STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 00 B. WING	10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GOLDEN LIVING CENTER-ELKHART	1001 W HIVELY AVE ELKHART, IN 46517

(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: September 27, 28, 29, 30 & October 1, 2021 Facility number: 000039 Provider number: 155685 AIM number: 100275130 Census Bed Type: SNF/NF: 85 Total: 85 Census Payor Type: Medicare: 8 Medicaid: 75 Other: 2 Total: 85 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on October 8, 2021.	F 0000		
F 0561 SS=E Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including			

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

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	sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on observation, interview and record review, the facility failed to ensure showers were provided in a timely manner and per their preference, for 4 of 4 residents reviewed for showers. (Residents 15, 28, 57 & 7) Findings include: 1. On 9/27/2021 at 2:25 P.M., Resident 57's hair was observed to be unwashed and unkempt. During an interview, on 9/27/2021 at 2:25 P.M., Resident 57 indicated he was not receiving his showers as scheduled. A clinical record review, was conducted, on 9/28/2021 at 11:40 A.M., and indicated Resident 57's diagnoses included but were not limited to: chronic obstructive pulmonary disease, type 2 diabetes and stage 4 chronic kidney disease.	F 0561	**F561 Self Determination** **The facility requests paper compliance for this citation**. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #28 no longer resides in	11/01/2021

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	A Shower Schedule form, dated 2/14/2021, indicated Resident 57 was scheduled to receive showers on Mondays and Thursday nights. A form, titled "RESIDENT SHOWER SHEET/SKIN CONCERN DOCUMENTATION", indicated Resident 57 received a shower on 7/13/2021, 7/16/2021 and 9/28/2021. Certified Nursing Assistant task documentation indicated Resident 57 had a shower on 7/10/2021, 9/6/2021 and 9/8/2021. Resident 57's medical record indicated no further showers had been received. During an interview, on 9/28/2021 at 3:01 P.M., the Interim DON (Director of Nursing) indicated there were no further documented showers available. 2. During an observation on 9/27/2021 at 3:16 P.M., Resident 15's nails and hair were dirty. A clinical record review was completed on, 9/29/2021 at 9:18 A.M., and indicated Resident 15's diagnoses included, but were not limited to: Alzheimer's disease, diabetes, anxiety disorder, dysphagia, and hallucinations. A quarterly MDS (Minimum Data Assessment), dated 8/30/2021, indicated Resident 15 had a BIMS (Brief Interview for Mental Status) score of 99, indicating the assessment was not able to be completed. Resident 15 required total assistance for bathing. A current care plan, dated 9/3/2020, indicated the resident had a physical functioning deficit related to requiring assist with adls (activities of daily living) due to dementia and schizophrenia and		facility. Resident #15, 57, and 7 were given showers once it was discovered that they did not have showers per their preferences. **2) How the facility identified other residents:** Audit conducted to determine if other residents shower preferences were being honored. Those affected were offered showers. Care plans and tasks reviewed and updated accordingly. **3) Measures put into place/ System changes:** Activity Director has been working with current residents and new residents to capture their shower preferences and those are documented in residents' profiles. The facility has now dedicated shower aide to offer showers to residents based on their preferences. Staff inserviced on how identifying and document shower schedule in POC. **4) How the corrective actions will be monitored:** DNS or designee will audit showers documentation 10x weekly for 4 weeks, then 10x monthly to ensure that residents are receiving showers per their preferences. Results of these audits will be reviewed in QAPI monthly for 6 months or until 100% compliance is achieved x3 consecutive months. Results of the audits will	

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	having impaired mobility. Interventions included, but were not limited to: bathing assistance dependant of one staff, and encourage choices with care. A current care plan, dated 5/10/202, indicated the resident preferred to take showers. A shower schedule for the south hall, indicated the resident was to receive a shower on Monday and Thursday evenings. Resident 15's shower documentation dated 8/1/2021 through 9/20/2021, indicated Resident 15 did not receive a shower on: 8/2, 8/5, 8/16, 9/9, 9/16, 9/20 and 9/23/2021 as he was scheduled to. During an observation on 9/30/2021 at 2:29 P.M., Resident 15 was observed with white long whiskers to her chin. 3. A clinical record review was completed on 9/28/21 at 3:07 P.M., and indicated Resident 28's diagnoses included, but were not limited to: dementia, delusional disorder, retention of urine, and hallucinations. A quarterly MDS (Minimum Data Set) assessment, dated 7/7/2021 indicated the resident required total assistance for bathing. A current care plan, dated 3/5/2019, indicated the resident had a physical functioning deficit related to impaired mobility and cognition, diagnosis of dementia. Interventions included, but were not limited to: bathing assistance -staff assist of one. A shower schedule for the south hall, indicated the resident was to receive a shower on Tuesday and Friday evenings.		be adapted or adjusted as need to maintain compliance. **5) Date of compliance:** 11.1.2021	

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Resident 28's shower documentation dated 8/1/2021 through 9/20/2021, indicated Resident 28 did not receive a shower on: 8/6, 8/13, 8/16, 8/31, 9/7, 9/10, 9/14, 9/17, 9/24, 9/28/2021 as scheduled.

During an interview, on 10/1/2021 at 11:49 A.M., the Director of Nursing indicated the residents should receive 2 showers weekly. 4. During an interview, on 9/27/21 at 3:23 P.M., Resident 7 indicated she did not get her showers regularly and wanted to have her showers at least 2 times a week.

A record review was conducted, on 9/30/21 at 11:05 A.M., for Resident 7 and indicated her diagnoses included, but were not limited to, Alzheimer's disease, sleep disorders, schizoaffective disorder, bipolar disorder, major depressive disorder, paranoid schizophrenia, attention-deficit hyperactivity disorder, anxiety disorder and dementia with behavioral disturbance,

A Quarterly MDS (Minimum Data Set) assessment, dated 9/15/21, indicated Resident 7 was cognitively intact.

A Care Plan, dated 8/2/21, indicated Resident 7 would like to receive showers any day during the week in the afternoon, and an intervention, dated 8/2/21, to "...Please remind and encourage me to take showers twice a week in the afternoons on any day of the week as requested...."

A bathing/showering Kardex, revised 8/7/21, indicated Resident 7 was to receive showers 2 times weekly on Monday and Thursday evenings.

A Resident Preferences Evaluation, dated 6/6/21,

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	indicated it was very important for Resident 7 to choose between a tub bath, shower, bed bath, or sponge bath, and her bathing preference was a shower. A Resident Preferences Evaluation, dated 9/1/21, indicated it was very important for Resident 7 to choose between a tub bath, shower, bed bath, or sponge bath, and her bathing preference was a shower. The shower documentation, for the month of July 2021, indicated Resident 7 received a shower on 7/17 and 7/21/21 and no refusals had been documented. The shower documentation, for the month of August 2021, indicated Resident 7 received a shower on 8/30/21 and had 1 refusal documented on 8/11/21. The shower documentation, for the month of September 2021, indicated Resident 7 received a bed bath on 9/16 and a shower on 9/13 and 9/29. No refusals documented. No documentation present in the progress notes for refused showers for the month of July, August or September 2021. There was no documentation for shower refusals in the progress notes present for review. During an interview, on 9/30/21 at 11:42 A.M., LPN (Licensed Practical Nurse) 12 if a resident refuses a shower it is documented in the progress notes and on the shower sheets. During an interview, on 9/30/21 at 2:22 P.M., the Corporate Consultant indicated Resident 7 should have her showers as per her preference 2 times weekly.			

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	A policy was provided by the on 9/30/21 at 2:54 P.M., titled "Resident Self Determination and Participation (Schedules)",undated , and indicated this was the policy currently used by the facility. The policy indicated "...Choose activities, schedules, and providers of health care services consistent with his or her interests, assessments and plans of care...Make choices about aspects of his or her life in the facility that are significant to the resident...Plans of care should be considerate of resident preferences and routines, to help avoid problem behaviors...." 3.1-3(u)(1) 3.1-3(u)(3)			
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at			

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	the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).			

