 cm, and was unable to be staged due to the amount of slough and purulent drainage present. During an interview on 3/19/24 at 2:31 P.M., the DON (Director of Nursing) indicated Resident 11		appropriate/followed. ***What measures will be put into place and what systematic changes will be made to ensure the deficient practice does not recur;*** Nursing will be in-serviced on the importance of completing wound prevention measures including daily skin checks and required follow up (as needed). ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;*** DON/Designee(s) will complete visual rounds throughout the facility to monitor 3 random residents to ensure skin assessments, care plans, interventions, orders are up to date/implemented, and treatments completed related to all pressure ulcer prevention measures as well as monitor 3 random employees to ensure they have access to, a physical copy of an updated CNA assignment sheet on their person, and are ensuring interventions are in place daily x 5 days a week for 4 weeks, then 3 x a week for 4 weeks, then weekly x 4 months with results of compliance being forwarded to QA committee quarterly thereafter for review and further suggestions/comments. ***By what date the systematic***	

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	did have an order for daily skin checks, was unsure how the wound on Resident 11's left achilles happened, and indicated the wound could have been left untreated and unchecked for 24 hours. A skin assessment or altered skin integrity policy was requested on 3/19/24 at 10:29 A.M, but was not provided. A policy titled Pressure Injury Prevention and Management, revised 12/23, was provided by the Administrator on 3/19/24 at 11:47 A.M., and indicated the policy is "To ensure that a resident who is admitted to the facility receives care consistent with professional standards of practice to prevent pressure ulcers...and prevent additional pressure injuries from developing. All dressings/pressure injuries will be assessed daily". 3.1-40(a)(1)		***changes for each deficiency will be completed;*** Completion Date 4-8-2024	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure residents received consistent implementation of interventions to prevent falls for 2 of 5 residents reviewed for accidents related to falls. Fall	F 0689	**Heritage Center** **Annual Recertification and Licensure Survey** **Plan of Correction** **3-19-2024**	04/08/2024

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	interventions were observed out of place, and care plans were not updated following falls. (Resident 115, Resident 86) Findings include: 1. On 3/13/24 at 2:50 P.M., Resident 115's clinical record was reviewed. The resident was admitted to the facility on 9/7/23 following surgical repair of a right shoulder fracture from a fall that occurred at the resident's home. Diagnoses included, but were not limited to, dementia and history of falling. The most recent full Admission MDS (Minimum Data Set) Assessment, dated 9/12/23, indicated Resident 115 had severe cognitive impairment, required extensive assistance of 2 or more staff for bed mobility and transfers, required extensive assistance of 1 or more staff for toileting, and had fallen resulting in a fracture in the 6 months prior to admission. No alarms were used. The most recent Quarterly MDS Assessment, dated 2/22/24, indicated Resident 115 had severe cognitive impairment, required extensive assistance of 2 or more staff for bed mobility, transfers, and toileting, and had 2 or more falls with no injury since the prior assessment and 2 or more falls with injury (not major) since the prior assessment. A bed alarm was used daily. A chair alarm was not used. An admission fall risk assessment, dated 9/7/23, indicated Resident 115 was at high risk for falls. The most current quarterly fall risk assessment, dated 2/22/24, indicated Resident 115 was at high risk for falls.		*Submission of the plan of correction is not an admission of guilt by the facility related to the alleged deficiencies noted in the 2567. The facility would like to formally request paper compliance.* F 689 Free of Accident Hazards/Supervision/Devices ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** Resident 86 and 115 were assessed for falls, fall care plan, interventions, physician orders, Fall Prevention sheets audited, and updated (as needed) to ensure appropriate/followed. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** All residents have the potential to be affected by the alleged deficient practice and through audits/assessments, alterations in processes and in servicing the facility will ensure correct actions will be taken related to all residents being assessed for falls, fall care plan, interventions, physician orders, Fall Prevention sheet will be audited, and updated	

