STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155496	A. BUILDING 00 B. WING	03/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
VALLEY VIEW HEALTHCARE CENTER	333 W MISHAWAKA RD ELKHART, IN 46517

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00402589, IN00402462, IN00402173 and IN00391830. Complaint IN00402589 - No deficiencies related to the allegation(s) are cited. Complaint IN00402462 - Federal/State deficiencies related to the allegations are cited at F698. Complaint IN00402173 - Federal/State deficiencies related to the allegations are cited at F698. Complaint IN00391830 - Federal/State deficiencies related to the allegations are cited at F804. Survey dates: March 6, 7, 8, 9, 10, 13 and 14, 2023 Facility number: 000523 Provider number: 155496 AIM number: 100266930 Census Bed Type: SNF/NF: 83 Total: 83 Census Payor Type: Medicare: 3 Medicaid: 75 Other: 5 Total: 83 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 3/22/23.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David E Henke	Executive Director	04/06/2023

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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F 0576 SS=E Bldg. 00	483.10(g)(6)-(9) Right to Forms of Communication w/ Privacy §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide			

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	such access to the resident. (iii) Such use must comply with State and Federal law. Based on observation and interviews, the facility failed to ensure mail was delivered to residents on Saturdays. (Residents 36, 39, 63 and 71) Finding includes: During the resident council/surveyor meeting, on 3/10/2023 at 2:00 P.M., 4 of 4 alert and oriented residents attending the meeting (Residents 36, 39, 63 and 71) indicated the resident mail was not delivered on Saturdays or Sundays. The residents indicated the mail, delivered to the facility, sat in a box in the front of the building. On 3/13/2023 at 9:03 A.M., on a Monday morning, a stack of mail with a large rubberband around it was observed on the receptionist's desk. During an interview with Employee 19, on 3/13/2023 at 9:04 A.M., she confirmed the stack of mail had been delivered on Saturday and no one sorted and delivered the mail to the residents on Saturdays. Employee 19 indicated the post office usually delivered the facility mail to the building around 5:00 P.M. and she sorted the mail the next weekday morning and placed any resident mail on a shelf in the copy room office. She indicated the Activity Director was responsible to deliver the resident mail to the residents. During an interview on 3/13/2023 at 3:04 P.M., with the Regional Nurse Consultant, she indicated the facility did not have a policy regarding resident mail delivery but followed the Resident's Rights.	F 0576	1. Resident 36, 39, 63, and 71 were part of a confidential survey and could not be identified. 2. All resident who receive personal mail have the potential to be affected. An audit was conducted to ensure there was no mail currently that had not been delivered. Any mail identified as not being delivered was immediately delivered to the intended resident. 3. The Executive Director has educated all members of the management team that participate in the Manager on Duty program on the facility's mail delivery process with emphasis on mail delivery on Saturdays and Sunday. The scheduled Manager on Duty or designee will collect the mail from the mail box and separate personal mail from business mail. The Manager on Duty or designee will deliver unopened mail to residents. Business mail and mail addressed to residents that no longer reside at the facility will be placed in the holding mail box now located in the main copy room. 4. The Executive Director/Designee will conduct an audit of 3 cognitively intact residents 3x/week x 4 weeks and 1x weekly x 8 weeks to ensure mail is being delivered. Audits will	04/06/2023

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			be conducted on an ongoing basis for 3 months with 100% compliance achieved. ED/Designee will report on audits monthly during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance achieved.	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.			

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	(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.			
	Based on observation, interview, and record review, the facility failed to perform a dressing change in a private area for 1 out of 1 reviewed for dignity. (Resident 17) Finding includes: The record for Resident 17 was reviewed on 3/7/2023 at 9:00 A.M. Diagnoses included, but not limited to: dementia without behavioral disturbances, psychotic disturbances, mood disturbances and anxiety disorder. A Physician Order, dated 3/1/2023 indicated staff were to apply skin prep to the left heel and cover the blister with a border gauze dressing daily, while the blister was intact. The order was discontinued on 3/8/2023 A Physician Order, dated 3/8/2023 indicated staff were to apply to a topical dressing to the left heel, once a day and apply skin prep daily. During an observation, on 3/7/2023 at 9:27 A.M., Registered Nurse (RN) 9 removed Resident 17's left boot, sock and dressing in the common area with six resident's presents. She proceeded to clean the area, apply the treatment and cover with a dressing to a pressure ulcer. During an observation, on 3/8/2023 at 9:50 A.M.,	F 0583	Personal Privacy/Confidentiality of Records Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Resident 17 was not harmed by the alleged deficient practice. Resident 17 dressing changes have been audited to ensure being performed in private area for dignity.	04/06/2023