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	(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on interview and record review, the facility failed to ensure residents were able to appeal a facility-initiated transfer prior to being discharged from the facility for 1 of 1 residents reviewed for facility-initiated transfers (Resident 89). Findings include: On 9/28/21 at 3:57 P.M., the closed record for Resident 89 was reviewed. Diagnoses included, but were not limited to, diabetes and partial amputation of finger with osteomyelitis (bone infection). The resident admitted to the facility following hospitalization and further need for intravenous antibiotics to treat his bone infection.	F 0622	**F622 Transfer and Discharge Requirements** **The facility requests paper compliance for this citation**. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or*	11/01/2021

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	He was discharged on 8/6/21. An admission MDS (Minimum Data Set) assessment, dated 7/10/21, indicated a BIMS (Brief Interview Mental Status) of 14-no cognitive impairment. He had delusions and behaviors not directed at others during the assessment. A care plan, dated 7/15/21, indicated the resident would like to discharge back to the community. The goal was for him to be able to go home safely when his care and rehab goals were met. Interventions were to educate him or his care giver about his medications, side effects and how to take them; help arrange for any equipment needed; and help with any services needed. Progress notes indicated the following: -8/6/21 at 5:19 p.m., late entry for 8/3/21 at 4:12 p.m., the Social Services Director (SSD) had spoken with Resident 89 regarding his discharge. He indicated he did not want to go home with the friends he had been living with before. The SSD spoke with the ED (Executive Director) who indicated the facility would be pay for a hotel for a week. The resident didn't have a physician so an appointment was made for him at a clinic. "Per therapy he no longer needs OT/PT (Occupational/Physical therapy) as he is at baseline and able to do his ADL's for himself" and "per nursing, he is able to do his own dressing changes". A hotel room would be secured for him at [hotel] prior to his discharge on Friday, 8/6/21. Resident 89's insurance was contacted to arrange discharge transportation and the SSD was told to call back the day of discharge on 8/6/21. -8/6/21 at 5:06 p.m., the ED and SSD met with the resident as he was refusing to discharge and reported he still had antibiotics to take. He was		*executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #89 no longer in the facility. **2) How the facility identified other residents:** All discharges for the past 30 days have been reviewed to ensure appeal rights were given. Appeal rights were mailed to any affected residents. **3) Measures put into place/ System changes:** ED has educated SSD on transfer and discharge requirements. SSD/designee will review all admissions to determine discharge plans and will provide appeal rights accordingly **4) How the corrective actions will be monitored:** SSD or designee will audit all new admit discharge plans x5 weekly for 4 weeks, then x10 monthly. Results of these audits will be reviewed in QAPI monthly for 6 months or until 100% compliance is achieved x3 consecutive months. Results of the audits will be adapted or adjusted as need to maintain compliance. **5) Date of compliance:** 11.1.2021	

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	reminded of a conversation "last Friday" and told that his antibiotic had ended on 8/6/21 and he would discharge on that day. Discharge paperwork indicated the paperwork had been incomplete per the facility checklist. The forms had a place for the resident to sign his name signifying that the discharge plan had been reviewed with him and he understood the information, his questions answered and copy of the plan given to him. Resident 89 signed the form and dated it 8/5/21. He wrote a note below his signature that stated "Has not been reviewed with me on this wrongful discharge". A copy of the Notice of Transfer or Discharge indicated the reason for the residents discharge was that the resident's health had improved sufficiently so the resident no longer needed the services provided by the nursing facility. The notice indicated the resident was informed of the Notice of Transfer or Discharge and wanted to appeal the discharge and requested a hearing on the facility's decision to discharge him from the facility. The notice had no signature or date of when the form had been provided to the resident nor was there a signature or date when the appeal was requested. On 10/1/21 at 11:00 A.M., the ED and SSD were interviewed. They indicated the resident's discharge had not been completed per regulations or facility policy and he had been discharged prior to his appeal being heard. The SSD indicated when the resident admitted to the facility, it was short term and only until his course of IV antibiotics were completed. The resident was to discharge back to the home he had lived in previously but had changed his mind. When questioned, the ED indicated the resident had not been discharged from his managed care insurance company but had finished the IV antibiotics he			

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	had been receiving skilled services for. A current policy, titled "Transfer and Discharge (including AMA)", was provided by the ED on 10/1/21 at 11:18 A.M. and stated the following: "Policy: It is the policy of this facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility except in limited situations when the health and safety of the individual or other residents are endangered...'Facility-initiated transfer or discharge' is a transfer or discharge which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences...When a resident exercises his or her right to appeal a transfer or discharge, the facility will not transfer or discharge the resident while the appeal is pending...." 3.1-12(a)(10)			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described			

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	in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form			

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	155685	A. BUILDING 00 B. WING	10/01/2021

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	and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as			

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	the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on interview and record review, the facility failed to notify the Ombudsman of discharges for 2 of 3 residents reviewed for Ombudsman notification (Resident 89 and Resident 32). Findings include: 1. On 9/28/21 at 3:57 P.M., the closed record for Resident 89 was reviewed. Diagnoses included, but were not limited to, diabetes and partial amputation of finger with osteomyelitis (bone infection). The resident admitted to the facility following hospitalization and further need for intravenous antibiotics to treat his bone infection. A Discharge Return not anticipated MDS (Minimum Data Set) assessment, dated 8/6/21, indicated Resident 89 discharged to the community. An admission MDS (Minimum Data Set) assessment, dated 7/10/21, indicated a BIMS (Brief Interview Mental Status) of 14-no cognitive impairment. He had delusions and behaviors not directed at others during the assessment. An undated Notice of Transfer or Discharge form indicated the reason for the residents discharge was that the resident's health had improved sufficiently so the resident no longer needed the services provided by the nursing facility. The notice indicated the resident was informed of the Notice of Transfer or Discharge and wanted to appeal the discharge and requested a hearing on the facility's decision to discharge him from the facility. The notice had no signature or date of when the form had been provided to the resident	F 0623	**F623 Notice Requirements before Transfer/Discharge** **The facility requests paper compliance for this citation**. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Ombudsman has been notified of residents #89 and 32 being discharged and/or transferred to the hospital respectively. **2) How the facility identified other residents:** All residents who transferred/discharged in the past 30 days have been reviewed to ensure the Ombudsman was notified and notifications made for any affected residents. **3) Measures put into place/ System changes:** ED has educated SSD on transfer and discharge notification to	11/01/2021

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	nor was there a signature or date when the appeal was requested. On 10/1/21 at 11:00 A.M., the Social Services Director was interviewed. She indicated the Ombudsman had been notified of the resident's discharge per the facility's monthly notification but had not been notified timely, that the resident had been discharged prior to his appeal being heard. 2. A record review was conducted, on 9/29/21 at 1:00 P.M., for Resident 32 and indicated his diagnoses included, but were not limited to, chronic obstructive pulmonary disease, post-traumatic stress disorder, major depressive disorder, alcohol dependence with alcohol-induced persisting dementia and generalized anxiety disorder. A Discharge Return Anticipated MDS (Minimum Data Set) assessment, dated 6/1/21, indicated Resident 32 discharged to an acute hospital. A Quarterly MDS assessment, dated 7/12/21, indicated Resident 32 had severe cognitive impairment and had a re-entry to the facility on 6/3/21 from acute hospital. No Ombudsman notification available for review for Resident 32. During an interview, on 9/29/21 at 1:45 P.M., SSD (Social Service Director) indicated she did not send notifications to the ombudsman when a resident goes to the hospital, and was unaware the Ombudsman needed notified for a hospital discharge. A policy was provided by the on 9/29/21 at 2:45 P.M., titled "Transfer and Discharge (including AMA)", undated, and indicated this was the		Ombudsman requirements. SSD or designee will notify the State Ombudsman of any transfers or discharges via monthly list. **4) How the corrective actions will be monitored:** SSD or designee will audit all discharges or transfers for the last 30 days and notify the Ombudsman for any residents affected by the deficiency. SSD will continue to monitor discharge and transfer residents with x5 weekly audits for 4 weeks, then x10 monthly. Results of these audits will be reviewed in QAPI monthly for 6 months or until 100% compliance is achieved x3 consecutive months. Results of the audits will be adapted or adjusted as need to maintain compliance. **5) Date of compliance:** 11.1.2021	

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	policy currently used by the facility. The policy indicated "...Social Service Director, or designee, shall provide notice of transfer to a representative of the State Long-Term Care Ombudsman via monthly list...." 3.1-12(a)(6)(A)			
F 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the			