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	Physician orders included, but were not limited to: Nursing to check placement and functioning of bed/chair alarm every shift for resident safety, dated 12/29/23. Falls prevention measures in place per care plan every shift, dated 9/7/23. The admission comprehensive falls care plan, dated 9/7/23, included the following interventions: Remind resident to use call light for assistance before transferring, initiated 9/7/23 and resolved 11/30/23. Bed in lowest position, initiated 9/7/23. Offer non-skid socks and/or non-skid shoes, initiated 9/7/23. Instruct on use of call light, initiated 9/7/23. Ensure frequently used items are within reach: call system, glasses, light cord, water, phone, tissues, initiated 9/8/23. The clinical record indicated Resident 115 sustained 24 falls from 9/12/23 through 1/25/24. Fall 1 9/12/23 at 1:30 A.M. Fall was not witnessed. The resident fell while attempting to use the bathroom unassisted. The new immediate nursing intervention was "bed in lowest position". Intervention "Add reminder sign to use call light at bedside" was added to the care plan on 9/12/24. Fall 2 9/12/23 at 7:35 P.M. Fall was not witnessed. The resident "stated that she crawled on the floor". The new immediate nursing intervention was "monitor reswal [sic]". Intervention "Toilet after supper and offer to place in bed" was added to the care plan on 9/13/23. Fall 3		(as needed) to ensure appropriate/followed. ***What measures will be put into place and what systematic changes will be made to ensure the deficient practice does not recur;*** Nursing will be in-serviced on fall care plans, interventions, physician orders, and that staff know how to access and understand the importance of using Fall Prevention sheets ensuring all interventions are appropriate/followed.. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;*** DON/Designee(s) will complete visual rounds throughout the facility to monitor 3 random residents to ensure fall interventions are care planned/implemented following a fall, no repeat fall interventions, no continue current fall interventions, the Fall Prevention sheet is updated with correct interventions and located in binder on unit, and monitor 3 random employees to ensure they know of /have access to/on their person/and are following the fall interventions outlined in the Fall Prevention sheet daily x 5 days a week for 4 weeks, then 3 x a week for 4	

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	9/17/23 at 8:12 A.M. Fall was not witnessed. The resident fell while attempting to use the bathroom unassisted. The resident complained of pain in her right arm and bruising was noted. The new immediate nursing intervention was "bed and chair alarms". Intervention "Bed/chair alarm" was added to the care plan on 9/18/23. Fall 4 10/17/23 at 5:30 P.M. Fall was not witnessed. The resident fell while walking in her room unassisted. The resident was documented to have a hematoma on the right side of the back of her head and a bruise on the lateral side of her right hip. The new immediate nursing intervention was "toilet res (resident) every 2 hours". A nurse's progress note, dated 10/18/23 at 10:29 A.M., indicated an order was received to send Resident 115 to the Emergency Room (ER) for treatment and evaluation after a small amount of blood was observed draining from the hematoma and the resident was unable to raise her right arm. A re-admission note, dated 10/18/23 at 4:26 P.M, indicated the resident returned from the ER with no new orders, and the CT (computed topography) scan (an imaging scan used to detect internal injuries) of the head and cervical spine was negative for injury. Intervention "Encourage resident to go to dining room for lunch and supper meals" was added to the care plan on 10/18/23. Fall 5 10/27/23 at 7:15 P.M. Fall was not witnessed. Staff found the resident on the fall mat by her bed on her knees. The new immediate nursing intervention was "continue current interventions". An IDT (Interdisciplinary Team) note, dated 10/30/23 at 9:54 A.M., indicated video monitoring would be added to the care plan.		weeks, then weekly x 4 months with results of compliance being forwarded to QA committee quarterly thereafter for review and further suggestions/comments. ***By what date the systematic changes for each deficiency will be completed;*** Completion Date 4-8-2024	

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	Intervention "video monitor in place in room to assure safety when in room" was added to the care plan one month later on 11/30/23. Fall 6 11/25/23 at 9:10 P.M. Fall was not witnessed. Staff found the resident lying on the floor next to the bed. The resident was documented to have a hematoma on the back of her head with bleeding present. The PCP (primary care physician) was notified, and orders were given to send the resident to the ER for treatment and evaluation. The new immediate nursing intervention was "continue current interventions". Intervention "remove fall mat" was added to the care plan on 11/27/23. A re-admission note, dated 11/29/23 at 2:27 P.M., indicated the resident was readmitted to the facility from the hospital with 11 staples to a laceration on the back of her head and bruising present. Fall 7 11/29/23 at 11:40 P.M. Fall was not witnessed. Staff found the resident on her knees in front of her bed. The new immediate nursing intervention was "must have floor pad in place when resident in bed". Intervention "winged mattress" was added to the care plan on 11/30/23. Fall 8 11/30/23 at 5:18 P.M. Fall was not witnessed. Staff found the resident with "her head on the floor and her body still in the chair" in a recliner in the dayroom. The new immediate nursing intervention was "Dycem in recliner or w/c [wheelchair]". Intervention "Dycem when sitting in recliner" was added to the care plan on 12/1/23. Resident 115 was admitted to hospice on 12/13/23.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HERITAGE CENTER	1201 W BUENA VISTA RD EVANSVILLE, IN 47710

