STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. BUILDING 00 B. WING	07/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVERGREEN CROSSING AND THE LOFTS	5404 GEORGETOWN ROAD INDIANAPOLIS, IN 46254

(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. This visit included the Investigation of Complaint IN00407141 and IN00413802. Complaint IN00407141 - No deficiencies related to the allegations are cited. Complaint IN00413802 - No deficiencies related to the allegations are cited. Survey dates: July 24, 25, 26, 27, 28 and 31, 2023. Facility number: 013280 Provider number: 155826 AIM number: 201270670 Census Bed Type: SNF/NF: 98 Total: 98 Census Payor Type: Medicare: 8 Medicaid: 76 Other: 14 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 9, 2023.	F 0000		
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) 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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stacy Cromer	8/21/2023	08/21/2023

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

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	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 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.			

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	§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on interview and record review, the facility failed to develop a care plan for a resident taking an anticonvulsant medication for 1 of 5 residents reviewed for unnecessary medications (Resident 89). Findings include: Resident 89's record was reviewed on 7/26/23 at 2:57 p.m. His diagnoses included, but were not limited to, respiratory failure, end stage renal disease (severe kidney dysfunction), and diabetes mellitus (blood sugar disorder). His diagnoses did not include epilepsy, seizures, or bipolar disorder. A physician's order indicated Resident 89 received lamotrigine (anticonvulsant) 25 mg, give one tablet by mouth, one time a day for seizure/bipolar (seizure - a sudden uncontrolled burst of electrical activity in the brain causing changes in behavior, movements, feelings and levels of consciousness)/(bipolar - both manic and depressive episodes, or manic episodes only). His care plans were reviewed, no care plan for the use of lamotrigine, epilepsy, seizures, or bipolar disorder was found. On 7/31/23 at 11:58 a.m., Resident 89's July Medication Administration Record (MAR) was reviewed. Lamotrigine tablets 25 mg were given once a day from 7/1/23 to 7/31/23.	F 0656	Requesting Desk Review on this Survey Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: No harm was caused to Resident 89 by the facilities deficient practice. Resident 89's records were reviewed by NP and an order was given to add a diagnosis of seizures to his medical chart. Resident 89's care plan was updated with his diagnosis. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected. The facility completed a review of all resident care plans to ensure accurate diagnosis was in medical record and reflected in the plan of care. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Education was completed for all licensed nurses utilizing the Care Plan Overview policy with emphasis on ensuring appropriate medical diagnosis are documented in the medical record	09/05/2023

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	On 7/31/23 at 12:26 p.m., the Vice President of Risk Management (VPRM) indicated Resident 89 had a non-traumatic traumatic brain injury (TBI). He was on the lamotrigine as a prevention for seizure activity. He had no history of seizures. She indicated he should have had a care plan for lamotrigine as a prevention for seizures. A current policy, titled, "Plan of Care Overview," with no date, was provided by the VPRM, on 7/31/23 at 1:05 p.m. A review of the policy indicated, " ...Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care ...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concerns for our residents, staff and visitors ...The facility will provide an RN [registered nurse] assessment of the resident as an on-going, periodic review that provides the foundation for resident focused care and the care planning process ...incorporate the resident's personal and cultural preferences in developing goals of care ...Members of the care planning team will coordinate care to meet resident preferences and care needs utilizing a holistic approach to care ...." 3.1-35(a) 3.1-35(b)(1)		and added to the care plan. How the corrective measures will be monitored to ensure the alleged deficient practice does not reoccur: The DON/Designee will audit 3 residents per week for 4 weeks and then 1 resident per week for 8 weeks, then 1 resident per month for 3 months to ensure the resident has an appropriate diagnosis in the plan of care. Any discrepancies will be immediately corrected and education will be provided as needed.The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation	
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			

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	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 ensure residents' care plans were updated to include person-centered culturally competent accommodations for 2 of 3 residents reviewed for culturally competent nursing services (Residents 84 and 42). Findings include: 1. On 7/24/23 at 12:54 p.m., Resident 42 was observed sitting on the edge of his bed. He was dressed and groomed appropriately. When asked questions, he indicated, "no English." He did not use any other English words. He was not engaged in any activity at all. He just stared with his eyes open. He was unable to see or communicate and did not indicate or point to the language line	F 0657	Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident 84 was interviewed utilizing the language line for cultural preferences and plan of care was updated for preferences with cultural foods and activities. Resident 42 was interviewed utilizing the language line for cultural preferences and audio books were purchased on his tablet for his cultural preferences and his plan of care were updated. Identification of other residents having the potential to be affected	09/05/2023

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	information on his wall. Paper signs were observed on Resident 42's wall for the Language Line to reach an interpreter with a specific number for this resident. On 7/26/23 at 12:30 p.m., 7/27/23 at 3:05 p.m., and 7/28/23 at 9:56 a.m., Resident 42 was observed sitting on the edge of his bed. He was dressed and groomed appropriately. He was not engaged in any activity at all. He just stared with his eyes open. He was unable to see or communicate. Resident 42's record was reviewed on 7/28/23 at 1:54 p.m. His diagnoses included, but were not limited to, end stage renal disease, kidney transplant, unspecified visual loss, cataract, and diabetes mellitus (blood sugar disorder). His communication care plan, dated 2/22/23, indicated he had a language barrier due to speaking Arabic. Use the Language Line Solutions. The goal was to maintain or improve his current level of communication. The nursing intervention only provided the phone number for the Language Line. His impaired visual function care plan, dated 6/29/23, indicated blindness, cataracts, diabetes mellitus retinopathy, and retinal detachment. The nursing interventions were, "I am blind," provide large print reading materials as needed, and read menus/letters, mail related to impaired sight. It did not indicate he only spoke Arabic and the Language Line Solutions needed to be utilized when reading to him. His cultural preference care plan, dated 3/1/23, only indicated he disliked pork. The nursing intervention indicated to, "do not give pork."		by the same alleged deficient practice and corrective actions taken: Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation	

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	His activity care plan, dated 10/15/21, indicated he had little or no activity involvement. A nursing intervention indicated to interview and determine resident activity preferences and use the Language Line Solutions to access an interpreter when needed. On 7/28/23 at 9:48 a.m., the Activity Director (AD) indicated she offered Resident 42 coffee and donuts. Him sitting on the side of the bed was his normal. He gets one on one to help him with getting dressed, that involves sensory and touching. She used the language line. He understood a little English. He only said one or two words in English. On 7/28/23 at 9:53 a.m., the Social Services Director (SSD) indicated he could talk into his phone and listen to movies. His phone was set to the Arabic language. Other activity assistants would assist him with his phone and use the language line. On 7/28/23 at 12:38 p.m., the AD indicated Resident 42 was completely blind. But sometimes came to the community area to listen to music. She was observed to call the Language Line. She put in the resident's number and asked for an Arabic interpreter. a. She asked him how was his day? He responded he went to an appointment today and no one spoke Arabic. He did not understand anything about his doctor's visit. b. She asked were there an activities he would like to do? He responded why had there not been any coffee. She told him the facility was out of coffee. c. She asked were there an activities he would like to do? He responded louder music, and he would like Braille books. He would like anything to read. d. She asked what was his favorite thing to do?			