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	resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, record review and interview, the facility failed to ensure a care plan for smoking was developed for 1 of 21 residents whose care plans were reviewed. (Resident 10) Finding includes: On 9/28/21 at 2:46 P.M., Resident 10 was observed to be smoking. A record review was conducted, on 9/28/21 at 3:04 P.M., for Resident 10 and indicated his diagnoses included, but were not limited to, severe protein-calorie malnutrition, vitamin B12 deficiency anemia and hypotension. A Quarterly MDS (Minimum Data Set), dated 9/17/21, indicated Resident 10 was cognitively intact. A Smoking Safety Evaluation, dated 9/7/21, indicated Resident 10 utilized tobacco. There were no smoking care plans available for review. During an interview, on 9/28/21 at 3:33 P.M., the	F 0656	**F656 Development/Implement Comprehensive Care Plan** **The facility requests paper compliance for this citation**. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Care plan for resident #10 has been reviewed/revised to reflect current plan of care. **2) How the facility identified other residents:** Care plan for all current smokers	11/01/2021

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	SSD (Social Service Director indicated there was not a care plan for smoking for Resident 10, but there should be one. 3-1-35(a)		have been reviewed and updated accordingly to ensure current care plans accurately reflect resident's smoking status. **3) Measures put into place/ System changes:** ED educated Social Services, Activities, Admissions, and Nursing on implementing Comprehensive Care Plans for residents. Admissions Director will notify SSD of new residents who are smokers and Activities and Nursing will notify SSD if a resident starts to smoke after admissions. **4) How the corrective actions will be monitored:** SSD or designed will audit all residents for smoking status. Any unknown smokers will be identified, and care plans updated accordingly. All current smokers will have smoking care plans reviewed and updated accordingly. New admissions will be audited x5 weekly for 4 weeks, then x10 monthly. Results of these audits will be reviewed in QAPI monthly for 6 months or until 100% compliance is achieved x3 consecutive months. Results of the audits will be adapted or adjusted as need to maintain compliance. **5) Date of compliance:**	

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F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview, and record review, the facility failed to revise the care plan for 2 of 23 residents whose care plans were reviewed. (Resident 12 & 28) Findings include:	F 0657	**F657 Care Plan Timing and Revision** **The facility requests paper compliance for this citation**. *This Plan of Correction is the center's credible allegation of compliance.*	11/01/2021

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	1. On 9/28/21 at 3:34 P.M., Resident 12's record was reviewed. Diagnoses included, but were not limited to, paranoid schizophrenia, bulimia nervosa, Parkinson's disease, and muscle wasting and atrophy. A care plan, initiated on 6/2/21, indicated the resident was at risk for dental problems related to broken, missing or dental caries. The goal was to be free of complications related to dental or oral issues. Interventions were to provide assistance with oral care as needed, inspect the oral cavity for bleeding of gums or other issues and medication and/or treatment as ordered. On 9/27/21 at 2:08 P.M., Resident 12 was observed lying in his bed. He complained of pain in his mouth. His front bottom teeth were observed to be broken and in poor condition. He indicated he was using a mouth rinse which helped but was waiting on the facility to set up an appointment with the dentist. On 9/30/21 at 3:45 P.M., Resident 12 was again, observed lying in his bed. He complained of his mouth still hurting, that it now hurt to eat, and the roof of his mouth was "burning". When questioned, he indicated he hadn't been told about getting a dental appointment and he hadn't been given any pain medication but thought he needed something for the mouth pain. Nurse Notes indicated the following: -8/24/21 at 3:47 p.m., the resident had been seen by the dentist and a referral given to contact an oral surgeon for tooth extractions. -9/20/21 at 3:39 p.m., the facility Nurse Practitioner had been in to see the resident who had		*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Residents #10 and 12 Care Plans were revised to reflect current needs. **2) How the facility identified other residents:** All residents had the potential to be affected by the alleged deficient practice. No residents had ill effect from the alleged deficient practice. **3) Measures put into place/ System changes:** IDT team were in-serviced on Care Plan timing and revision. Director of Nursing services or design will review 24 hour report to ensure all residents with acute changes have their care plans revised to reflect their current condition. **4) How the corrective actions will be monitored:** Residents with acute conditions will be audited 5x weekly for 4 weeks, then 10x monthly. Results of these audits will be reviewed in QAPI monthly for 6	

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	complained of mouth and gum pain. New orders were received for an oral antiseptic mouth rinse 2 times per day for 10 days. There were no further nurse notes regarding the resident's mouth/gum pain nor was an appointment for the oral surgeon documented as being completed. The care plan hadn't indicated Resident 12 was having acute mouth/teeth pain, that he had been referred to the oral surgeon, or how the mouth pain affected his ability to eat and drink. On 10/1/21 at 11:15 A.M., the Director of Nursing was interviewed and indicated acute dental issues should be put onto the resident's care plan. 2. A clinical record review was completed on 9/2820/21 at 3:07 P.M., and indicated Resident 28's diagnoses included, but were not limited to: dementia, delusional disorder, retention of urine, and hallucinations. A quarterly MDS (Minimum Data Assessment), dated 7/7/2021, indicated the resident was receiving a psychotropic medication. A current care plan, dated 12/4/2020, indicated the resident was receiving an anti-psychotic medication (Olanzapine) for a diagnoses of psychotic disorder with delusions. Resident 28's current physician orders, dated October 2021, lacked the order for the antipsychotic medication. The medication had been discontinued in August. During an interview, on 10/1/2021 at 11:55 A.M., the Director of Nursing indicated the care plan should have been updated.		months or until 100% compliance is achieved x3 consecutive months. Results of the audits will be adapted or adjusted as need to maintain compliance. **5) Date of compliance:** 11.1.2021	

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	On 10/1/2021 at 3:30 P.M., the Corporate Nurse provided the policy titled, "Care Plan Revision Upon Status Change" undated, and indicated the policy was the one currently used by the facility. The policy indicated"...The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. d. The care plan will be updated with new or modified interventions...." 3.1-35(d)(2)(b)			
F 0659 SS=D Bldg. 00	483.21(b)(3)(ii) Qualified Persons §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to administer medications per physician orders for 1 of 1 residents reviewed for physician orders (Resident 12). Findings include: On 9/28/21 at 3:34 P.M., Resident 12's record was reviewed. Diagnoses included, but were not limited to, paranoid schizophrenia, bulimia nervosa, Parkinson's disease, and muscle wasting and atrophy. An admission MDS (Minimum Data Set) assessment, dated 6/17/21, indicated a BIMS (Brief Interview Mental Status) of 14-no cognitive	F 0659	**F659 The facility has Qualified Staff to Care for its Residents. The facility requests paper compliance for this citation**. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is*	11/01/2021

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	impairment. He had no behaviors observed during the assessment. A Care Plan, dated 5/26/21, indicated the resident had a diagnosis of paranoid schizophrenia which put him at risk for target behaviors of refusing care and agitation. The goal was for noted target behaviors to be redirected. Interventions included, but were not limited to, give medications as per doctors orders. A hospital transfer form with medication orders, dated 5/18/21 upon admission, was for Haloperidol Decanoate (antipsychotic) 100 mg/ml (milliliter)-1 ml intramuscular every 3 weeks for schizophrenia. There was a note on the order that indicated "unable to determine when next dose is due". A physician order, dated 5/20/21, was for Haloperidol Decanoate solution 100 mg/ml-"inject 100 mg intramuscularly one time a day starting on the 6th and ending on the 9th every month" and take "1 intramuscular injection once every 3 weeks starting on 6/9/21". A physician visit note, dated 5/28/21, indicated the resident was receiving Haloperidol Decanoate 100 mg/ml solution-inject 100 mg every 3 weeks intramuscular for paranoid schizophrenia. A June 2021 MAR (Medication Administration Record) indicated Haloperidol Decanoate solution 100 mg/ml-"inject 100 mg intramuscularly one time a day starting on the 6th and ending on the 9th every month" and take "1 intramuscular injection once every 3 weeks starting on 6/9/21" was administered on 6/8/21 at 9:19 a.m. into the left deltoid (upper arm muscle).		*required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Physician and family notified resident #12 received Haldol injection on 7/7/2021 instead of 6/29/2021. **2) How the facility identified other residents:** All other residents with new orders in the last 7 days were reviewed to ensure that all medications were administered per physician's orders. No other residents were affected by the alleged deficiency. **3) Measures put into place/ System changes:** Licensed nursing staff were in-serviced on medication administration per physician's orders. New medication orders will be reviewed daily in morning meeting for accuracy of order entry. Medication Audit report will be reviewed daily in morning meeting for any medications listed unavailable. Pharmacy will be contacted immediately for delivery status on those medications. If needed, backup pharmacy will be contacted to deliver needed medication that was not delivered by pharmacy. **4) How the corrective actions will be monitored:** eMar will be audited 5x weekly for 4 weeks, then 10x monthly.	