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	Fall 9 12/16/23 at 12:00 A.M. Fall was witnessed through the video monitor. The resident fell while walking with her walker. The new immediate nursing intervention was "resident placed near nurse's station in recliner for closer observation". Interventions "Offer recliner in dayroom when restless" and "have hospice review meds for restlessness" were added to the care plan on 12/18/23. A social service progress note, dated 12/18/23 at 12:14 P.M., indicated the resident tested positive for COVID-19. A physician's order, dated 12/18/23 at 11:00 P.M., indicated "Strict in room isolation, single room occupancy, droplet precautions, all services brought to room, must remain in room r/t [related to] having an active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission [COVID-19] every shift for precaution" with an end date of 12/27/23. Fall 10 12/22/23 at 1:05 P.M. Fall was not witnessed. The resident fell after getting up out of bed without assistance. An initial falls note, dated 12/22/23 at 1:05 P.M., indicated the bed alarm was not in place and the chair alarm was in the bed but was not turned on. The new immediate nursing intervention was "educate staff to follow fall care plans". The care plan was not updated with a new intervention at that time. Fall 11 12/22/23 at 5:07 P.M. Fall was not witnessed. Staff			

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	saw the resident on the floor in front of her bed through the video monitor. The new immediate nursing intervention was "seat resident in recliner in room with TV [television] on [channel] or news when restless". The care plan was not updated with a new intervention at that time. Fall 12 12/22/23 at 7:07 P.M. Fall was not witnessed. Staff found the resident lying on the floor in front of her bed. The new immediate nursing intervention was "bed in lowest position, call light within reach - staff to monitor and check Q2H [every two hours]". The care plan was not updated with a new intervention at that time. Fall 13 12/25/23 at 3:00 A.M. Fall was not witnessed. Staff found the resident lying on the floor in front of her bed. The new immediate nursing intervention was "strongly recommend for resident to be moved closer to nurse's station so that staff can reach her room quicker". The care plan was not updated with a new intervention at that time. Fall 14 12/25/23 at 1:00 P.M. Fall was not witnessed. Staff found the resident sitting on her bathroom floor. There was no new immediate nursing intervention documented. The care plan was not updated with a new intervention at that time. Fall 15 12/25/23 at 2:50 P.M. Fall was not witnessed. Staff found the resident sitting on the floor in front of her bed. The new immediate nursing intervention was "re-educated regarding call, don't fall and placed call light in hand after securing to shirt and had resident demonstrate appropriate use of call light". The care plan was not updated with a new			

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	intervention at that time. Fall 16 12/25/23 at 3:50 P.M. Fall was not witnessed. Staff found the resident sitting on the floor in front of her bed. There was no new immediate nursing intervention documented. Intervention "ask family if they can provide assist [sic] to sit with resident during the day while sick with COVID" was added to the care plan on 12/26/23. Fall 17 12/28/23 at 5:33 P.M. Fall was not witnessed. The initial falls note, dated 12/28/23 at 5:33 P.M., indicated the resident was found lying on the floor next to the bed and the alarm was not sounding. The new immediate nursing intervention was "check resident Q2H [every 2 hours], falls mat ineffective d/t [due to] tripping hazard, ensure alarm is on and functioning". "Nursing to check placement and functioning of bed/chair alarm every shift for resident safety", dated 12/29/23, was added to physician's orders. The care plan was not updated with a new intervention at that time. Fall 18 12/29/23 at 1:52 P.M. Fall was not witnessed. Staff found the resident on one knee at the bedside. The initial falls note, dated 12/29/23 at 1:52 P.M., indicated the alarm was not functioning. The new immediate nursing intervention was "resident to come off isolation precautions for COVID, resident to be in common areas when aggitated [sic]". Intervention "place in common area when aggitated [sic]" and "toileting schedule" was added to the care plan on 12/29/23. Fall 19 12/30/23 at 2:00 P.M. Fall was not witnessed. Staff			