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	Registered Nurse (RN) 9 removed Resident 17's boot, sock, applied the treatment and dressing to pressure ulcer on the left heel in the common area with 2 residents present. During an interview, on 3/8/2023 at 9:58 A.M., the RN 9 indicated that the common area was not the appropriate area to do a treatment, it should have been done in her room. On 3/9/2023 at 1:57 P.M., the Director of Nursing provided a policy titled, "Resident Rights", dated 10/10 2022, and indicated the policy was the one currently used by the facility. The policy indicated"...d. To have their privacy respected when treatment, medication, or care is being administered including, i. door closed or privacy curtain drawn, ii. not have treatment, medication or care performed in common area (unless requested by resident) such as hallways, dining rooms or other including but not limited to 2. Treatments include but not limited to a. Including but not limited to: i. Dressing or wound care...." 3.1-9		2. All residents receiving treatments have the potential to be affected by same alleged deficient practice. All residents receiving treatments have been audited to ensure being performed in private area. 3. DON/Designee has educated all licensed nurses on the resident rights policy with an emphasis on maintaining confidentiality of resident information at all times. 4. DON/Designee will audit 3 residents with a treatment order to ensure privacy is maintained. This will occur 3 x wk x 4 wks, then 1 x wk x 8 wks. DON/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	
F 0637 SS=D Bldg. 00	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant			

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	change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)			
	Based on observation, record review and interviews, the facility failed to ensure a significant change assessment was completed after a significant decline in transfer, ambulation, bed mobility, toileting and bowel and bladder continency was noted for 1 of 2 residents reviewed for ADL (Activities of Daily Living) declines and bowel and bladder continency. (Resident 70) Finding includes: Resident 70 was observed, on 3/9/2023 continuously from 8:53 A.M. - 12:00 P.M. The resident was noted to sit herself up independently and feed herself when her meal tray was delivered. Nursing staff were observed administering medication, asking her about her personal hygiene supplies and trimming her nails but otherwise, no nursing care was observed for Resident 70. She was not observed to be assisted to toilet or to toilet herself. During an interview with CNA 22, on 3/10/2023 at 9:30 A.M., she indicated Resident 70 was independent for dressing, wore underwear and was continent and toileted herself. CNA 22 indicated the only help she gave Resident 70 was supervision and washing her back for showers.	F 0637	F637 Comprehensive Assessment After Significant Change Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Resident 70 was not harmed by the alleged deficient practice. Resident 70 assessments have been audited to ensure significant change	04/06/2023

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	She indicated Resident 70 had only been incontinent for the first few days after her admission. She indicated the resident ambulated by herself and only went to Bingo and meals, but otherwise spent her time in bed. Resident 70 was admitted to the facility with diagnoses, including but not limited to: fracture of the left femur, drug induced Parkinsonism, difficulty walking, history of falling and dementia with other behavioral disturbance, Review of the admission Minimum Data Set (MDS) assessment, completed on 2/6/2023, indicated the resident was moderately cognitively impaired and required limited one person assistance for all needs, including transfers, toileting, eating and ambulation and hygiene. The resident was also assessed as occasionally incontinent of her bowels and bladder.. A quarterly MDS assessment, completed on 2/27/2023 indicated the resident remained moderately cognitively impaired but had declined significantly and now required extensive staff assistance of two staff for bed mobility and transfers, required extensive staff assistance of one staff for locomotion to walk in the corridor and for toileting needs. In addition, the resident was now occasionally incontinent of her bladder and frequently incontinent of her bowels. The bowel and bladder assessment portion of the Admission assessments, completed on 1/30/2023 indicated the resident was continent of her bowels and bladder. There was no additional bowel and bladder continence assessment completed to reflect the resident's current MDS assessment. The current care plans for Resident 70, dated as		assessment has been completed. 2. All residents with a significant change have the potential to be affected by same alleged deficient practice. All residents with a significant change within the last 30 days have been reviewed to ensure an assessment has been completed. - 3. DON/Designee has educated the IDT team on the RAI manual guidelines for significant change with an emphasis on declines in transfer, ambulation, bed mobility, toileting, and bowel and bladder continency. 4. DON/Designee will audit 2 residents with a significant change. This will occur 3 x wk x 4 wks, then 1 x wk x 8 wks. DON/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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reviewed on 2/15/2023 indicated the resident requires limited assistance of one staff for all activities of daily living except eating. There was also a plan to address the resident's urine incontinence but the only interventions were to check the resident for incontinence and provide peri care as needed and to assess the resident for signs and/or symptoms of a urinary tract infection. There was no plan to address the residents bowel incontinence.