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	The resident was due for his next Haloperidol injection 3 weeks later on 6/29/21. The June 2021 MAR did not indicate the resident had been administered his medication as ordered. A July 2021 MAR indicated Haloperidol Decanoate solution 100 mg/ml-inject 100 mg intramuscularly was administered on July 6 and on July 7 by 2 different nurses. The resident's next injection was scheduled for 7/27/21. On 10/1/21 at 11:15 A.M., the Director of Nursing (DON) was interviewed. She provided a copy of the manifest from their pharmacy which showed one Haloperidol injection was delivered in June and one delivered in July. She indicated the MAR was initialed incorrectly and the resident received only one dose of the medication in July. The DON indicated Resident 12 should have received his dose of Haloperidol on 6/29/21-3 weeks after the last dose, and shouldn't have received it on 7/7/21. There was confusion with the order because it had been written to be given between days 6-9 each month so if it were late, staff would have 3 days to administer it however, the medication was to be administered every 3 weeks and not monthly. The DON indicated they had no specific policy for physician orders but that nurses were expected to follow physician orders as written. 3.1-35(g)(2)		Results of these audits will be reviewed in QAPI monthly for 6 months or until 100% compliance is achieved x3 consecutive months. Results of the audits will be adapted or adjusted as need to maintain compliance. **5) Date of compliance:** 11.1.2021	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the			

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	155685	A. BUILDING 00 B. WING	10/01/2021

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	resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview and record review, the facility failed to follow a physician order regarding range of motion and hand splint application for a resident with a hand contracture. The deficient practice affected 1 of 1 resident reviewed for range of motion and mobility (Resident 24). Findings include: During observations, on 9/27/21 at 10:45 A.M., 9/28/21 at 9:52 A.M., and 9/30/21 at 2:52 P.M., Resident 24's right hand was noted to be contracted and in a fist position. A splint was not being worn during any observation times. On 09/30/21 at 2:34 P.M., Resident 24's record was reviewed. Diagnosis included, but were not limited to, hemiplegia and hemiparesis following cerebrovascular accident affecting right dominant side, contracture, and vascular dementia with behavioral disturbance. The Quarterly MDS (Minimum Data Set) assessment, dated 9/15/21, indicated Resident 24	F 0688	**F688 Increase/Prevent Decrease ROM/Mobility** **The facility requests paper compliance for this citation**. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Order entry corrected to pull into eMar documentation for resident #24 to have splint in place. **2) How the facility identified**	11/01/2021

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	had a BIMS (Brief Interview Mental Status) score of 12-cognitively intact. She required extensive assistance with 2 staff members for dressing, bed mobility and transfers. The MDS assesssment indicated no restorative nursing programs for range of motion or splinting and impairment on one side of the body. A physcian order written on 5/5/20 of, "Please apply resting hand splint to R [right]hand daily as tolerated by patient 6 to 8 hrs [hours] post range of motion and hand hygiene". An order written on 5/24/21 indicates "continue OT [occupational therapy] 3 x [times] week 4 weeks for therapeutic ex/act [exercise/activity], w/c mange [wheelchair management], orthotic fitting and training" A care plan written, on 6/27/18 indicated Resident 24 is "...At risk for pain related to contracture of right hand & arm...." with an intervention dated 3/26/21 "...please apply resting hand splint to R hand daily as tolerated by patient 6 to 8 hrs [hours] post range of motion and hand hygiene...." A therapist progress and discharge summary written on 6/3/21, indicated a short term goal of "Patient may able to tolerate WHO [whole hand orthotic] or palm guard in right hand to aid in maintaining ROM [range of motion] to prevent further contracture and deformity". During an interview, on 9/27/21 at 10:45 A.M. , Resident 24 indicated she did not have a splint available to wear. During an interview, on 9/30/21 3:26 PM, LPN 6 indicated that the facility currently did not have any restorative programs to perform range of motion or splinting programs. LPN 6 indicated if a		**other residents:** All other residents with splints had orders reviewed. No other residents were affected by the alleged deficiency. **3) Measures put into place/ System changes:** Licensed nursing staff and therapy were in-serviced on correct order entry into PCC for ROM equipment. EMar will be reviewed daily in morning meeting for documentation of ROM equipment placement. **4) How the corrective actions will be monitored:** eMar and visual placement of ROM equipment will be audited 5x weekly for 4 weeks, then 10x monthly. Results of these audits will be reviewed in QAPI monthly for 6 months or until 100% compliance is achieved x3 consecutive months. Results of the audits will be adapted or adjusted as need to maintain compliance. **5) Date of compliance:** 11.1.2021	

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	splint is needed, therapy writes an order and it will show up on the MAR [Medication Administration Record]. LPN 6 indicated if an order is written for a splint, the resident should be wearing the splint per the order. LPN 6 indicated the nurse/QMA is responsible for placement of the splint. During an interview, on 10/01/21 at 12:02 P.M., the Therapy Coordinator and COTA [Certified Occupational Therapist Assistant], both indicated Resident 24 should be receiving range of motion exercise and wearing a splint as ordered. On 10/1/21 at 1:24 P.M., the Corporate Consultant provided a current copy of the facility policy titled, "Preventionof Decline in Range of Motion" which stated the following: "The facility in collaboration with the medical director, director of nurses and as sppropriate, physical/occupational consultant shall establish and utilize a systematic approach for prevention of decline in range of motion, including the assesssment, appropriate care planning, and preventative care...." 3.1-42(a)(2)			
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 follow care planned	F 0689	**F689 Free of Accident Hazards/Supervision/Devices**	11/01/2021

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	interventions for falls for 1 of 1 resident reviewed for accidents. (Resident 75) Findings include: During observations, on 9/27/21 at 10:58 A.M., Reesident 75 was observed laying in bed with eyes closed without the bedside floor mat next to the bed. The bedside floor mat was leaning upward against the wall. On 9/30/21 at 1:37 P.M., Resident 75's record was reviewed. Diagnoses included, but were not limited to, schizophrenia, peripheral vascular disease and muscle weakness. The Admission MDS (Minimum Data Set) assessment, dated 9/1/21, indicated Resident 75 had a BIMS (Brief Interview Mental Status) score of 5-severe cognitive impairment. He required extensive assistance with 2 staff members for toileting, bed mobility and transfers. Nurse's notes indicated Resident 75 had falls on 9/2/21, 9/5/21, and 9/9/21. An interdisciplinary team note dated, 9/3/2021 9:39 A.M., indicated "[Resident name] had a fall 9/2/21 at 17:48 he was found lying on his back next to bed, no injury occurred, he stated he was trying to walk. Other interventions in place, bed in low position, keep call light in reach. [Resident name] is currently in PT/OT [physical therapy/occupational therapy] for strengthening. He was educated that walking was not safe for him at this time, especially with protective footing in place. res [Resident] verbalized understanding. call light in reach." A nurse's note dated, 9/3/2021 at 10:37 A.M.,		**The facility requests paper compliance for this citation**. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #75 has no ill effect from the alleged deficiency. Staff educated to place fall mat by resident's bed when resident in bed. **2) How the facility identified other residents:** All residents with falls in the last 7 days were reviewed to ensure that interventions are in place. **3) Measures put into place/ System changes:** All staff inserviced to place fall mats for those residents Care planned with fall mats whenever resident in bed. All staff inserviced on how to locate fall care plans in PCC and POC and how to follow fall care plan interventions.	