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	found the resident on her knees in front of her bed. The new immediate nursing intervention was "continue current interventions". Intervention "Assist to recliner after meals" was added to the care plan on 12/30/23. Fall 20 1/3/24 at 5:23 P.M. Fall was not witnessed. Staff found the resident sitting on the floor in front of her bed. The resident indicated she hit her head but was unable to give any other information regarding the fall. The new immediate nursing intervention was "family et [and] staff education. Staff education r/t [related to] bringing resident out of her room et into the dayroom at mealtimes et for activities. Family education to inform staff when leaving so staff can ensure interventions are in place". Intervention "educate family to let staff know when they leave so resident can be moved back to common area" was added to the care plan on 1/4/24. Fall 21 1/11/24 at 3:30 A.M. Fall was not witnessed. Staff found the resident lying on the floor near the doorway of her room. The new immediate nursing intervention was "resident needs to be moved closer to nurse's station". Intervention "room moved closer to nurses station" was added to the care plan on 1/11/24. Fall 22 1/11/24 at 9:57 A.M. Fall was witnessed. The resident was observed walking without assistance and fell. The initial falls note, dated 1/11/24 at 11:18 A.M., indicated the resident hit the back of her head against a dresser. The resident was documented to have a laceration on the back of her head with bleeding present. The initial falls note and progress notes did not indicate whether			

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	the bed alarm was sounding at that time. The new immediate nursing intervention was "checked function of bed/chair alarm - changed batteries". The PCP was notified, and orders were received to send the resident to the ER for treatment and evaluation. A physician visit note, dated 1/11/24 at 3:15 P.M., indicated the resident returned from the ER with 3 staples in place to the laceration on the back of her head with no active bleeding and orders to remove the staples in 8 days and monitor for any changes. Intervention "offer to get up in Broda to eat breakfast on back porch" was added to the care plan on 1/12/24. Facility census information indicated Resident 115 was moved to a different room on 1/12/24 at 6:26 A.M. There were no progress notes related to that move. Fall 23 1/16/24 at 3:07 P.M. Fall was not witnessed. Staff found the resident lying next to her bed in her room. The resident indicated she needed to get the blankets off the bed. The new immediate nursing intervention was "continue with current intervention". Intervention "Hospice to review meds" was added to the care plan on 1/17/24. Fall 24 1/25/24 at 8:25 P.M. Fall was not witnessed. Staff found the resident sitting on the floor next to her bed. The resident indicated she was trying to get up. The new immediate nursing intervention was "bed bolster to side of bed not against wall". Intervention "floor alarm" and "low bed" were added to the care plan on 1/26/24. On 3/14/24 at 11:38 A.M., Resident 115 was			

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	observed sitting in a wheelchair while participating in an activity with a chair alarm in place. The gray cord going from the chair alarm pad to the alarm box attached to the back of her wheelchair was not plugged in and hanging on the floor, and the lights on the alarm box were not on. On 3/14/24 at 11:56 A.M., CNA (Certified Nurse Aide) 4 indicated the cord to Resident 115's chair alarm was not plugged in and the alarm was not functioning. At that time, she indicated the cords had been loose and staff made a request for new ones, but they had not received them. On 3/14/24 at 11:59 A.M. in an interview with Resident 115's family member, it was indicated that the alarms were not always plugged in when she visited. At that time, she indicated she had made her concerns regarding the safety of the resident known to staff during a previous care conference meeting. On 3/17/24 at 11:30 A.M., the DON (Director of Nursing) indicated care plans should be updated with new and relevant interventions following a fall. She indicated that nurses would update the care plan immediately after a fall and the MDS Coordinator updated the care plans once an intervention was agreed upon in the IDT meeting. On 3/19/24 at 9:21 A.M., MDS Coordinator 7 indicated the chair alarm was coded wrong on the 2/22/24 Quarterly MDS Assessment and it should have been checked. 2. On 3/18/24 at 11:08 A.M., Resident 86's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, history of falling, and muscle weakness. The most recent Quarterly			

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	MDS, dated 2/20/24, indicated Resident 86 was severely cognitively impaired and required extensive assistance of 1 staff for mobility, transfers, and toileting. Current physician orders included, but were not limited to: Fall prevention measures in place per careplan every shift, start date 10/6/23. Ativan (antianxiety) 2MG/ML (milligrams/milliliter) Give 0.25 mL sublingually at bedtime for anxiety, restlessness. Start date 3/11/24 Morphine 20 MG/ML Give 0.25 mg/mL by mouth every 30 minutes as needed for pain until comfortable. Start date 11/13/24 Current care plans included, but were not limited to: I have a history fall with T11 fracture prior to my admission and have experienced fall with left hip fracture since my admission, remain at risk for fall with injury related to muscle weakness, impaired balance, impaired cognition related to dementia, use of narcotic. Interventions include: Bed/chair alarm date initiated 11/6/23, revision on 3/5/24; Floor mat at bedside date initiated 3/5/24; Video monitor in room date initiated 12/18/23; Bed in lowest position date initiated 10/6/23. Falls that occurred, and interventions implemented following each fall, in the past 5 months were recorded in the clinical record: Fall 1 An initial falls note, dated 10/14/23 at 12:05 A.M., indicated Resident 86 had an unwitnessed fall in her room. The new intervention placed following the fall stated "Remind resident to call for assist". Fall 2			