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	He responded raise the volume of the music. e. She asked about his mood, how was he feeling? He responded he was used to sitting alone. He received his strength from God. On 7/31/23 at 9:31 a.m., the Vice President of Risk Management (VPRM) indicated she and the Administrator used the language line to talk with Resident 42. He indicated he did not read or write. The VPRM indicated she would order a recorded book and headphones for him. On 7/31/23 at 9:42 a.m., the VPRM indicated the facility ordered him an electronic tablet. It would be used to download Arabic books when it arrives. She verified Arabic books were available and she would be able to get the Qur'an on the electronic tablet for him to listen to. On 7/31/23 at 9:44 a.m., the Administrator indicated it was her expectation that the Activity Director (AD) and the Social Service Director (SSD) know the resident's likes and dislikes and have the items of what they like to do. He had only one person who knew him and had no family the facility was aware of. The facility should have known that he could not read or write. Cross reference F699.2. On 7/27/23 at 8:47 a.m., Resident 84 was observed in her room as she laid in bed. She was able to speak some broken English, and with a translation software, she was able to communicate. She indicated she was from Mexico. Her room lacked decorations or personalized items of her heritage. There was an activity calendar in her room but printed in English. Resident 84 indicated she mostly stayed in her room and watched videos on her phone in Spanish. Sometimes she visited her neighbor who also spoke Spanish, but that was it.			

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	On 7/27/23 at 8:50 a.m., Registered Nurse (RN) 38 entered Resident 84's room. She used her cell phone to connect with a Spanish interpreter. Resident 84 indicated her stomach hurt, and she did not want to eat the breakfast because she did not like it. She did not want to take her medicine without eating first but had not eaten breakfast. Instead of the pancakes she was brought, Resident 84 requested 2 fried eggs. RN 38 indicated she would call and order 2 fried eggs. During the conversation, Resident 84 became tearful and covered her face with her hand. During an interview on 7/27/23 at 9:04 a.m., RN 38 indicated she did not know if Resident 84 liked pancakes or the breakfast which had been served, but she would try to order 2 fried eggs as she had requested. During an interview on 7/28/23 at 4:14 p.m., Resident 84's guardian indicated she did not believe staff utilized the language interpreter line as often as they should, otherwise staff may have been aware Resident 84 did not eat the food because she did not like it. The language barrier seemed like an issue and although several care plan conferences had been held, it seemed as if staff understood what Resident 84 wanted but never followed through. It was also difficult for her to participate in activities that were scheduled as they were all English/American based. During an interview on 7/31/23 at 11:05 a.m., Activity Assistant 40 indicated, he had worked with Resident 84 a few times and although she spoke Spanish, he was able to communicate with her via a translating app on his phone. She would come down for some activities, like Cinco-de-Mayo. He indicated there was no			

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	activity calendar in Spanish at that time. On 7/27/23 at 9:15 a.m., Resident 84's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, major depressive disorder, diabetes, and delusional disorder. A Diet History/Food Preference assessment dated 2/1/23 indicated, Resident 84's food preferences were obtained by her guardian, which included, but were not limited to, Mexican cultured food, soups, beans and small snacks. Although an initial Activity Preference, dated 9/27/22, was completed, it indicated the resident refused and/or were, "not assessed." Her comprehensive care plans lacked revision to include documentation of her cultural preferences, heritage and/or customs, food and activity preferences. Cross reference F699. On 7/28/23 at 10:13 a.m., the vice President of Risk Management, (VPRM) provided a copy of current, but undated facility policy, titled, "Plan of Care Overview." The policy indicated, " ...for the purpose of this policy the Plan of Care, also Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care ... It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents... planning includes the provisions of services to enable the resident to love with dignity and supports the resident's goals, choices and preferences... the facility will ... incorporate the resident's personal			

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	and cultural preferences in developing goals of care...." 3.1-35(d)(2)(B)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on interview and record review, the facility failed to ensure licensed nursing staff assessed and documented wound accurately for 2 of 2 residents reviewed for wound care (Resident 65 and 305). Findings include: 1. A comprehensive record review was completed on 7/27/23 at 1:35 p.m. Resident 305 admitted to the facility on 7/19/23. Her diagnoses included, but were not limited to, type 2 diabetes, hypertension, pressure ulcers, feeding tube, anxiety, and chronic respiratory failure.	F 0686	Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: No resident was harmed by the alleged deficient practice. Resident 65 has been discharged from the facility per his plan of care. Upon discharge 4 of the 5 wounds the resident admitted with were resolved. Resident 305 stills resides at the facility and continues to be evaluated weekly by a Certified Wound Nurse Practitioner and a licensed nurse at the facility which include accurate description of the wounds including measurements	09/05/2023

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	Resident 305's hospital discharge record was reviewed on 7/27/23 at 2:35 p.m. Her discharge documents from the hospital indicated she had stage 4 (full-thickness skin loss extending through the fascia with considerable tissue loss where there might be possible involvement of the muscle, bone, tendon, or joint) pressure ulcer to her sacrum and a stage 4 pressure ulcer to her right ischium (in the pelvis). Her admission assessment to the facility indicated she had skin areas noted. Description indicated "other" wound. The nurse indicated the area was new as of 7/19/23 and that it was a non-pressure injury. The location was the right buttock and only 1 pressure ulcer on the assessment. 2. A comprehensive record review was completed on 7/27/23 at 11:30 a.m. Resident 65 admitted to the facility on 6/14/23. His diagnoses included, but were not limited to, type 2 diabetes mellitus, hyperlipidemia, anemia, hypothyroidism, pressure ulcer of the left buttock and left heel and chronic kidney disease. Resident 65's admission assessment indicated he had excoriated skin concerns on his right rear thigh, left rear leg, and left lower leg. He had pressure ulcers to his left heel and sacrum. The nurse indicated there was only 1 pressure ulcer to the left heel. The left buttock was not assessed. A policy titled, "Skin Care and Wound Management Overview," with no date was provided by the Vice President of Risk Management (VPRM) on 7/28/23 at 10:32 a.m. It indicated, " ...Each resident/patient is evaluated upon admission and weekly thereafter for changes		and location of each wound. Resident 305 wounds continue to improve. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected. The facility conducted a full house skin sweep on 8/15/23 and 8/18/23 to ensure all wounds were documented. Any new findings were documented in the medical chart, treatment orders were obtained and the plan of care was updated to reflect the changes. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Education has been provided to all licensed nurses utilizing the Wound Care Overview policy with emphasis on assessing skin upon admission and documenting location and type of wounds with measurements. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur The DON/Designee will complete a head to toe skin assessment within 24 hours of admission on all new admission/readmissions and audit 3 residents charts per week for 4 weeks and then 1 resident per week for 8 weeks, then 1 resident per month for 3 months to ensure admission assessment	