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	indicated, "Spoke with resident today to discuss recent fall. Resident stated he was trying to get up to go to the bathroom and realized he can't walk. Resident has agreed to try keeping a urinal at bedside." A nurse's note dated, 9/7/2021 at 1:44 P.M., indicated, "IDT [interdisciplinary team] met to discuss recent report of resident sitting on the floor and visitors assisted him back to bed. Bed will be kept in low position with a mat beside his bed. Sign in room to remind him to use call light for assistance." A nurse's note dated, 9/9/2021 at 4:51 P.M., indicated, "Resident has had 2 recent falls where he has been found beside his bed, one intervention was to keep urinal at bedside and then mat was placed by his bed and bed in low position while in the bed. No more incidents at this time." A care plan writte, on 8/25/21 indicated Resident 75 is "...At risk for falls related to: New environment, impaired mobility, incontinence...." with intervention dated, 9/7/21, "...fall mat beside bed...." During an interview, on 10/01/21 at 1:49 P.M. , LPN 7 indicated interventions for falls are communicated in the 24-hour report and during the shift huddle. LPN 7 indicated floor mats should be beside the bed on the floor when the bed is occupied with the resident. LPN 7 indicated the mats should not be leaning against the wall when the bed is ocuppied. On 10/1/21 at 1:24 P.M., the Corporate Consultant provided a current copy of the facility policy titled, Fall Prevention" which states the following,		**4) How the corrective actions will be monitored:** DNS/ Designee will review resident's falls care plans to ensure that staff followed residents' falls interventions per resident's care plans. These audits will be conducted 5 days/week x 4 weeks, then 10x monthly. Results of these audits will be reviewed in QAPI monthly for 6 months or until 100% compliance is achieved x3 consecutive months. Results of the audits will be adapted or adjusted as need to maintain compliance. **5) Date of compliance:** 11.1.2021	

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	"...Provide interventions that address unique risk factors...." 3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure Dietician recommendations for supplements were followed up timely for 2 of 7 residents reviewed for nutrition. (Residents 15 and 28) Findings include: 1. A clinical record review was completed on 9/29/2021 at 9:18 A.M., and indicated Resident 15's diagnoses included, but were not limited to:	F 0692	**F692 Nutrition Hydration Status Maintenance** **The facility requests paper compliance for this citation**. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the*	11/01/2021

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	Alzheimer's disease, diabetes, anxiety disorder, dysphagia, and hallucinations. A quarterly MDS (Minimum Data Set) assessment, dated 8/30/2021, indicated the resident was severely cognitive impaired. Required extensive assist of 1 staff for bed mobility, transfers, toileting and supervision and set up for eating. A current care plan, dated 5/12/2021, indicated Resident 15 was at risk for alteration in nutrition and weight changes related to Alzheimer's, dementia, diabetes, schizophrenia, gastro esophageal reflux disease and mechanical altered diet, as well as needing assistance with eating at times. Significant weight loss. Resident 15's weights from March 2021 through September 2021 were: 3/10/2021--174 4/10/2021--178 +4 pounds 5/6/2021--169 -9 pounds 6/6/2021--156 -13 pounds 7/4/2021--156 8/1/2021--153 -3 pounds 9/5/2021--158 +5 pounds A Registered Dietician's note, dated 5/12/2021 indicated the resident has had some gradual significant weight loss x 30 days. Current weight is 166# (pounds). Meal intake is good at 76-100% consumption. Is offered a Mechanical soft diet with nectar thick liquids related to dysphasia. Is also receiving 2 cal med pass (supplement) of 120 cc BID (twice daily) for additional nutrition support. Recommend provide health shakes with all meals for additional calories and protein due to weight loss.		*facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #15 had no ill effects from the alleged deficiency as she was receiving other supplements. Orders updated to document % of intake. Resident #28 no longer resides in facility. **2) How the facility identified other residents:** All residents with dietary supplements audited to ensure documentation of intake added to orders. All residents with dietary recommendations in the last 7 days were reviewed to ensure that the dietary recommendations were addressed. **3) Measures put into place/ System changes:** Licensed nursing staff were inserviced on answering dietary recommendations timely and how to enter intake documentation for supplement orders. **4) How the corrective actions will be monitored:** DNS/Designee will review to confirm dietary recommendations were followed through weekly x5,	

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	The Health shakes were ordered on 5/25/20/21, 13 days after the recommendation was made. A Medical Nutrition Therapy Recommendations form, dated 6/3/2021, indicated the Registered Dietician's recommendation was to increase the 2 cal med pass supplement to 120 cc TID (three times a day) at 10:00A.M., 2:00 P.M., and at bedtime. Health shakes with all meals and to record the consumption in the MAR (Medication Adminsitration Record). A Registered Dietician's note, dated 6/16/2021 indicated the residents' current weight 158# 6/10/2021, 156# on 6/6/2021. The resident has had a significant weight loss related to decreased po (by mouth) intakes. Resident is very mobile. She does not usually sit very long at the table. Staff tries to provide foods that she can drink or eat while walking but she has been giving her food away recently. She is offered a Mech soft diet with nectar thick liquids, sandwich at 2 P.M. & HS cottage cheese at lunch and dinner, 2 cal med pass supplement and health-shakes. She takes health-shakes and 2 cal fairly well therefore will increase these to TID. Staff will continue to redirect and encourage increased po intakes of meals and snacks. The physicians order to increase the med pass supplement to three times a day was not received until 7/1/2021, 13 days after the first recommendation was made. 2. A clinical record review was completed on 9/28/2021 at 3:07 P.M. and indicated Resident 28's diagnoses's included, but were not limited to: dementia, delusional disorder, retention of urine, and hallucinations.		then x10 monthly. Results of these audits will be reviewed in QAPI monthly for 6 months or until 100% compliance is achieved x3 consecutive months. Results of the audits will be adapted or adjusted as need to maintain compliance. **5) Date of compliance:** 11.1.2021	

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	A quarterly MDS (Minimum Data Set) assessment, dated 7/7/2021, indicated the resident required extensive assist of 2 staff for bed mobility, transfers, and toileting, and 1 staff extensively for dressing and and eating. A current care plan, dated 11/16/2020 indicated the resident was at risk for alteration in nutrition and weight changes related to dementia, Alzheimer's and depressive disorder. Prefers to eat in her room. 10/2020 Significant weight loss. Resident 28's weights from January 2021 to September 2021 were: 1/5--178 2/1--181 +3 pounds 3/1--178 - 3 pounds 4/8--175 - 3 pounds 5/2--170 - 5 pounds 6/4--164 - 6 pounds 7/4--159 - 5 pounds 8/3--160 - 1 pound 9/2--158 - 2 pounds A Registered Dietician's note, dated 3/25/2021 indicated: Current weight 177 Lbs. Significant weight loss x 180 days but weight has remained stable since November. Meal intake is good at 76-100% consumption usually. Is offered a Regular Diet with ice cream at lunch and supper. No new recommendations. Current diet and intake are appropriate. A Medical Nutrition Therapy Recommendation form, dated 4/16/2021, indicated: Recommend provide 120 cc 2 cal med pass supplement BID (twice a day) at 10:00 A.M., and 8:00 P.M. and record % consumed in MAR (Medication Administration Record).			

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	The April 2021 MAR lacked the documentation to show Resident 28 had received the med pass supplement. The May 2021 MAR lacked the documentation to show Resident 28 had received the med pass supplement. A Registered Dietician's note, dated 6/16/2021, indicated the current weight was 162# 6/11, 160# 6/8, 165# 5/5, 170# 5/2, 166# 4/25, 176# 4/18. Significant weight loss x 180 days but no significant weight loss x 90/30 days. Meal intake is usually <50% most meals. Is offered a Mech soft diet with nectar thick liquids and fortified foods all meals and magic cup at lunch and dinner. Skin is intact. Recommended to start on 2 cal med pass supplement 120 cc BID (twice a day) for additional calories and protein due to decreased Po intakes and weight loss. Will follow via intakes, weekly weights and NAR. The June 2021 MAR indicated the 2 cal med pass supplement had been ordered on June 16 th and was documented as received, but no intake % were documented. A nurses's note, dated 6/16/2021 indicated the resident has had a gradual weight loss. New orders for 2 cal supplement BID (twice a day. Family notified and aware The July 2021 MAR indicated the 2 cal med pass supplement had been received, but no intake % were documented. A Registered Dietician's note, dated 7/8/2021 indicated: Current weight vary 7/4/2021 159#. Significant weight loss X 180 days. Has had 4# weight loss recently. Recommend consideration of			

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	appetite stimulant or increase 2 cal med pass supplement to 120 cc med pass supplement TID (three times a day) at 10:00 A.M., 2:00 P.M., and HS (bed time) and record % consumed in MAR. A Registered Dietician's note, dated 8/11/2021 indicated: Recommend to record % consumed of 2 cal med pass & magic cup supplements in MAR. Resident 28's current physician's orders, dated October 2021, indicated the order to increase the 2 cal med pass supplement was not received until 10/1/2021. During an interview, on 10/1/2021 at 11:59 A.M., the Director of Nursing indicated she was unsure why the dietary recommendations were not followed up on sooner and should have been. On 10/1/2021 a policy was requested for Dietary Recommendations, but one was not provided. 3.1-46(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review, the facility failed to ensure cleanliness of the oxygen concentrator and filter for 1 of 1	F 0695	**F695 Respiratory/Tracheostomy Care and Suctioning** **The facility requests paper**	11/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155685	A. BUILDING 00 B. WING	10/01/2021