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	An initial falls note, dated 12/16/23 at 10:30 P.M., indicated Resident 86 had an unwitnessed fall in the room of another Resident. The new intervention placed following the fall stated "Resident brought to nurse's station to ease with anxiety/confusion." Fall 3 An initial falls note, dated 12/21/23 at 10:09 A.M., indicated Resident 86 had an unwitnessed fall in her room. The new intervention placed following the fall was blank . Fall 4 An initial falls note, dated as a late entry on 1/6/24 at 10:15 P.M., indicated Resident 86 had an unwitnessed fall in her room. The new intervention placed following the fall was blank. Fall 5 An initial falls note, dated as a late entry on 2/17/24 at 2:30 P.M., indicated Resident 86 had an unwitnessed fall in her room and the pressure alarm was on silent at the time of the fall. The new intervention placed following the fall stated a medication review would be completed per hospice. Fall 6 An initial falls note, dated as a late entry 2/23/2024 at 7:10 P.M., indicated Resident 86 had an unwitnessed fall in her room. The new intervention placed following the fall stated "Continue current interventions." During an observation on 3/19/24 at 8:45 A.M., Resident 86's video monitor was facing the window and was not in view of the Resident, and no bed or chair alarm were in the Resident's room. RN 5 indicated staff turn the camera when			

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	providing care and forgot to turn the camera back within view of the Resident, and that the bed alarm was removed due to the Resident no longer weighing enough to keep the sensor working properly. During an observation on 3/19/24 at 10:53 A.M., RN 5 indicated Resident 86's bed should be in the lowest position but was not in the lowest position, and lowered the bed to the lowest position. During an interview on 3/19/24 at 2:31 P.M., the DON indicated the interdisciplinary team was going to discontinue orders and care plans but we have been too busy update documentation due to the survey being in progress. The clinical record lacked documentation regarding communication with hospice or documentation that orders or care plans pertaining to falls were to be discontinued during the survey review period from 3/11/24 to 3/19/24. On 3/19/24 at 8:51 A.M., the Administrator provided a current Interdisciplinary Care Plans policy, revised 9/23, that indicated "Assessments are made and revisions of the care plan are completed as necessary to maintain a current profile of the resident. A weekly high-risk meeting will be held to discuss with IDT...any other high risk residents for potential significant changes, to include but not limited to falls ... Progress or lack of progress toward their goals or approaches should be addressed at this time". On 3/19/24 at 8:51 A.M., the Administrator provided a current Falls Checklist for Incident/Accident Report, revised 8/2023, that indicated "An intervention is something that you			

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	will do to prevent another fall from occurring. Look at previous interventions, if the same intervention has been used do not use this intervention again. Intervention must be appropriate for the fall. Do not leave this portion out. You must have an intervention ... This intervention must be added to Care Plan and put in progress note". 3.1-45(a)(2)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure the appropriate care of the PEG (Percutaneous Endoscopic Gastromy)/ G-tube (Gastromy) tube	F 0693	**Heritage Center** **Annual Recertification and Licensure Survey** **Plan of Correction**	04/08/2024

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	feeding tubing for 1 of 2 residents. The tubing lacked a date when changed, label of contents, and initials of the nursing staff. (Resident 1) Findings include: On 3/12/24 at 1:07 P.M., Resident 1's tube feeding container was observed hanging in the room on an IV pole on a pump. The feeding bag lacked a label of what the formula was and a date of when the tubing was changed. On 3/13/24 at 1:10 P.M., Resident 1's tube feeding container was observed hanging in the room on an IV pole on a pump. The feeding bag lacked a label of what the formula was and a date of when the tubing was changed. On 3/13/24 at 2:53 P.M., Resident 1's clinical record was reviewed. Diagnoses included but were not limited to, diffuse traumatic brain injury with loss of consciousness greater than 24 hours with return to pre-existing conscious level and persistent vegetative state. The most current Quarterly MDS (Minimum Data Set) Assessment dated 2/4/24 indicated Resident 1 was severely cognitively impaired and was totally dependent on all care. Physician orders included but were not limited to: Jevity 1.5 Cal Liquid (Nutritional Supplements).Give 60 ml/hr. (Milliliters per hour) via G-Tube (Gastromy) every shift for feeding continuous via pump x 20 hr (off from 9:30 A.M. -1:30 PM). When hanging feeding document rate, date and time on the bottle place Nurses initials. Chart total amount of feeding in TAR (Treatment Administration Record) dated 2/15/22.		**3-19-2024** *Submission of the plan of correction is not an admission of guilt by the facility related to the alleged deficiencies noted in the 2567. The facility would like to formally request paper compliance.* F 693 Tube Feeding Mgmt/Restore Eating Skills ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** Resident 1's tubing and feeding bag was changed, dated, labeled appropriately, and initialed by nursing staff. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** Any resident requiring a PEG/G-tube and feeding have the potential to be affected by the alleged deficient practice and through audits/assessments, alterations in processes and in servicing the facility will ensure correct actions will be taken related to tubing and feeding bag being changed, dated, labeled appropriately, and initialed by nursing staff.	