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	in skin condition. Complete an Admission Observation Tool. Identify areas of skin impairment and pre-existing signs ....). 3.1-40		completed by the licensed nurse captures all wounds upon admission and has accurate documentation with type of wounds as well as measurements. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendations.	
F 0689 SS=E Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on observation, interview, and record review, the facility failed to prevent the potential for accidents for a resident who was at risk for falls for 1 of 13 residents reviewed for smoking, (Resident 47), and the facility failed to ensure adequate assessments and/or monitoring tools were implemented to ensure residents who smoked had the ability to smoke safely and demonstrated the ability to keep their smoking materials safely secured for 6 of 13 residents reviewed for smoking (Residents 47, 18, 61, 202, 213, and 81). B. Based on observation, interview, and record	F 0689	**Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** No residents were harmed by the alleged deficient practice. Resident 47's seating system was assessed and weights were added to the seating system to prevent tipping and resident has had no further concerns. The facility replaced the transition strip in the doorway to the smoking area to prevent	09/05/2023

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	review, the facility failed to prevent the potential for accidents by maintaining a safe water temperature range for 4 of 15 residents reviewed for accidents (Residents 23, 38, 36, and 17). C. Based on observation, interview, and record review, the facility failed to prevent the potential for accidents by adequately monitoring a resident during medication administration to ensure the medications were taken, and not spit out, forgotten, or hidden for 1 of 15 residents reviewed for accidents (Resident 84). Findings include: A1. On 7/26/23 at 12:00 p.m., Resident 47 was observed attempting to reenter the facility from the smoking area. An unknown staff member was holding the door for Resident 47 as she approached the threshold in her motorized scooter. When Resident 47 went over the threshold with the wheels of her chair, she tipped backwards in the chair and would have fallen backwards to the ground if the unknown staff member did not intercept and stop her from tipping backwards. Resident 47 expressed fear of falling in the future. On 7/26/23 at 12:20 p.m., the Administrator and Vice President of Risk Management were made aware of Resident 47 tipping backwards. The Vice President of Risk Management immediately implemented a measure to prevent further tipping backwards. Resident 47 had a fall care plan, dated 10/11/22, indicating she was at risk for falls. The care plan did not address the risk of falls from her wheelchair. Resident was at risk for tipping related to the distribution of her weight related to		potential for injury when residents self-propel wheelchairs to smoking area and a push plate system has been added to the door to promote independence. Residents 47, 18, 61, 202, 213, and 81 were given locked devices and educated to secure their smoking materials in the device and the plan of care was updated. During annual survey the survey team identified that water temperatures in the rooms of Residents 23, 38, 36, and 17 were above regulation temps. The facility immediately tested the water temperature of all resident rooms in the building and called for service repair to the hot water heater. The water was turned off until the repair was made and all residents were checked for any skin concerns with no findings. Resident 84 was identified as having medication left at bedside by a surveyor during annual survey. The for facility staff immediately searched the room medication and removed all medications from room and notified NP. Resident 84 was assessed for change of condition with none noted. A medication review was completed to ensure compliance with medication regimen and a speech referral was made to identify swallowing concerns with none noted. Resident guardian was educated to notify nursing staff if she noted	

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	the amputations. During an observation and interview on 7/31/23 at 11:14 a.m., Resident 47 was observed as she was assisted by a staff member back inside from the smoking area. Resident 47 indicated she required assistance to exit and enter the building from the smoking area. Her cigarettes and lighter were observed on the seat of her wheelchair with her. She indicated she always kept her smoking materials with her. On 7//26/23 at 2:00 p.m., a record review was completed. Resident 47 had the following diagnoses, but not limited to amputation of both legs above the knee, seizures, asthma, diabetes type 2, major depressive disorder and cerebral infarction (stroke). She had a smoking assessment, dated 7/12/23, indicating she was independent with the need for adaptive equipment. Her care plan, dated 10/11/22, lacked documentation of resident requiring assistance in and out to smoke. The care plan lacked documentation of resident's ability to safeguard his cigarettes and lighter from others. A2. During an interview on 7/26/23 at 2:10 p.m., Resident 18 indicated he kept his smoking materials in his room, in a nightstand, and at that time, a single cigarette was observed in his shirt pocket. On 7/26/2312:00 p.m., Resident 18's medical record was reviewed. He had diagnoses which included, but were not limited to, to acute kidney failure, atrial fibrillation, type 2 diabetes mellitus, essential hypertension, anxiety disorder, and chronic obstructive pulmonary disease.		resident to be non-compliant with medications or any changes of condition with stated understanding. The facility completed an immediate search of all other resident rooms to identify any medications left at bedside without findings. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken:** All residents whom wish to smoke have the potential to be affected. The facility replaced the transition strip in the doorway to the smoking area to prevent potential for injury when residents self-propel wheelchairs to smoking area and a push plate system has been added to the door to promote independence. Residents whom are identified as independent and have the capability to secure their smoking materials were given a locked device to secure their materials. Those resident whom cannot secure their smoking materials will have their smoking materials secured by staff and be supervised with smoking. The smoking policy was reviewed with all residents whom wish to smoke and added to the medical record. Care plans have been updated to reflect changes. All residents have the potential to be affected by unsafe water temperatures. The facility	

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	A smoking assessment, dated 7/3/23, indicated he had vision problems and required one-on-one assistance with his adaptive equipment and smoking. He had a comprehensive care plan, revised 3/16/23, indicated he was independent with smoking. The care plan lacked documentation of resident's ability to safeguard cigarettes from others, and an intervention indicated "provide_____ during smoke times," but had not been specified. A3. During an observation and interview on 7/26/23 at 1:03 p.m., Resident 61 indicated she required a staff member to push her in her wheelchair to the smoking area, entering and exiting to the smoking area and back to her room. Resident 18 indicated staff would not take her out on the evening shift. On 7/26/23 at 2:45 p.m., a comprehensive record review was completed. She had the following diagnoses, but not related to hemiplegia, visual disturbance, GERD (gastro-esophageal reflux disease), major depressive disorder, general anxiety disorder, agoraphobia, and cerebral infarction. She had an overdue smoking assessment, dated 4/19/23 indicated she was independent with the use of adaptive equipment. She had a comprehensive care plan, dated, 4/19/23, which lacked documentation of the need for her to have assistance to and from the smoking area. Her care plan lacked documentation of resident's ability to safeguard smoking materials from others.		conducts daily audits of the water temperatures in resident care areas to ensure water temperatures are maintained below 120 degrees. Any discrepancies have been immediately corrected. All residents whom receive medications have the potential to be affected. Daily observations are conducted by the facility IDT team and no other resident have been found to be affected. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Residents who are smokers will be educated on smoking policy to include residents identified as independent smokers will be able to secure smoke materials. An audit will be completed to identify all residents wishing to smoke and the plan of care will be updated to include the smoking policy and interventions. The facility staff has been educated utilizing the facility smoking policy with emphasis on securing smoking materials and providing supervision for those residents deemed dependent with smoking. The Maintenance Director was educated on how to obtain accurate water temperatures. Facility staff and residents were educated to notify Maintenance if water feels too hot upon use.	