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GOLDEN LIVING CENTER-ELKHART	1001 W HIVELY AVE ELKHART, IN 46517

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	resident reviewed for oxygen therapy. (Resident 51) Findings include: During an observation, on 9/27/21 10:45 A.M. and 9/28/21 at 3:40 P.M., the oxygen concentrator had brown and white debris on the top and the sides. The oxygen concentrator filter was covered with a thick amount of dust and lent. A record review was completed, on 09/28/21 at 3:07 P.M., and indicated Resident 51's diagnosis included, but not limited to, chronic obstructive pulmonary disease, dementia with behavioral disturbances, and generalized anxiety. The Quarterly MDS (Minimum Data Set) assessment dated, 9/14/21, indicates resident uses oxygen. The MDS indicates extensive assistance with 2 staff members to assist for bed mobility, extensive assist with one staff member to assist for transfers and toileting. Resident 51 had a BIMS (Brief Interview Mental Status) score of 9-moderate cognitive impairment. An order review indicated, "O2 [oxygen] 2L [2 liters] via NC [nasal cannula] every night shift related to obstructive sleep apnea" written on 1/9/19. During an interview, on 9/28/21 at 3:46 P.M., QMA 1 indicated oxygen concentrators should be cleaned as needed when visibly soiled. QMA 1 was not aware of a policy related to cleaning oxygen concentrators. QMA 1 observed the debris on the oxygen concentrator of Resident 51, and indicated the debris was food and saliva from Resident 51 spitting into the trash can next to the oxygen concentrator. QMA 1 removed the		**compliance for this citation**. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #51 no longer resides in this facility. **2) How the facility identified other residents:** All the residents on oxygen had the potential to be affected by the alleged deficient practice. No residents had ill effect from the deficient practice. All the residents on oxygen were reviewed, and orders were put in place to change the concentrator filters once a week. **3) Measures put into place/ System changes:** Licensed nursing staff were re-educated on cleaning the oxygen concentrator filters weekly and entering orders orders to clean filters weekly for all new O2 orders.	

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	oxygen concentrator filter and acknowledged the filter covered in thick dust and lent. QMA 1 indicated he was not aware of the cleaning schedule, but the oxygen concentrator filter should be cleaned once weekly. On 10/1/21 at 1:24 P.M., the Corporate Consultant provided a current copy of the facility policy titled, "Oxygen Concentrator". The policy indicated under the precautions and hazards section, "1) DO NOT operate the oxygen concentrator without the filter or with a dirty filter", and under the daily maintenance section, 3) Clean the air inlet filter PRN [as needed] and weekly." An additional policy also titled, "Oxygen Concentrator" was provided by the Corportate Consultant, and indicated, "The main body cabinet should be dusted when needed and can be wiped clean with a damp cloth and mild household cleaner if neccessary." 3.1-47(a)(6)		**4) How the corrective actions will be monitored:** Director of Nursing Services or designee will audit oxygen concentrators 5x weekly for 4 weeks, then x10 monthly. The results of these audits will be brought to QAPI monthly x 6 months or until 100% compliance is achieved x3 consecutive months. Results of the audit will be adapted or adjusted as needed to maintain compliance. **5) Date of compliance:** 11.1.2021	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to			

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	meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to ensure physician ordered medications were administered for 1 of 5 residents reviewed for unnecessary medications. (Resident 40) Finding includes: A clinical record review was completed on 9/30/2021 at 11:29 A.M., and indicated Resident 40's diagnoses included, but were not limited to: Alzheimer's disease, seizures, and depression. Current physician orders, dated 10/1/2021 indicated Resident 40 was to receive the following medications: Aricept (Alzheimer's medication) 5 mg (milligrams) at bedtime: Atorvastatin Calcium (high cholesterol) 10 mg every day; Keppra (anticonvulsant) 500 mg twice a day and Sertraline (antidepressant) 25 mg at bed time.	F 0755	**F755 Pharmacy Services and Procedures** **The facility requests paper compliance for this citation**. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Resident #40 did not have adverse	11/01/2021

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	A MAR (medication administration record), dated 9/1/2021 through 9/30/2021, indicated on 9/2/2021 the Aricept and the Atorvastatin medications were coded as 7 (see nurses notes). On 9/17/2021 the Astorvastatin, the Keprra and Sertraline medications were coded as 7 (see nurses notes). The nurses notes indicated the medications were not available. During an interview, on 10/1/2021 at 8:55 A.M., the interim Director of Nursing indicated the staff should pull the medications out of the ADU (automated dispensing unit). On 10/1/2021 at 3:30 P.M., the Corporate Nurse provided the policy titled, "Unavailable Medications", dated 11/2017, and indicated the policy was the one currently used buy the facility. The policy indicated"...1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn, and emergency medications. 2. A STAT supply of commonly used medications is maintained in-house for timely initiation of medications. 3. The facility shall follow established procedures for ensuring resident have a sufficient supply of medications...." On 10/1/2021 at 3:30 P.M., the Corporate Nurse provided the policy titled, Emergency Pharmacy Service and Emergency Kits", dated 12/2017,and indicated the policy was the one currently used by the facility. The policy indicated"... D. Medications are not borrowed from other residents. The ordered medication is obtained either from the emergency kit, the electronic medication cabinet (EMC) or Automated Dispensing Unit (ADU), from the provider pharmacy or a back up pharmacy that is		effect from the alleged deficiency. This facility contracts with Pharmacy to provide routine and emergency drugs and Biologicals to its residents. **2) How the facility identified other residents:** Medications administration audit report was reviewed to ensure that residents received their medications as prescribed. No other residents were affected by the alleged deficiency. **3) Measures put into place/ System changes:** Licensed nursing staff were inserviced on medication administration and the steps to take to receive medications from pharmacy in a timely manner. This includes utilization of the ADU or contacting backup pharmacy. **4) How the corrective actions will be monitored:** Director of Nursing Services or Designee will review medication administration audit report to ensure that all medications are available and were administered per order daily in morning meeting. These reviews will be conducted 5days a week x 4weeks, then x10 monthly. The results of these audits will be brought to QAPI monthly x 6 months or until 100% compliance is achieved x3 consecutive	

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	determined by the provider pharmacy...." 3.1-25(a)(b)		months. Results of the audit will be adapted or adjusted as needed to maintain compliance. **5) Date of compliance:** 11.1.2021	
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the			

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	medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on interview and record review, the facility failed to ensure pharmacy recommendations were followed up on in a timely manner for 2 of 5 residents reviewed for unnecessary meds. (Resident 62 & 12) Findings include: 1. A clinical record review was conducted, on 9/30/2021 at 1:47 P.M., and indicated Resident 62's diagnoses included but were not limited to: paraplegia, tremor and anxiety disorder. A form, titled "Note To Attending Physician/Prescriber", dated 4/13/2021, indicated Resident 62 had a current physician order for: "...Loranzepam [an anti-anxiety medication] 0.5 mg [milligrams] HS [at bed time] since 4/16/2019...." and a pharmacy recommendation to: "...Please consider a trial reduction to: Loranzepam 0.25 mg HS...." The form indicated the physician had not seen it. A Review of Psychotropic Medication form, dated 8/24/2021 indicated Resident 62 was still prescribed Loranzepam 0.5 at bedtime. During an interview, on 9/30/2021 at 4:12 P.M., the	F 0756	**F756 Drug Regimen Review, Report Irregular Act On** **The facility requests paper compliance for this citation**. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Medications for residents #62 and 12 have been discontinued. **2) How the facility identified other residents:** All psychotropic pharmacy recommendations for the past 30 days have been reviewed to	11/01/2021