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	The current care plan indicated the Resident 1 required a feeding tube to meet nutritional needs related to the vegetative state, anoxic brain damage. Interventions included but were not limited to, document date, rate, time and initial bottle/bag, tubing. Change feeding supplies at least every 24 hours. Change formula and water administration tubing every 24 hours and prn. (as needed) During an interview on 3/19/24 at 10:25 A.M., the ADON (Assistant Director of Nursing) indicated tube feeding and tubing should be changed every 24 hours. The bag should be labeled with the date, type, flow rate. On 3/19/22 at 11:46 A.M., the Administrator provided the current Manufacturer's label for Jevity 1.5 cal (calorie) indicating that as a precaution the formula should not hang longer than 24 hours. On 3/19/24 at 8:51 A.M., the Administrator provided a current policy "Enteral Tube Feedings" revised 10/23 indicated "...the feedings must be used within the date limitations and hung only as long as the manufacturer suggestions. 3.1-44(a)(2)		***What measures will be put into place and what systematic changes will be made to ensure the deficient practice does not recur;*** Nursing will be in-serviced on the importance PEG/G-tube and feeding bag being changed, dated, labeled appropriately, and initialed by nursing staff. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;*** DON/Designee(s) will complete visual rounds throughout the facility to monitor 3 random residents requiring a PEG/G-tube and feeding bag to ensure changed, dated, labeled appropriately, and initialed by nursing staff daily x 5 days a week for 4 weeks, then 3 x a week for 4 weeks, then weekly x 4 months with results of compliance being forwarded to QA committee quarterly thereafter for review and further suggestions/comments. ***By what date the systematic changes for each deficiency will be completed;*** Completion Date 4-8-2024	

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure oxygen equipment was properly labeled and oxygen properly administered for 3 of 6 residents at risk for respiratory complications. (Resident 10, Resident 55, Resident 11) Findings include: 1. On 3/12/24 at 1:30 P.M., an oxygen humidification water bottle dated 3/5/24 without an oxygen storage bag was observed in Resident 10's room. On 3/13/24 at 1:03 P.M., an oxygen humidification water bottle dated 3/5/24 without a oxygen storage bag was observed in Resident 10's room. On 3/13/24 at 12:46 P.M., Resident 10's clinical record was reviewed. Diagnoses included but were not limited to, malignant neoplasm of unspecified part of bronchus or lung and chronic pain syndrome. The current Quarterly MDS (Minimum Data Set) Assessment dated 12/20/23 indicated the resident was severely cognitively impaired, needed	F 0695	**Heritage Center** **Annual Recertification and Licensure Survey** **Plan of Correction** **3-19-2024** *Submission of the plan of correction is not an admission of guilt by the facility related to the alleged deficiencies noted in the 2567. The facility would like to formally request paper compliance.* F 695 Respiratory/Tracheostomy Care and Suctioning ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** Resident 10's humidification bottle and O2 tubing was changed, bagged, and labeled appropriately. Resident 55's O2 tubing was changed, bagged, and labeled	04/08/2024

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	155104	A. BUILDING 00 B. WING	03/19/2024