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	A4. During an observation and interview with Resident 202 on 7/27/23 at 1:09 p.m. while she was smoking a cigarette. Resident 202 indicated she kept her smoking materials on her, and she required assistance getting in and out of the smoking door. She indicated she waited on staff to come and get her to come back in the building. A comprehensive record review was completed on 7/27/23 at 1:45 p.m. Resident 202 had the following diagnoses but not limited to heart failure, end stage renal disease, anemia, cardiac defibrillator, and major depression. Resident 202 had a smoking assessment, dated 7/25/23, indicating she was independent with need for adaptive equipment. Her care plan, dated 7/25/23, indicated she was independent with smoking. Resident interventions lacked resident required assistance to and from the smoking area. It lacked documentation of resident's ability to safely store her smoking materials. A5. During an observation and interview with Resident 213 on 7/28/23 at 1:14 p.m. Resident 213 was outside smoking a cigarette. She indicated she could not exit and enter the building from the smoking area and required assistance. Resident 213 indicated she kept her smoking materials with her. A record review was completed on 7/31/23 at 9:45 a.m. Resident 213 had the following diagnoses, but not limited to chest pain, GERD (gastro-esophageal reflux disease), hypothyroidism, anemia, and vitamin D deficiency. Resident 213 had a smoking assessment completed on 7/25/23 indicating she was		Education has been provided to all licensed nursing utilizing the Medication Administration Policy with emphasis on remaining with resident until medications are consumed and not leaving medications at bedside. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The DON/Designee will conduct observations of all smoking residents to ensure they can enter and exit the building safely as well as observing that independent smokers safely secure their smoking materials in the provided locked devices for 3 residents per week for 4 weeks and then 1 resident per week for 8 weeks, then 1 resident per month for 3 months. Any discrepancies will be immediately addressed and education will be provided as needed. Maintenance Director will conduct weekly audits of water temps in 10 resident rooms. Any discrepancies will be immediately addressed. The DON/Designee will conduct observations for 3 residents per week for 4 weeks and then 1 resident per week for 8 weeks, then 1 resident per month for 3 months to ensure no medication are left at bedside. Any discrepancies will be immediately addressed and education will be provided as needed.	

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	independent with adaptive equipment needs. Her care plan, dated 7/25/23, lacked documentation of an intervention of resident requiring assistance exiting and entering from the smoking area. The care plan lacked documentation of resident's ability to safeguard her smoking materials. A6. A record review completed on 7/27/23 at 2:00 p.m., indicated Resident 81 was a smoker. His last smoking assessment was dated 4/25/23 and indicated he was safe to smoke independently. His next smoking assessment was overdue.B1. During an observation on 7/24/23 at 11:00 a.m. Resident 23's bathroom sink was felt to be too hot to touch and burned the skin. Resident 23's record was reviewed on 7/26/23 at 12:48 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 5/8/23, indicated Resident 23 was cognitively intact and required a two-person physical assistance with bed mobility and transfers. She required one-person physical assistance with toilet use. Resident 23 had a diagnoses which included, but were not limited to, end stage renal disease (occurs when the kidneys are no longer able to work at a level needed for day to day life), dependence on renal dialysis (a treatment to clean your blood when your kidneys are not able to), and chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe). During an interview on 7/24/23 at 11:00 a.m., Resident 23 indicated she had noticed the water temperature was often too hot but was able to turn on the cold water to mix with the hot water. She had not told anyone about the hot water temperature.		The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation	

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B2. During an observation on 7/24/23 at 11:05 a.m., Resident 17's bathroom sink was felt to be too hot to touch and burned the skin.

Resident 17's record was reviewed on 7/27/23 at 10:08 a.m. A quarterly MDS assessment, dated 5/23/23, indicated Resident 17 had a severe cognitive impairment and required a two-person physical assistance with bed mobility, transfers, and toilet use.

Resident 17 diagnoses which included, but were not limited to, hemiplegia and hemiparesis (hemiplegia refers to a severe or complete loss of strength, whereas hemiparesis refers to a relatively mild loss of strength), cerebral infarction (occurs a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), and type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar).

B3. During an observation on 7/24/23 at 11:10 a.m., Resident 38's bathroom sink was felt to be too hot to touch and burned the skin.

Resident 38's record was reviewed on 7/27/23 at 9:29 a.m. An annual MDS assessment, dated 7/3/23, indicated Resident 38 had a moderate cognitive impairment and required a one-person physical assistance with bed mobility, toilet use, and dressing.

Resident 38 had diagnoses which included, but were not limited to, hemiplegia and hemiparesis (hemiplegia refers to a severe or complete loss of strength, whereas hemiparesis refers to a relatively mild loss of strength), cerebral infarction (occurs a result of disrupted blood flow to the

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brain due to problems with the blood vessels that supply it), and paroxysmal atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow).

During an interview on 7/24/23 at 11:10 a.m., Resident 38 indicated he had noticed the water temperature was too hot.

B4. During an observation on 7/24/23 at 11:15 a.m., Resident 36's bathroom sink was felt to be too hot to touch and burned the skin.

Resident 36's record was reviewed on 7/27/23 at 9:44 a.m. A quarterly MDS assessment, dated 7/5/23, indicated Resident 36 had a severe cognitive impairment and required a two-person physical assistance with bed mobility, transfer, toilet use, and dressing.

Resident 36 had diagnoses which included, but were not limited to, Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors) and chronic congestive heart failure (a long-term condition that happens when your heart can't pump blood well enough to give your body normal supply).

During an interview on 7/24/23 at 11:56 a.m., LPN 13 indicated she was not aware of any resident complaints related to hot water temperatures.