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	Interim DON (Director of Nursing) indicated the pharmacy recommendations should have been followed up on in a timely manner and they were not. 2. On 9/28/21 at 3:34 P.M., Resident 12's record was reviewed. Diagnoses included, but were not limited to, paranoid schizophrenia, bulimia nervosa, Parkinson's disease, and muscle wasting and atrophy. A Pharmacy Medication Regimen Review (MMR) note to Resident 12's attending physician, dated 6/2/21, indicated the resident's medications had been reviewed and a concern identified. Resident 12 was prescribed Olanzapine (anti-pyschotic)-20 mg (milligrams) by mouth at bedtime; Haloperidol (anti-pyschotic)-5 mg by mouth 2 times per day; and Haloperidol decanoate 100 mg/ml intramuscularly monthly. The concern was "The use of more than one antipsychotic concurrently may be considered duplicate therapy and contribute to polypharmacy, unnecessary medication use, and the risk for additional side effects. The Pharmacy Recommendation was for the physician to review the above orders due to duplicate therapy. The Pharmacy MMR recommendation form was not signed by the physician and the resident continued to receive all 3 antipsychotic medications as ordered until 7/27/21 when Haloperidol decanoate 100 mg/ml intramuscularly monthly was discontinued. Haloperidol 5 mg by mouth 2 times per day was discontinued on 8/18/21. A current facility policy, titled "Medication Regimen Review" was provided by the Director of		ensure they have been addressed. Recommendations were sent to the PCP/NP to address for any affected residents. **3) Measures put into place/ System changes:** SSD and Nurse managers have been re-educated on ensuring pharmacy recommendations are followed up on timely. All psychotropic medications will be reviewed and addressed by the SSD when sent by the pharmacist. The DNS will review the recommendations as well to ensure SSD received all psychotropic recommendation reviews and that they have been addressed. **4) How the corrective actions will be monitored:** SSD or designee will audit 10 recommendations monthly to ensure follow through on pharmacy recommendations completed timely. The results of these audits will be brought to QAPI monthly x 6 months or until 100% compliance is achieved x3 consecutive months. Results of the audit will be adapted or adjusted as needed to maintain compliance. **5) Date of compliance:** 11.1.2021	

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	Nursing on 10/1/21 at 9:15 a.m. which stated the following: "The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart...with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication...Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregulartities." 3.1-25(i)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit			

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	package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on record review, interview and observation, the facility failed to ensure medications were properly stored, labeled appropriately and dated when opened, for 1 of 3 medication pass observations and 2 of 2 medication storage observations. (LPN 6, medication cart 1 and 3). Findings include: 1. During a medication observation, on 9/30/2021 at 7:55 A.M., LPN (Licensed Practical Nurse) 6 pulled out medication cards for room 415. LPN 6 punched out the pills from the cards she was going to administer. LPN 6 returned some of the medication cards back in to the medication cart. LPN 6 then went into the residents room and administered the medications she had just pulled from the cards. Upon exiting the residents room, LPN 6 observed 4-6 medication cards lying on top of the medication cart with pills/capsules remaing in the cards. During an interview, on 9/30/2021 at 7:59 A.M., LPN 6 indicated she should have placed all the medication cards back in the medication cart. 2. During an medication storage observation on 9/30/2021 from 3:52 P.M. to 4:07 P.M., the following were observed: Medication cart 3 had an undated opened bottle of Latanoprost eye drops; an undated opened bottle of Mira lax; an undated opened bottle of Dyna Hex 4 (surgical scrub liquid) stored with other liquid medication; a closed box with a tube of Diaper Rash ointment with no label or resident identifiers; an undated opened bottle of Milk of Magnesium; an undated	F 0761	**F761 Label/Store Drugs and Biologicals** **The facility requests paper compliance for this citation**. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Medications undated or labelled for Latanoprost eye drops, Mira lax, Dyna Hex, Diaper Rash ointment, Milk of Magnesium, Siltussin liquid, artificial tears, 2 bottles of Miralax, and hand held puffer were labelled and dated. No residents were affected by the alleged deficient Practice. LPN #6 was re-educated on medication best practice for medication pass. **2) How the facility identified other residents:** All medication carts were audited for opened/unlabeled medications	11/01/2021

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	opened bottle of Siltussin liquid (cough medicine). 3. During an medication storage observation on 9/30/2021 from 4:08 P.M. to 4:22 P.M., the following were observed: an undated opened bottle of artificial tears; 2 undated opened bottles of Miralax; a hand held puffer with an opened date of 4/25/2021 with 26 puffs remaining in the container. The label indicated 2 puffs three times a day and a reorder date of 5/15/2021. During an interview, on 9/302021 at 4:22 P.M. LPN (Licensed Practical Nurse) 8 indicated the medications should have had a date opened, a label for the diaper rash ointment, the soap should not be in with the medications, and was unsure if the inhaler was expired. On 10/1/2021 at 3:30 P.M., the Corporate Nurse provided the policy titled, "Medication Storage in the Facility", dated 03/2017, and indicated the policy was the one currently used by the facility. The policy indicated"...Medications and biological's are stored safely, securely, and properly, following manufactures recommendations or those of the supplier. C. d. When the original seal of a manufactures container or vial is initially broken, it is recommended that a nurse write the date opened on the medication container or vial...." On 10/1/2021 at 3:30 P.M., the Corporate Nurse provided the policy titled,"Administration Procedures for All Medications", dated 12/2017, and indicated the policy was the one currently used by the facility. The policy indicated"... C. Review 5 Rights (3) times: ... 3). After the dose has been prepared and before returning the medication to storage. D. ...When opening a multi-dose container, place the date on the		and separating medications appropriately. Any deficiencies found were corrected. **3) Measures put into place/ System changes:** Licensed nursing staff were inserviced on medications pass, labeling of medications and storage of medications, and dating of medications once the medications are opened. Licensed nursing staff were also inserviced on separating oral medications from, ointments, and soaps. **4) How the corrective actions will be monitored:** DNS or Designee will randomly check the medications carts to ensure all the medications are stored, labeled and dated correctly. These checks will be completed 5days a week x 4weeks, then 10x monthly. The results of these audits will be brought to QAPI monthly x 6 months or until 100% compliance is achieved x3 consecutive months. Results of the audit will be adapted or adjusted as needed to maintain compliance. **5) Date of compliance:** 11.1.2021	

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	container..." On 10/1/2021 at 3:30 P.M., the Corporate Nurse provided the policy titled,"Medication Labels", dated 12/2017, and indicated the policy was the one currently bused by the facility. The policy indicated"... F. Resident specific nonprescription medications provided by the pharmacy that are not labeled by the pharmacy are kept in the manufacturer's original container and identified with the resident's name. Facility personnel may write the resident's name on the container or label as long as the required information listed above is not covered...." 3.1-25(j) 3.1-25(m)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing			

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	155685	A. BUILDING 00 B. WING	10/01/2021

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	services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.			

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	§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on record review, observation and interview, the facility failed to ensure proper infection control practices were implemented related to not handling medications with an ungloved hand and not fanning an area for insulin administration after being cleansed with alcohol in 2 of 2 medication administration observations. (QMA 2 & LPN 8) Findings include: 1. During a medication administration observation, on 9/20/2021 at 7:17 A.M., QMA (Qualified Medication Aide) 2 punched out a Colace (stool softener) capsule from the medication card into a plastic souffle cup. QMA 2 then indicated this resident did not have the medication and then with an ungloved hand removed the capsule from the cup and placed it back into the medication slot where she had just punched it out of and placed the medication card back into the medication cart. During an interview, on 9/30/2021 at 7:50 A.M., QMA 2 indicated she should have tossed the pill and not placed it back into the medication card. 2. During a medication administration, on 9/30/2021 at 8:57 A.M., LPN (Licensed Practical Nurse) 8 donned gloves and wiped the right upper arm on Resident 51 with an alcohol pad for	F 0880	**F880 Infection Prevention and Control** **The facility requests paper compliance for this citation**. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** QMA 2 educated on Medication Administration guidelines. LPN 8 educated on Insulin Administration. **2) How the facility identified other residents:** All residents have the potential to be affected by the deficient	11/01/2021