Review of the therapy documentation, provided by the therapy manager on 3/10/2023 at 2:30 P.M., indicated the resident had received both occupational; and physical therapy from 1/31/2023 through 3/1/2023. She had been discharged from therapy after having met all of her goals and was determined to be independent for toileting needs, transfer and ambulation needs and was discharged with "Modified Independence" due to cognitive deficits.

During an interview with LPN 23, the MDS coordinator, and the Administrator, on 3/10/2023 at 11:07 A.M., both staff members insisted the quarterly MDS assessment for Resident 70, completed on 2/27/2023 was an accurate reflection of the resident because she would "sun down" in the late afternoons and evenings and required more assistance during those time frames. LPN 23 indicated a quarterly MDS had been completed early on 2/27/2023 for Resident 70 to "grab" the resident's participation in therapy. LPN 23 indicated a significant change assessment was required if there were significant changes. When the significant declines in condition between the assessments were pointed out to LPN 23 she indicated the quarterly MDS review would "catch it." and indicated the resident was being seen by therapy services. When the inaccurate bowel

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	and bladder incontinence assessment was pointed out to LPN 23, she indicated nursing staff were responsible for completing and updating those assessments and she was responsible for updating the care plans. LPN 23 indicated she had not implemented any specific interventions to address the resident's current status mobility and incontinence status, after having completed the 2/27/2023 quarterly MDS assessment. During an interview, on 3/13/2023 at 4:00 P.M., with the Regional Nurse Consultant, she indicated the facility did not have a policy for completing significant change MDS assessments but followed the RAI (Resident assessment instrument) manual. Review of the clinical record, completed on 3/14/2023, indicated the facility had not initiated a Significant Change Minimum Data Set assessment. 3.1-31(d)(1)			
F 0655 SS=B Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a			

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	resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			
	Based on interview and record review, the facility failed to provide a written summary of the base line care plan to the resident and resident representative within 48 hours of admission for 1 of 2 newly admitted residents reviewed for base line care plans. (Resident 56) Finding includes:	F 0655	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is	04/06/2023

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	The record for Resident 56 was reviewed on 3/8/2023 at 9:05 A.M. Diagnoses included, but not limited to: benign prostatic hyperplasia, heart failure, and vascular dementia without behavioral disturbances. During an interview, on 3/8/2023 at 9:42 A.M., the Social Worker indicated that they did not provide the resident or residents representative a copy of the plan of care nor any documentation in the progress notes of one given and should have provided one. On 3/8/2023 at 10:12 A.M., the Regional Nurse provided a policy titled, "Baseline/Care Plan/48 Hour Care plan", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...b. The facility will provide a copy of the baseline care summary to the resident and/or resident representative. c. There must be documentation in the medical record that the baseline care plan was provided to the resident and resident representative, either in the Progress Notes or by utilizing a signature of resident/representative on the care plan signature page...."		required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Resident 56 was not harmed by the alleged deficient practice. The resident no longer resides at the facility. 2. All new admissions have the potential to be affected by same alleged deficient practice. All new admissions for the last 30 days have been reviewed to ensure a written summary of the baseline care plan has been provided to the resident and/or the resident representative. 3. DON/Designee has educated the IDT on the baseline care plan policy with an emphasis on providing summaries within 48 hours of admission. 4. DON/Designee will audit 5 new admissions for baseline care plans being signed and uploaded into the resident charts. This will occur 3 x wk x 4 wks, then 1 x wk	

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			x 8 wks. DON/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	
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 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			

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	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. §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 observation, record review and interviews, the facility failed to ensure a care plan was initiated to address medications utilized for behaviors and insomnia for 1 of 5 residents reviewed for medication use. (Resident 70) Findings include: The record for Resident 70 was reviewed on 03/09/23 at 7:40 A.M. . Resident 70 was admitted to the facility with diagnosis, including but not limited to: dementia with other behavioral disturbance, vascular dementia without behavioral disturbance, major depressive disorder, single episode, insomnia, anxiety disorder and adult personality and behavior disorder. The current physician's orders for medications included the antipsychotic medication, Quetiapine	F 0656	Develop/Implement Comprehensive Care Plan Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices.	04/06/2023