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	extensive assistance with 2 people for mobility, transfer, and toileting, and used oxygen. Current physician orders included but were not limited to: Change O2 (Oxygen) tubing and supplies every evening shift every Tuesday (Tuesday) for Maintenance dated 9/5/23. Oxygen at 1-2 liters per nasal cannula d/t (due to) hypoxia at bedtime every evening and night shift for hypoxia and check O2 sats (saturations) routinely dated 9/1/23. The current care plan indicated the resident has atrial fibrillation that increases the risk for decreased cardiac output. Interventions included but were not limited, administer oxygen as ordered and monitor oxygen saturations as needed/ordered. 2. On 3/12/24 at 9:53 A.M., the oxygen tubing was observed in Resident 55's room on the oxygen concentrator, in an undated storage bag. On 3/14/24 at 10:00 A.M., Resident 55's clinical record was reviewed. Diagnoses included but were limited to, major depressive disorder and unspecified dementia without behavioral disturbance. The current Annual MDS Assessment dated 1/27/24 indicated the resident was cognitively impaired, needed extensive assist with assist of 2 for all activities of daily living and used oxygen. Current physician orders included but were not limited to, change O2 tubing and supplies every evening shifts every Tuesday for Maintenance date 6/29/23.		appropriately. Resident 11's oxygen saturation level was obtained, O2 was checked to ensure placement/turned on/functioning as ordered, and staff educated on physician notification related altered O2 condition. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken;*** All residents have the potential to be affected by the alleged deficient practice and through audits/assessments, alterations in processes and in servicing the facility will ensure correct actions will be taken related to humidification bottle and O2 tubing being changed, bagged, labeled appropriately, oxygen saturation levels obtained, O2 checked to ensure placement/turned on/functioning as ordered, and that physician notifications are made related altered O2 conditions. ***What measures will be put into place and what systematic changes will be made to ensure the deficient practice does not recur;*** Nursing will be in-serviced on the importance of humidification bottle and O2 tubing being changed, bagged, labeled appropriately,	

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	The current care plan indicated the resident has an altered cardiovascular status and interventions include but were not limited to oxygen as ordered by the physician. On 3/14/24 at 9:41 A.M., QMA (Qualified Medicine Aide) 12 indicated tubings are changed at night. They will not date the canula tubing just the bag. This is their policy. QMA 12 also indicated the oxygen people will come every Tuesday and clean and maintenance the concentrators. 3. On 3/14/24 at 8:26 A.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease, chronic respiratory failure with hypoxia, and dependence on supplemental oxygen. The most recent Quarterly MDS Assessment, dated 2/20/24, indicated Resident 11 was cognitively intact, required extensive assistance of two staff for mobility, transfers, and toileting, and was receiving oxygen therapy. Active physician orders included, but were not limited to: O2 (oxygen) @2/l (liters) per/m (minute) per NC (nasal cannula) continuous every shift for to relieve hypoxia, start date 2/9/24. Elevate head of bed at all times due to the shortness of breath while lying flat related to the diagnoses of COPED, start date 2/9/24. Current care plans included, but were not limited to: "I have COPD. I require use of oxygen and my hob (head of bed) elevated, date initiated 5/5/22. Monitor for report to physician signs/symptoms/complications related to		oxygen saturation levels obtained, O2 checked to ensure placement/turned on/functioning as ordered, and that physician notifications are made related altered O2 conditions. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;*** DON/Designee(s) will complete visual rounds throughout the facility to monitor 3 random residents to ensure humidification bottle and O2 tubing is changed, bagged, labeled appropriately, oxygen saturation levels obtained, O2 checked to ensure placement/turned on/functioning as ordered, and that physician notifications are made related altered O2 conditions daily x 5 days a week for 4 weeks, then 3 x a week for 4 weeks, then weekly x 4 months with results of compliance being forwarded to QA committee quarterly thereafter for review and further suggestions/comments. ***By what date the systematic changes for each deficiency will be completed;*** Completion Date 4-8-2024	

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	respiratory status change such as: change in respirations, decline in pulse oximetry/oxygen saturation, increased heart rate, restlessness, lethargy/confusion, use of accessory muscle, change in skin color, changes in lung sounds." A progress note, dated 3/9/24 at 2:56 P.M., indicated Resident 11 was anxious, belly breathing, had an oxygen saturation of 67%, and was not wearing the nasal cannula for oxygen. Staff elevated Resident 11's head of the bed, and increased the oxygen to 4 liters; Resident 11's oxygen saturation rose to 91%. The documentation lacked a notification to the physician in relation to Resident 11's altered condition. A progress note, date 3/12/24 at 10:46 P.M., indicated Resident 11 had an oxygen saturation of 66% on 2 liters of oxygen, and was experiencing short and shallow respirations. Staff increased Resident 11's oxygen to 4 liters; Resident 11's oxygen saturation rose to 94%. The documentation lacked a notification to the physician in relation to Resident 11's altered condition. A progress note, dated 3/14/24 at 12:17 P.M., indicated Resident 11 had an oxygen saturation of 78% on 4 liters of oxygen, and appeared blue when staff entered the Resident's room. The documentation lacked a notification to the physician in relation to Resident 11's altered condition. A progress note, dated 3/14/24 at 4:22 P.M., indicated Resident 11 was receiving 4 liters of oxygen through a nasal cannula, had very little movement in lungs, no movement noted in bilateral bases, using abdominal muscles to			