On 7/24/23 at 1:23 p.m., the Maintenance Technician was observed as he tested the water temperature in Resident 23's bathroom. He turned on the faucet, filled a Styrofoam cup with hot water and placed in thermometer in the cup. The Maintenance Technician indicated he did not obtain water temperature by holding his thermometer under the running water because it

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	took "too long." During an interview on 7/24/23 at 1:23 p.m., the Maintenance Technician indicated the water temperatures should be maintained between 115 to 120 degrees F (Fahrenheit). He had not observed water temperature issues in the building and was not aware of any mixing valve issue. The following water temperatures were obtained by the technician with the facility thermometer: a. Room 212's bathroom sink hot water temperature measured 122 degrees F. b. Room 211's bathroom sink hot water temperature measured 122 degrees F. c. Room 203's bathroom sink hot water temperature measured 124 degrees F. d. Room 208's bathroom sink hot water temperature measured 122 degrees F. The administrator provided a piece of paper with hot water temperatures dated 7/24/23 at 1:10 p.m. The piece of paper indicated additional rooms throughout the facility with elevated hot water temperatures. The paper indicated: a. Room 108's bathroom sink hot water temperature measured 128 degrees F. b. Room 159's bathroom sink hot water temperature measured 128 degrees F. c. Room 216's bathroom sink hot water temperature measured 130 degrees F. During an interview on 7/24/23 at 1:41 p.m., the Administrator indicated, a service person had been called and would be at the facility soon to turn down the water temperature. During an interview on 7/24/23 at 2:57 p.m., the Maintenance Director indicated, a service			

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	company had been out to the facility and lowered the mixing valve temperature in the building. He indicated the temperature was too hot and should be below 120 degrees F. When asked how water temperatures should be monitored/checked, he indicated the Maintenance Technician should have turned on the water faucet and let the water run for a little while to reach maximum temperature, then the thermometer should be placed under running water. On 7/24/23 at 3:10 p.m., the Administrator provided an undated document, titled, "Resources," and indicated it was the policy currently being used by the facility. The policy indicated, " ... 1. Hot water temperature meets regulatory requirements ...3. IN 100-120F ...." C. On 7/27/23 at 8:47 a.m., Resident 84 was observed in her room as she laid in bed. She was able to speak some broken English, and with a translation software, she was able to communicate. At that time, she indicated she did not feel well, rubbed her stomach, and rubbed her head. She indicated through the translator and with hand gestures, that she felt sick to her stomach and thought she might throw up. She indicated she wanted pain medication. At that time, a small beige oval pill was observed on her pillowcase, and a second, identical pill was observed on her floor near the foot of her bed. When Resident 84 lifted her shirt to rub her stomach (indicating pain) a small circular white pill was observed on her stomach. On 7/27/23 at 8:50 a.m., Registered Nurse (RN) 38 was notified of Resident 84's pain, and that several pills were observed. At that time, RN 38 went immediately to Resident 84 and removed the pills. RN 38 used her cell phone to connect with a Spanish interpreter. Resident 84 indicated her			

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	stomach hurt, and she did not want to eat the breakfast because she did not like it. She indicated she did not want to take her medicine without eating first but had not eaten breakfast. Instead of the pancakes she was brought, Resident 84 requested 2 fried eggs. RN 38 indicated she would call and order 2 fried eggs. During the conversation, Resident 84 became tearful and covered her face with her hand. During an interview on 7/27/23 at 9:04 a.m., RN 38 pulled Resident 84's medication cards and indicated, the 2 oval pills were mirtazapine (an antidepressant medication) 15mg (milligrams), and the small white pill ropinirole (a medication used to treat Parkinson's and restless leg syndrome). During an interview on 7/28/23 at 11:45 a.m., the Vice President of Risk Management (VPRM) indicated she had interviewed several nurses and Qualified Medication Aids (QMA) who worked with Resident 84. It was revealed, Resident 84 often took her medications by pouring them into her hand and taking one pill at a time with bites of food. It was thought perhaps some of the pills spilled as she brought her hand to her mouth. During an interview on 7/28/23 at 4:14 p.m., Resident 84's guardian indicated she was not surprised to hear some medication had been found in the resident's room. The guardian indicated she had found medication before and let the nurses know. Particularly, Resident 84 would hide her evening pills in the second drawer of her dresser and take them when she wanted to, closer to her bedtime. Evening medication administration usually happened around 6 to 7 p.m., and because Resident 84 thought they made her sleepy, she would often hide her pills to take them later. Resident 84's guardian had even asked the			

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	prescribing psychiatrist to ensure they wrote her new prescription for Zyprexa (an antipsychotic medication) to be scheduled at 10:00 p.m., to help meet Resident 84's preference to receive her medications later in the evening. On 7/31/23 at 10:19 a.m., Resident 84 was observed. She appeared in better spirits and sat up in bed to have a conversation. Resident 84 was informed of the conversation with her guardian and with Resident 84's permission, her second dresser drawer was observed. Under some napkins there were 14 unidentified pills/tablets. Resident 84 indicated she saved the pills for nighttime as they were meant to help her with her headaches and to be able to sleep. On 7/31/23 at 11:15 a.m., Resident 84's second drawer was observed with the VPRM, who removed the medication and indicated she would identify them and talk with the nurses about a different approach. On 7/31/23 at 11:40 a.m., the VPRM provided a list of medications found in Resident 84's drawer which included: a. 2 Remeron (an antidepressant) 15mg, for which she had an active physician's order. b. 1 Calcium Citrate (calcium supplement) 250mg, for which she had an active physician's order. c. 1 B-12 vitamin tablet 1000 micrograms (mcg), for which she had an active physician's order. d. 1 prenatal supplement, for which she had an active physician's order. e. 2 Acarbose (an anti-diabetic medication) 25mg, for which she had an active physician's order. f. 1 Trazadone (an antidepressant and sedative medication) 50mg, for which she had an active physician's order. g. 1 Celebrex (an anti-inflammatory pain medication) 100 mg, for which she had an active			

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	physician's order. h. 2 Zoloft (an antidepressant medication) 100mg, for which she had an active physician's order. i. 1 Tessalon Perel (a cough suppressant medication), which she did not have an active physician's order for. j. 1 Amitriptyline (an antidepressant and nerve pain medication), which she did not have an active physician's order for. k. 1 Omeprazole (medication used to treat heart burn), which she did not have an active physician's order for. During a follow up interview on 7/31/23 at 4:18 p.m., Resident 84's guardian indicated she visited Resident 84 the previous Friday on 7/28/23. During the visit, she found a cup of pills hidden in a drawer and she turned them over to the nurse at that time. On 7/27/23 at 9:15 a.m., Resident 84's medical record was reviewed. She was a long-term care resident with diagnoses which included, but were not limited to, major depressive disorder, diabetes, and delusional disorder. Her nursing progress notes were reviewed and lacked documentation of her preference to take medications at a certain time, refusing medication, and/or hiding medication in her room. Resident 84 was not granted a physician order to have medication at bedside or to self-administer her own medications. Her comprehensive care plans lacked revision to include her personal preferences or specific choices for when and how she received her medications.			