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	Fumarate 50 mg in the morning for vascular dementia with behavioral disturbance, the antiepileptic medication, Divalproex Sodium Oral Tablet Delayed Release 500 MG (Divalproex Sodium) Give 500 mg orally three times a day for Vascular dementia with behavioral disturbance and the antidepressant, TraZODone HCl Oral Tablet 50 MG (Trazodone HCl) Give 125 mg orally at bedtime for Insomnia. The current care plans for Resident 70 included a plan to address the side effects of the Seroquel and Depakote, but no plans to address the behaviors and no plan to address the resident's insomnia. During an interview, on 3/13/2023 at 2:30 P.M. with the Social Service Director, she indicated she worked together with the nursing department and the rest of the IDT team to develop behavioral care plans. She did not know what specific behaviors Resident 70 exhibited which required the use of the Seroquel and Depakote. The facility policy and procedure, titled, "Plan of Care Overview" included a policy for the facility to provide resident centered care that met the psychosocial, physical and emotional needs and concerns of the residents. 3.1-35(a)		1. Resident 70 was not harmed by the alleged deficient practice. Resident 70 care plan has been updated to address medications used for behaviors and insomnia. 2. All residents who receive medications for behaviors and insomnia have the potential to be affected by same alleged deficient practice. All residents receiving these medications have been reviewed to ensure care plans have been updated for medication use. 3. DON/Designee has educated all licensed nurses on the plan of care overview policy with an emphasis on resident specific plan of care. 4. DON/Designee will audit care plans for 5 residents receiving medications for behaviors and insomnia. This will occur 3 x wk x 4 wks, then 1 x wk x 8 wks. DON/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting.	

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			The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	
F 0657 SS=E 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.			
	1. Based on observation, record review and interviews, the facility failed to ensure care plan	F 0657	Care Plan Timing and Revision	04/06/2023

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	meetings, involving the resident and/or their representative, were completed when a comprehensive assessment and/or quarterly review of the assessment was completed. This deficient practice affected (Residents C, D, 13, 19 and 25) and the facility failed to ensure care plans were revised after a resident declined for 1 of 2 residents reviewed for Activities of Daily Living declines. (Resident 70). Findings include: 1. The record for Resident C was reviewed on 3/7/2023 at 2:30 P.M. Resident C was admitted to the facility on 1/27/2023 with diagnoses, including but were not limited to: hemiplegia and hemiparesis, epiilepsy and epileptic syndromes with seizures, asthma, obstructive sleep apnea, obesity, dysphagia, gastostomy, history of falling, difficulty walking, unsteadiness on feet, sleep disorder and muscle weakness. An admission MDS assessment was completed on 2/3/2023. During an interview with alert and oriented Resident C, on 3/7/23 at 11:04 A.M., he indicated he did not recall being invited to a care plan meeting. He indicated he was planning on discharging from the facility and was setting up his discharge care and appointments himself. He indicated the facility was not really assisting him to set up his discharge but had just requested he give them a few days notice when he decided to discharge so they could ensure he had everything set up correctly. There was no documentation in Resident C's electronic record indicating he had been included in a care plan meeting.		Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Residents C, D, 13, 19, 25 were not harmed by the alleged deficient practice. Resident C no longer resides at the facility. Care plan conferences of residents D, 13, 19, and 25 have been completed. Resident 70 was not harmed by the alleged deficient practice. Resident 70 care plans have been revised to reflect her current activities of daily living. 2. All residents have the potential to be affected by same alleged deficient practice. All residents have been reviewed to ensure a care conference has been completed in the last 90 days. All residents care plans for	