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	breath, was reaching for items not there, and making a lot of jerking movements in lower extremities. The clinical record lacked an oxygen saturation obtained or a notification to the physician in relation to Resident 11's altered condition. During an observation on 3/19/24 at 10:11 A.M., Resident 11 was transferred by two staff from the bed to the wheelchair using a mechanical lift. RN 8 observed as CNA 6 removed the Resident's nasal cannula from the oxygen concentrator during transfer, and attached the nasal cannula to the portable oxygen tank hanging on the Resident's wheelchair after the transfer was completed. CNA 6 began to wheel Resident 11 to activities without turning on the portable oxygen tank. During an interview on 3/19/24 at 10:23 A.M., CNA 11 indicated Resident 11 should be receiving 2 liters of oxygen through nasal cannula and indicated the portable oxygen tank was not turned on, and turned the oxygen to 2 liters at that time. RN 8 checked Resident 11's oxygen saturation after the portable oxygen tank was turned on, and the pulse oximetry read 93%. On 3/19/24 at 1:05 P.M., the Administrator provided a current policy "Respiratory Change Policy" revised 9/23. The policy indicated "... all supplies will be in bags marked with room number and date the change outs are made..." On 3/19/24 at 1:05 P.M., the Administrator provided a current policy titled "Oxygen Administration", revised 9/23, and indicated "The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the			

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	physician's orders for oxygen administration... Adjust the oxygen delivery device so that so that it is comfortable for the resident and the proper flow of oxygen is being administered. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated." 3.1-47(a)(6)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or			

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	written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, record review, and interview, the facility failed to post the actual shift times worked of licensed and unlicensed nursing staff directly responsible for resident care per shift daily for 9 of 9 days reviewed. Finding includes: During an observation, on 3/15/24 at 1:11 P.M., the staff numbers posted at the Harbor nurses station reflected the census was 126 residents. The form indicated staff worked one half or three quarters of a shift and did not include the actual shift times worked by nursing staff. On 3/19/24 at 11:23 A.M., staff posting sheets were provided by the Administrator for the following dates: 3/11/24 3/12/24 3/13/14 3/14/24 3/15/24 3/16/24 3/17/24 3/18/24 3/19/24 Each staff posting sheet included the date, census, and total hours each discipline was in the building. Disciplines included RN (registered	F 0732	**Heritage Center** **Annual Recertification and Licensure Survey** **Plan of Correction** **3-19-2024** *Submission of the plan of correction is not an admission of guilt by the facility related to the alleged deficiencies noted in the 2567. The facility would like to formally request paper compliance.* F 732 Posted Nurse Staffing Information ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*** No residents were affected by the deficient practice. The Posted Nurse Staffing Sheet was updated to reflect the actual hours worked. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective***	04/08/2024

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	nurse), LPN (licensed practical nurse), QMA (qualified medication aide), and CNA (certified nursing aide). The actual shifts worked by each shift were not included on the sheets. During an interview on 3/19/24 at 11:48 A.M., the Administrator indicated he could not determine which portion of a shift nursing staff worked by looking at the facilities nursing staffing sheet. On 3/19/24 at 11:23 A.M., a Posted Nurse Staffing policy, dated 12/2023, was provided by the Administrator and indicated "The facility posts the following information daily: 3. The hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: registered nurses, licensed practical nurses, and certified nurse aides".		***action will be taken;*** No residents have the potential to be affected by the deficient practice. ***What measures will be put into place and what systematic changes will be made to ensure the deficient practice does not recur;*** Nursing Schedular will be in-serviced on ensuring the Posted Nurse Staffing Sheet reflects the actual hours worked. ***How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;*** DON/Designee(s) will complete visual rounds throughout the facility on all units to monitor and ensure the Posted Nurse Staffing Sheets are updated and reflect actual hours worked daily x 5 days a week for 4 weeks, then 3 x a week for 4 weeks, then weekly x 4 months with results of compliance being forwarded to QA committee quarterly thereafter for review and further suggestions/comments. ***By what date the systematic changes for each deficiency will be completed;*** Completion Date 4-8-2024	