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	On 7/27/23 at 12:37 p.m., the VPRM provided a copy of current, but undated facility policy titled, "Medication Administration." The policy indicated, "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. Safety of residents, visitors and employees is a top priority ... bb. remain with resident until the medication is swallowed, cc. do not leave medications at bedside ...." 3.1-45(a)(1) 3.1-45(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure proper cleaning and maintenance of respiratory equipment for 1 of 3 residents reviewed for respiratory care (Resident 8). Finding includes: On 7/24/23 at 2:34 p.m., 7/26/23 at 10:23 a.m., and 7/26/23 at 2:15 p.m., Resident 8's oxygen concentrator was noted to have a brown dried substance all down the front, sides, and back of it.	F 0695	Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: The resident had no harm related to the alleged deficient practice. The facility contacted O2 safe solutions to assess the oxygen concentrator to ensure proper functioning. The filter and concentrator was cleaned and the resident had no concerns.	09/05/2023

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	The oxygen concentrator filter was covered in dust. Resident 8's record was reviewed on 7/26/23 at 9:43 a.m. The profile indicated the resident diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems) and type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). A quarterly Minimum Data Set (MDS) assessment, dated 5/8/23, indicated the resident was cognitively intact and received oxygen therapy. A care plan, dated 1/06/22, indicated the resident has oxygen therapy related to CHF (congestive heart failure) and COPD. Interventions included but were not limited to, 2L(liters) by nasal route for hypoxia (absence of enough oxygen in the tissues to sustain bodily functions) and COPD. A physician's order, dated 6/18/23, indicated clean oxygen concentrator filter with soap and water weekly and prn (as needed) every night shift every Sunday for oxygen care. During an interview, on 7/26/23 at 2:15 p.m., Resident 8 indicated she had never seen anyone clean her oxygen concentrator or the filter. She indicated staff changed out the tubing, but that was it. During an interview, on 7/26/23 at 2:24 p.m., Unit Manager indicated it appeared as if Resident 8's oxygen concentrator filter had not been cleaned and the concentrator was dirty. She assumed that the respiratory company cleaned the equipment		Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents whom receive oxygen therapy have the potential to be affected. The facility completed an audit of all oxygen concentrators and found no other concerns. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Education was provided to all licensed nurses utilizing the Oxygen Therapy Using Concentrators Policy with emphasis on how and when to clean the concentrators and filters. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The DON/Designee will complete audits for 3 residents per week for 4 weeks and then 1 resident per week for 8 weeks, then 1 resident per month for 3 months to ensure oxygen concentrators and filters are clean. Any discrepancies will be immediately addressed and education will be completed as needed. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation	

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	when they came monthly. She was unaware the resident had an order to have the filter cleaned weekly and as needed. The Unit Manager indicated she would have this taken care of immediately. On 7/27/23 at 10:15 a.m., Resident 8 had a different oxygen concentrator in her room and was clean and the filter was also noted to be clean. The resident indicated that staff had brought in the new equipment yesterday afternoon. On 7/27/23 at 9:55 a.m., the Vice President of Risk Management (VPRM) provided an undated document, titled, "Oxygen Therapy Using Concentrators," and indicated it was the policy currently being used by the facility. The policy indicated, " ...a. Filters and machines are to be cleaned once a week ...b. Clean the surface of the machine with an EPA approved disinfectant ...." 3.1-47(a)(6)			
F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on observation, interview, and record review, the facility failed to ensure residents received appropriate person-centered culturally competent accommodations for 2 of 3 residents reviewed for culturally competent nursing services (Residents 84 and 42).	F 0699	Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: No resident was harmed by the alleged deficient practice. Resident 84 was interviewed	09/05/2023

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	Findings include: 1. On 7/27/23 at 8:47 a.m., Resident 84 was observed in her room as she laid in bed. She was able to speak some broken English, and with a translation software, she was able to communicate. At that time, she indicated she did not feel well, and rubbed her stomach, and rubbed her head. She indicated through the translator and with hand gestures, that she felt sick to her stomach and thought she might throw up. Her room was very warm and the thermostat on her wall read 83 degrees Fahrenheit (F). She indicated she wanted her room hot and had opened her window. She indicated she was from Mexico and preferred it to be warm. Her room lacked decorations or personalized items of her heritage. There was an Activity calendar in her room, but printed in English. Resident 84 indicated she mostly stayed in her room and watched videos on her phone in Spanish. Sometimes she visited her neighbor who also spoke Spanish, but that was it. On 7/27/23 at 8:50 a.m., Registered Nurse (RN) 38 entered Resident 84's room. She used her cell phone to connect with a Spanish interpreter. Resident 84 indicated her stomach hurt, and she did not want to eat the breakfast because she did not like it. She indicated she did not want to take her medicine without eating first but had not eaten breakfast. Instead of the pancakes she was brought, Resident 84 requested 2 fried eggs. RN 38 indicated she would call and order 2 fried eggs. During the conversation, Resident 84 became tearful and covered her face with her hand. During an interview on 7/27/23 at 9:04 a.m., RN 38 indicated Resident 84 always kept her room hot, a lot of older people liked their rooms hot. RN 38 did		utilizing the language line for cultural preferences and plan of care was updated for preferences with cultural foods and activities. The facility also provided resident with a Spanish version activities calendar and menu. Resident 42 was interviewed utilizing the language line for cultural preferences for food and activities and audio books were purchased on his tablet for his cultural preferences and his plan of care was updated. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected. The facility completed interviews with all residents using the “Getting to Know Me” questionnaire to identify cultural preferences and the plan of care has been updated to reflect the preferences. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Education has been provided to facility staff utilizing the Trauma Informed Care policy with emphasis on providing resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:	

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	not know if Resident 84 like pancakes or the breakfast which had been served, but she would try to order 2 fried eggs as she had requested. During an interview on 7/28/23 at 4:14 p.m., Resident 84's guardian indicated, she did not believe staff utilized the language interpreter line as often as they should, otherwise staff may have been aware Resident 84 did not eat the food because she did not like it. The language barrier seemed like an issue and although several care plan conferences had been held, it seemed as if staff understood what Resident 84 wanted but never followed through. It was also difficult for her to participate in activities that were scheduled as they were all English/American based. On 7/31/23 at 10:19 a.m., Resident 84 was observed. She appeared in better spirits and sat up in bed to have a conversation. Her bedside table was observed with an empty bowl of oatmeal and a banana. Through a translator, Resident 84 indicated, she had eaten the oatmeal so she could get her medicine, but she did not like it. Again, she requested fried eggs. She indicated she was from Mexico and preferred spicy foods and more staples from her country like rice and beans. She liked stews and soups as well. On 7/31/23 at 10:22 a.m., Certified Nursing Aid (CNA) 24 entered Resident 84's room and asked her, in English, if she was done with breakfast. Resident 84 handed her the empty bowl and banana. She indicated, "no like." CNA 24 did not ask if Resident 84 would like anything else. During an interview on 7/31/23 at 10:26 a.m., Dietary Aid (DA) 39 was observed as she returned a hall-tray cart to the dining room. She indicated, usually by the time the staff picked up		The SSD/Designee will review the "Getting to Know Me" questionnaire for 3 residents per week for 4 weeks and then 1 resident per week for 8 weeks, then 1 resident per month for 3 months to ensure the preferences and the plan of care are being followed. Any discrepancies will be immediately corrected and education will be provided as needed. The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendation.	