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	During an interview, with the Social Service Designee, on 3/7/23 at 4:16 P.M., she indicated there was no documentation of any care plan meeting for Resident C, expect a progress note, dated 3/7/2023 which indicated the resident was discharging on 3/8/2023 with home health. During interview with SSD she looked on her computer and indicated there was no care plan meeting note documentation except a note today indicating the resident was discharging tomorrow with home health. During an interview with the SSD, on 3/7/2023 at 4:20 P.M., she indicated the facility had no policy and procedure regarding care plan meetings and/or revising care plans but followed the MDS schedule and RAI (Resident Assessment Instrument) manual. 2. The record for Resident D was reviewed on 3/7/2023 at 2:00 P.M. Resident D was admitted to the facility with diagnoses, including but not limited to: central cord syndrome at C4 level, hypertension, anxiety disorder, constipation, radiculopathy cervical region, intervertebral disc degeneration, lumbar region, difficulty walking, unsteadiness on feet, history of falling, muscle weakness, nicotine dependence, spinal stenosis and arthrodesis. The admission MDS assessment was completed on 2/2/2023. There was no documentation a care plan meeting had been conducted for Resident C. During an interview with alert and oriented Resident D, on 3/7/23 at 10:42 A.M., he indicated he had attended a resident council meeting but he did not remember being invited to and/or attending an individual care plan meeting.		activities of daily living have been reviewed to reflect the current function level. 3. DON/Designee has educated interdisciplinary team regarding Plan of care overview policy with an emphasis on care plan meeting schedules and updating care plans for ADL decline. 4. DON/Designee will audit the care plan conference schedule to ensure all residents receive a care plan conference and will audit 5 residents ADL care plans to ensure updated ADL care plans are in place. This will occur 3 x wk x 4 wks, then 1 x wk x 8 wks. DON/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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During an interview with the SSD, on 3/7/23 at 4:18 P.M., she indicated there had not been any care plan meeting conducted yet for Resident D. She indicated the care plan meetings should follow the MDS schedule. 3. The record for Resident 13 was reviewed on 3/7/2023 at 3:45 P.M. The diagnoses included, but not limited to: Parkinson's, chronic obstructive pulmonary disease, peripheral vascular disease, atrial fibrillation, and post-traumatic stress disorder.

During an interview, on 3/6/2023 at 10:39 A.M., Resident 13 indicated that he made no decisions on medication, therapy and had no care plan meetings.

During an interview, on 3/7/2023 at 3:56 P.M., the Social Worker indicated when she has a care conference she enters documentation under social service notes in the progress notes.

During an interview, on 3/7/2023 at 4:06 P.M., the Social Worker indicated his last care conference was on 10/11/2021. He should have had a care conference quarterly in 2022 and 2023, they go along with the Minimum Data Set (MDS) assessment schedule. He should have had a care conference around the time of the following quarterly MDS schedule: 2/17/2022, 5/17/2022, 8/15/2022, annual 11/14/2022 and quarterly 2/14/2023.

4. The record for Resident 19 was reviewed on 3/8/2023 at 8:45 A.M. The diagnoses included, but not limited to: type 2 diabetes, cerebral palsy, depression, hallucinations and anxiety disorder.

During a interview, on 3/6/2023 at 2:46 P.M., Resident 19's daughter indicated she has not been

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invited to care conferences quarterly. She was invited when she first came into the facility but has not had any more.

During an interview, on 3/8/2023 at 9:17 A. AM., the Social Worker indicated that her last care conference was on 10/19/2021, and she should have had a conference done quarterly following the MDS schedule. She should have had a care conference around the time of the following MDS schedule: quarterly 2/22/2022, 4/19/2022, 6 /24/2022, annual 8/2/2022, quarterly 11/21/2022, and 1/3/2023.
5. During an interview, on 3/7/23 at 11:46 A.M., Resident 25's niece, indicated she was not sure if her aunt and/or uncle had attended a care plan meeting and she had not been invited to a care plan meeting.

During an interview, on 3/7/23 at 3:56 P.M., with the Social Service Designee, she indicated her notes are located in the progress notes under custom documentation, she indicated the conferences were to be done quarterly according to the resident's MDS (Minimum Data Set) assessment.

During an interview, on 3/8/23 at 10:49 A.M., the SSD indicated a care plan meeting for Resident 25 had been held on 10/12/2021. She indicated they should have held care plan meetings by following the MDS schedule.

During an interview, on 3/10/2023 at 2:00 P.M., LPN 16, the Unit Manager, indicated a care plan conference should have been completed as the family is very invested in the residents care.

During an interview with the SSD on 3/7/2023 at 4:18 P.M. she indicated she had not scheduled

and/or conducted care plan meetings for any resident since 2021.

6. Resident 70 was admitted to the facility with diagnoses, including but not limited to: fracture of the left femur, drug induced Parkinsonism, difficulty walking, history of falling, dementia with other behavioral disturbance, muscle weakness and cognitive communication deficit.

The Admission Minimum Data Set (MDS) assessment, completed on 2/6/2023, indicated the resident was moderately cognitively impaired, required limited one person assistance for all needs, including transfers, toileting, eating and ambulation and hygiene and was continent of her bowel and bladder.