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	an insulin injection. LPN 8 then with an opened hand fanned the area she had just cleansed with alcohol. During an interview, on 9/30/2021 at 9:00 A.M., LPN 8 indicated she should not have fanned the arm after cleaning with alcohol. On 10/1/2021 at 1:33 P.M., the Corporate Nurse provided the policy titled," Administration Procedures For All Medications", dated 2014, and indicated the policy was the one currently used by the facility. The policy indicated"... C. Review 5 Rights (3) times: 1) Prior to removing the medication package/container from the cart/drawer; a. Check MAR/TAR for order. 2. Prior to removing the medication from the container; a. Check the label against the order on the MAR/TAR...." A policy was requested for proper insulin administration but one was not provided. 3.1-18(b)(1)		practice. All Licensed staff educated on Medication Administration guidelines and Insulin Administration. **3) Measures put into place/ System changes:** DNS/IP/designee to educate all licensed staff regarding Administration Procedures for all medications and on Insulin Administration. IP or designee to observe licensed staff completing a medication pass and administering insulin. **4) How the corrective actions will be monitored:** DNS/IP/designee to educate all licensed staff regarding Administration Procedures for All Medications and on Insulin Administration. DNS/IP/designee to observe licensed staff completing a medication pass and administering insulin. These observations to be conducted daily x 6 weeks, then 2x weekly x 4 weeks, then weekly x 4 months. These observations to be random and include all shifts. IP/DNS/designee to complete daily visual infection control rounds. These rounds to be conducted daily x 6 weeks, then 2x weekly x 4 weeks, then weekly x 4 months to ensure staff are practicing appropriate infection control practices. The results of these audits will be brought to QAPI monthly x 6	

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			months or until 100% compliance is achieved x3 consecutive months. Results of the audit will be adapted or adjusted as needed to maintain compliance. **5) Date of compliance:** 11.1.2021	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on record review, interview and observation, the facility failed to ensure a clean, sanitary and comfortable environment was maintained related to: missing wall paint; gouged walls; base boards missing; missing closet doors; heaters rusted and dented; stained and broken ceiling tiles; missing faucet hot water knob; floor cracked; broken window blinds; missing floor tiles exposing concrete floor in a bathroom; broken and gouged window seal board; black mold to a shower room, closet doors hanging by one side; black mold to the door of the ice machine and dirty stained linens in 2 of 2 units observed for environment. (South Unit and Southwest Unit) Findings include: 1. During an environmental tour on 10/1/2021 at 9:15 A.M., with the Maintenance Director and the Housekeeping supervisor, on the South Unit, the following was observed: Room 302 had no closet doors. Room 304 had missing paint on the walls, missing closet doors, part of the floor baseboard heater was missing part of the slats, and there was no	F 0921	**F921** **The facility requests paper compliance for this citation**. *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** Room 302 had closet doors installed. Room 304 walls painted, closet doors added, floor baseboard replaced, heater slats replaced, paper towel holder installed in bathroom, and floor	11/01/2021

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	paper towel holder in the bathroom. The floor had a large brown colored stain of 3 x 2 feet by the residents bed. Room 306 had no closet doors. Three ceiling tiles outside of the dining room were stained with a brown substance. Room 307 had no hot water handle to turn it on, the trash can had trash in it with no trash bag, the heater along the wall was bent, rusty and dirty. Room 310 a wall was gouged and had missing paint, a board was holding up the blind that was falling down and a gouged area above the top of the heater. Room 311 had a gouged walls behind both beds, baseboards peeling off the wall, no closet doors, the bathroom had with mold around the toilet and the wall had a brown substance on it. Room 312 had a gouged bathroom wall, walls were dirty with a brown substance and the wall behind the toilet had gouged area. Room 316 had missing paint on walls, raised area of spackling behind the door of a patched area not painted not sanded and no closet doors. Room 317 had no toilet paper holder, 2 toilet plungers not bagged sitting on the floor, the wall across from the toilet has exposed drywall. Room 318 had missing paint on the walls. The pantry had a dirty plate in a cabinet. The refrigerator had dirty drawers, the top shelve had a spilled liquid yellow area. There was no log for checking the temperature of the refrigerator. 2. During an environmental tour on the Southwest unit on 10/1/2021 at 9:50 A.M., with the Maintenance Director and the Housekeeping supervisor the following was observed: The floor going into the 2nd dining area had a crack extending from one side of the walkway to the other with numerous missing pieces exposing		replaced in stained area. Room 306 closet doors installed. Ceiling tiles outside dining room repaired. Room 307 hot water handle replaced and heater repaired. Room 310 wall repaired and painted and blind replaced. Room 311 wall repaired and painted, baseboards replaced, closet doors added, bathroom mold removed and cleaned. Room 312 bathroom wall repaired, painted, and cleaned. Room 316 patched, sanded, and painted with closet doors replaced. Room 317 toilet paper holder replaced, bagged toilet plungers, and drywall painted. Room 318 painted. Refrigerator in pantry cleaned, spoiled liquid removed. Log for temperature checks added to refrigerator pantry. 2nd Dining area floor repaired. Room 424 wall repaired and painted, closet doors fixed, bathroom tile replaced. Room 430 window ledge replaced and repaired. Ceiling tiles outside room 432 replaced. 400 hall shower room mold removed and cleaned off. Ice machine cleaned. Resident 51 sheets replaced. **2) How the facility identified other residents:** Walkthrough conducted of resident rooms. Other areas affected added to work orders for repairs, replacements, or cleaning.	

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	the concrete. Room 424 had a gouged wall by the window, blinds were broken, the closet doors are loosely hanging, the bathroom floor had 6 missing tiles exposing concrete floor. Room 430 had a broken window ledge, gouged areas on the ledge and missing Formica coverings. The ceiling tiles outside of room 432 were stationed and had a missing area around a sprinkler head. The shower room on the 400 hall had black mold on the floor along the base board and closet doors on the floor. The ice machine had black mold along the back seal of the opening. During an interview, on 10/1/2021 at 10:35 A.M., the Maintenance Director indicated she does a preventative maintenance on every room each quarter. She indicated the staff can also make out a work order for things that need to be repaired or fixed. The Maintenance director indicated the wall gouges should be repaired and painted, the heaters needed cleaned, painted and fixed, a paper towel holder needed to be replaced, the blinds needed repaired, the ceiling tiles needed replaced, the floor tiles needed repaired, the plungers should be bagged and the mold should be removed. She indicated the crack in the floor by the 2nd dining area was due to a leak and had been that way for 1/12 years. 3. During an observation, on 9/27/21 at 10:45 A.M. and 9/28/21 at 9:26 A .M., Resident 51 was laying his bed that had five nickel sized dark red stains and a light brown stain the size of a football on the fitted sheet and a half-dollar sized dark brown stain on flat sheet. During an observation, on 9/28/21 at 3:51 P.M., CNA 3 indicated the linens for the bed should		**3) Measures put into place/ System changes:** All staff inserviced on how to enter work orders, refrigerator temperature logs replaced monthly and temped daily, checking and replacing linens twice weekly and as needed, cleaning ice machine, bagging toilet plungers, and cleaning refrigerators to ensure the deficient practice does not recur. **4) How the corrective actions will be monitored:** The Maintenance Director or designee will audit rooms, linens, and temperature logs 10x weekly for 4 weeks, then 10x monthly. 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. Results of the audits will be adapted or adjusted as needed to maintain compliance. **5) Date of compliance:** 11.01.2021	

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	have been changed when the soiled linens were seen by staff. A clinical record review was completed on 09/28/21 at 3:07 P.M., and indicated Resident 51's diagnosis included, but not limited to, chronic obstructive pulmonary disease, dementia with behavioral disturbances, and generalized anxiety. The Quarterly MDS (Minimum Data Set) assessment dated, 9/14/21, indicates Resident 51 has a BIMS (Brief Interview Mental Status) score of 9-moderate cognitive impairment.. The MDS indicates extensive assistance with two staff members for bed mobility, extensive assist with one staff member for tansfers and toileting. During an interview, on 09/28/21 at 3:23 P.M., CNA 3 indicated linens should be changed twice weekly, and whenever soiled. On 10/1/2021 at 11:23 A.M., the Maintenance Director provided a Quarterly Preventative Maintenance form, indicating the areas that she is to complete on a quarterly schedule on every resident room. The areas, included but were not limited to: ... "4. Check wall conditions (painted wall paper) and repair as needed. 5 Check for mold or mildew and refer to (Beverly Indoor Air Quality Policy). 6. Inspect wall cove base and repair as needed. 7. Inspect flooring and repair as needed. 8. Inspect ceilings and repair as needed. 12. Inspect windows and repair as needed. 13. Inspect doors, hardware and frames, entrance and toilets and repaint or refinish as required. 20. Check condition of ceramic tiles and repair as needed. 21. Verify that all closet pulls, knobs & handles are secure and in place. 29. Inspect radiator/Baseboard heater."			

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	A policy on dirty linens was requested on 9/30/2021 at 1:48 P.M., but one was not provided. 3.1-19(f) 3.1-19(g)(5) 3.1-19(m)(4)			