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	breakfast it was too late to order additional breakfast. Because it was late morning, lunch was already being prepared and DA 39 was not sure if Resident 84 could get 2 fried eggs, but she would check with the Dietary Manager. On 7/31/23 at 10:28 a.m., DA 39 returned from the kitchen and indicated, the Dietary Manager, (DM) was preparing lunch at that time, and as she was the only cook, could not prepare 2 fried eggs, but she would be happy to do so after lunch. During an interview on 7/31/23 at 11:05 a.m., Activity Assistant 40 indicated, he had worked with Resident 84 a few times and although she spoke Spanish, he was able to communicate with her via a translating app on his phone. She would come down for some activities, like Cinco-de-Mayo. He indicated there was no activity calendar in Spanish at that time. On 7/31/23 at 11:30 a.m., Activity Assistant 40 provided a copy of the April, May, and June Activity Calendars which were reviewed at this time. The April 2023 calendar lacked inclusionary activities for Hispanic and Spanish speaking residents. The May 2023 calendar lacked inclusionary activities for Hispanic and Spanish speaking residents. The June 2023 calendar lacked inclusionary activities for Hispanic and Spanish speaking residents. On 7/27/23 at 9:15 a.m., Resident 84's medical record was reviewed. She was a long-term care			

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	resident with diagnoses which included, but were not limited to, major depressive disorder, diabetes, and delusional disorder. A copy of her diet/menu cars was provided by the Administrator on 7/31/23 at 11:30 a.m. Although her ticket indicated she preferred boiled or fried eggs, Resident 84 was not observed to received either (without direct request) throughout the survey period. Her nursing progress notes were reviewed and lacked documentation of her cultural preferences, heritage and/or customs. A Diet History/Food Preference assessment dated 2/1/23 indicated, Resident 84's food preferences were obtained by her guardian, which included, but were not limited to, Mexican cultured food, soups, beans and small snacks. Although an initial Activity Preference, dated 9/27/22, was completed, it indicated the resident refused and/or were, "not assessed." The record lacked documentation of additional Activity Preference reviews/assessments. Her comprehensive care plans lacked revision to include documentation of her cultural preferences, heritage and/or customs.2. On 7/24/23 at 12:54 p.m., Resident 42 was observed sitting on the edge of his bed. He was dressed and groomed appropriately. When asked questions, he indicated, "no English." He did not use any other English words. He was not engaged in any activity at all. He just stared with his eyes open. He was unable to see or communicate and did not indicate or point to the language line information on his wall. Paper signs were observed on			

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	Resident 42's wall for the Language Line to reach an interpreter with a specific number for this resident. On 7/26/23 at 12:30 p.m., Resident 42 was observed sitting on the edge of his bed. He was dressed and groomed appropriately. He was not engaged in any activity at all. He just stared with his eyes open. He was unable to see or communicate. On 7/27/23 at 3:05 p.m., Resident 42 was observed sitting on the edge of his bed. He was dressed and groomed appropriately. He was not engaged in any activity at all. He just stared with his eyes open. He was unable to see or communicate. On 7/28/23 at 9:56 a.m., Resident 42 was observed sitting on the edge of his bed. He was dressed and groomed appropriately. He was not engaged in any activity at all. He just stared with his eyes open. He was unable to see or communicate. Resident 42's record was reviewed on 7/28/23 at 1:54 p.m. His diagnoses included, but were not limited to, end stage renal disease, kidney transplant, unspecified visual loss, cataract, and diabetes mellitus (blood sugar disorder). His communication care plan, dated 2/22/23, indicated he had a language barrier due to speaking Arabic. Use the Language Line Solutions. The goal was to maintain or improve his current level of communication. The nursing intervention only provided the phone number for the Language Line. His impaired visual function care plan, dated 6/29/23, indicated blindness, cataracts, diabetes mellitus retinopathy, and retinal detachment. The			

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nursing interventions were, "I am blind," provide large print reading materials as needed, and read menus/letters, mail related to impaired sight. It did not indicate he only spoke Arabic and the Language Line Solutions needed to be utilized when reading to him.

His cultural preference care plan, dated 3/1/23, only indicated he disliked pork. The nursing intervention indicated to, "do not give pork."

His activity care plan, dated 10/15/21, indicated he had little or no activity involvement. A nursing intervention indicated to interview and determine resident activity preferences and use the Language Line Solutions to access an interpreter when needed.

A progress note, dated 5/24/23 at 11:06 a.m., indicated Resident 42 was legally blind.

A nurse practitioner's progress note, dated 7/12/23 at 3:52 p.m., indicated her assessment and plan was Resident 42's depression had improved. He needed therapy, outside time, increased use of the interpreter line, and psychotherapy.

On 7/28/23 at 9:48 a.m., the Activity Director (AD) indicated she offered Resident 42 coffee and donuts. Him sitting on the side of the bed was his normal. He gets one on one to help him with getting dressed, that involves sensory and touching. She used the language line. He understood a little English. He only said one or two words in English.

On 7/28/23 at 9:53 a.m., the Social Services Director (SSD) indicated he could talk into his phone and listen to movies. His phone was set to the Arabic language. Other activity assistants

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	would assist him with his phone and use the language line. On 7/28/23 at 12:38 p.m., the AD indicated Resident 42 was completely blind. But sometimes came to the community area to listen to music. She was observed to call the Language Line. She put in the resident's number and asked for an Arabic interpreter. a. She asked him how was his day? He responded he went to an appointment today and no one spoke Arabic. He did not understand anything about his doctor's visit. b. She asked were there an activities he would like to do? He responded why had there not been any coffee. She told him the facility was out of coffee. c. She asked were there an activities he would like to do? He responded louder music, and he would like Braille books. He would like anything to read. d. She asked what was his favorite thing to do? He responded raise the volume of the music. e. She asked about his mood, how was he feeling? He responded he was used to sitting alone. He received his strength from God. On 7/31/23 at 9:31 a.m., the Vice President of Risk Management (VPRM) indicated she and the Administrator used the language line to talk with Resident 42. He indicated he did not read or write. The VPRM indicated she will order a recorded book and headphones for him. On 7/31/23 at 9:42 a.m., the VPRM indicated the facility ordered him an electronic tablet. It would be used to download Arabic books when it arrives. She verified Arabic books were available and she would be able to get the Qur'an on the electronic tablet for him to listen to. On 7/31/23 at 9:44 a.m., the Administrator			

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	indicated it was her expectation that the Activity Director (AD) and the Social Service Director (SSD) know the resident's likes and dislikes and have the items of what they like to do. He had only one person who knew him and had no family the facility was aware of. The facility should have known that he could not read or write. On 7/31/23 at 10:10 a.m., the SSD indicated in her role as Social Services Director, she took care of his ancillary care services. If an ancillary service made a recommendation, she would follow-up with implementation.. Before and after his kidney transplant, he had a lot of appointments, a specialized Gatorade, and other drinks. He was ok after the transplant for activities. He liked the saxophone. The saxophone player came once a month. That was the only activity that he liked that she was aware of. A current policy, titled, "Trauma Informed Care," dated 10/2/22, was provided by the VPRM, on 7/31/23 at 9:59 a.m. A review of the policy indicated, " ...Cultural Competence is defined as the capacity for individuals and organizations to work and communicate effectively in cross-cultural situation. Policies, structures, practices, procedures, and dedicated resources can support this capacity. Cultural and linguistic competency occurs through adopting and implementing strategies to ensure appropriate awareness of, attitudes toward, and actions about diverse populations, cultures, and language ...." A current policy, titled, "Plan of Care Overview," with no date, was provided by the VPRM, on 7/31/23 at 1:05 p.m. A review of the policy indicated, " ...Care Plan is the written treatment provided for a resident that is resident-focused and provides for optimal personalized care ...It is			

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	the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents. Safety is a primary concerns for our residents, staff and visitors ...The facility will provide an RN [registered nurse] assessment of the resident as an on-going, periodic review that provides the foundation for resident focused care and the care planning process ...incorporate the resident's personal and cultural preferences in developing goals of care ...Members of the care planning team will coordinate care to meet resident preferences and care needs utilizing a holistic approach to care ...." 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
F 0812 SS=D Bldg. 00				

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	Based on observation, interview, and record review, the facility failed to ensure proper handwashing for 1 of 2 dining observations, failed to ensure proper handling of food during 1 of 2 dining observations, and facility further failed to ensure beard restraints were worn in the kitchen and dining room during for 2 of 2 random kitchen and dining room observations. Findings include: 1. During a dining observation, on 7/24/23 at 12:32 p.m., the Director of Public Relations washed her hands for less than 20 seconds. She walked to the counter to wait for a tray to serve, she pulled her phone out of her back pant pocket, looked at her phone then placed it in her back pant pocket. She then obtained a tray and served a resident her tray of food and drinks. 2. During a dining observation, on 7/24/23 at 12:40 p.m., the Director of Public Relations washed her hands for less than 20 seconds and served a resident their lunch tray. 3. During a dining observation, on 7/24/23 at 12:48 p.m., the Director of Nursing (DON) served a resident his lunch tray, she sat the tray on the table and adjusted her glasses on her face. She picked up the resident's spoon and placed the food on it and fed the resident. She gave the resident one bite of food and walked over to another resident and touched her blanket and adjusted her pillow. The DON touched another resident on the shoulder and picked up her Styrofoam cup asking the resident if she wanted something else to drink. No hand sanitizer or handwashing was observed during this time. During an interview, on 7/26/23 at 10:42 a.m., LPN	F 0812	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** · No resident was identified as having been affected by practice · Cook #31 & Cook #32 were immediately re-educated on ensuring facial hair covered when working in the kitchen and placed two beard covers to ensure no facial hair was exposed. · Staff were immediately reeducated on the requirement to perform hand hygiene before serving food items. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** · Residents who receive food items from the kitchen have the potential to be affected. The facility provided immediate education to all staff serving in dining rooms and placed meal monitor in all dining rooms at all meal times to ensure facial coverings are worn per policy and hygiene is conducted per policy **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · Education has been	09/05/2023

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	13 indicated handwashing for less than 20 seconds was not enough. During an interview, on 7/27/23 at 11:53 a.m., the Dietary Manager indicated staff should be washing their hands for at least 20 seconds and should not be touching their phone, face, or other residents when serving in the dining room. On 7/26/23 at 2:33 p.m., the Vice President of Risk Management (VPRM) provided a document, with a revised date of 4/1/17, titled, "Standard Precautions," and indicated it was the policy currently being used by the facility. The policy indicated, ...II. When to perform Hand Hygiene ...B. Before and after direct contact with a resident's intact skin ...D. After contact with inanimate objects including medical equipment in the immediate vicinity of the residents ...F. For care between residents ...4. Rub hands vigorously for at least 20 seconds, covering all surfaces of the hands, tops of hands and fingers, and wrists ...." 4. During a random dining observation, on 7/26/23 at 12:25 p.m., Cook 32 was observed to be serving food onto residents' plates and his mustache was exposed. A beard restraint was on but was not covering all his facial hair. 5. During a kitchen observation, on 7/27/23 at 11:53 a.m., Cook 31 was pureeing food for the residents and his beard restraint was fully covering his facial hair. His mustache was exposed. During an interview, on 7/27/23 at 12:28 p.m., the Dietary Manager indicated staff was to wear hair and beard restraints when preparing and serving food. She indicated the male staff were wearing		provided to all dietary staff utilizing the policy on Staff Attire with emphasis on the requirement to cover facial hair when in the kitchen. All staff have been educated utilizing the Hand Hygiene Policy with emphasis on when hand hygiene is required while passing trays and assisting residents during meals. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · The Dietary Manager/designee will perform routine observations to ensure dietary associates have facial hair covered while in the kitchen, and Administrator observations to ensure that hand hygiene is being completed when necessary. Observations to occur: 4 random observations daily M-Fri x's 4 wks, 4 random observations wkly x's 4 wks, then 4 random observations monthly x's 4 months for a total of 6 months of monitoring. Any findings will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly thereafter for a total of 6 months. Frequency and duration of reviews will be increased as needed if any areas	

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	beard restraints, but their mustaches were exposed. On 7/28/23 at 1:37 p.m., the Administrator provided a document, titled "Dining Service Department," the document was an in-service attendance record and indicated dietary staff were educated on facial hair and that it needs to be properly restrained. The in-service was conducted on 7/28/23 at 8:00 a.m. On 7/28/23 at 10:13 a.m., the VPRM provided a document, with a revised date of 9/17, titled, "Staff Attire," and indicated it was the policy currently being used by the facility. The policy indicated, ...1. All staff members will have their hair off the shoulders, confined hair net or cap, and facial hair properly restrained ...." 3.1-21(i)(3)		of noncompliance are identified during the auditing process.	