A quarterly MDS assessment, completed on 2/27/2023, indicated the resident remained moderately cognitively impaired, had declined and now required extensive staff assistance of two staff for bed mobility and transfers, required extensive staff assistance of one staff for locomotion to walk in the corridor and toileting needs and was now occasionally incontinent of her bowel and bladder.

The care plans, reviewed as current on 2/15/2023 indicated the resident required one assist with bed mobility and ambulation, and indicated the resident was incontinent of urine but the interventions, in place since her admission was to check the resident for incontinence and observe her for signs and symptoms of a urinary tract infection.

During an interview, on 3/10/2023 at 11:07 A.M. , the MDS coordinator indicated any care plan revision she relied on the quarterly MDS

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	assessment to "catch" any declines and she would then update/revise the care plans as needed. The MDS coordinator indicated she had not updated Resident 70's care plans regarding the declines in bed mobility, transfers, locomotion and bowel and bladder continency. 3.1-35(d)(2)(B) 3.1-35(e)			
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.			

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	(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis			

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	based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.			
	Based on interview and record review, the facility failed to have a discharge care plan for 1 of 2 closed records reviewed for care plans. (Resident 75) Finding includes: The record for Resident 75 reviewed on 3/13/2023 at 2:10 P.M., indicated his diagnoses included, but not limited to: chronic kidney disease stage 3, atrial fibrillation, and type 2 diabetes. During an interview, on 3/13/2023 at 2:27 P.M., the Social Service Designee indicated when there was a new admission, she wrote a care plan for code status and for discharge planning. She indicated she had initiated a care plan for code status but did not initiated a care plan for his discharge. She confirmed the resident should have had a care plan implemented for discharge planning. On 3/13/2023 at 3:09 P.M., the Regional Nurse provided a policy titled, "Plan of Care Overview", undated, and indicated the policy was the one currently used by the facility. The policy indicated"... The purpose of the policy is to provide guidance to the facility to support the inclusion of the resident or resident representative in all aspects of person-centered care planning and that this planning includes the provision of	F 0660	Discharge Planning Process Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Resident 75 was not harmed by the alleged deficient practice. Resident 75 no longer resides at the facility. 2. All residents have the potential to be affected by same	04/06/2023

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	services to enable the resident to live with dignity and supports the resident's goals, choices, and preferences including, but not limited to, goals related to the their daily routines and goals to potentially return to a community setting...." 3.1-12		alleged deficient practice. All residents have been reviewed to ensure a discharge care plan has been completed. 3. DON/Designee has educated the interdisciplinary team on discharge planning policy with a focus on development of the discharge plan. 4. DON/Designee will audit discharge care plans for 5 residents. This will occur 3 x wk x 4 wks, then 1 x wk x 8 wks. DON/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to ensure residents received personal hygiene such as shaving and	F 0677	ADL Care Provided for Dependent Residents	04/06/2023

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	nail care for 5 of 8 residents reviewed for activities of daily living. (Residents 10, 13, 17, 27 & 56) Findings include: 1. The review for Resident 13 was reviewed on 3/7/2023 at 3:45 P.M. Diagnoses included, but were not limited to: Parkinson's, chronic obstructive pulmonary disease, peripheral vascular disease, atrial fibrillation, and post-traumatic stress disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 2/14/2023, indicated he was totally dependent for bathing and extensive assist of one person for personal hygiene, extensive assist of two for bed mobility, transfers, and toilet use. During an observation and interview, on 3/6/2023 at 9:09 A M., Resident 13 was eating, raising a fork and had tremors, and was observed with facial hair that was more than a couple days of growth. He indicated that he could not get a shave, it was not offered. During an observation, on 3/7/2023 at 10:18 A.M., he was in his room bent over in his wheelchair sleeping with facial hair noted. During an observation and interview on 3/9/2023 at 9:28 A.M., he was sitting in his room eating breakfast and unshaved. He indicated that he had a shower yesterday and asked to be shaved and they responded with, "I will see you in a little bit." He indicated sometimes they will tell him they are too busy. During an interview on 3/9/2023 at 4:09 P.M., Certified Nurse Aide (CNA) 8 indicated when she		Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Residents 10, 13, 17, 27, 56 were not harmed by the alleged deficient practice. Resident 56 no longer resides at the facility. Residents 10, 13, 17 and 27 have been assessed to ensure personal hygiene such as shaving and nail care has been provided. 2. All residents who require assistance with ADLs have the potential to be affected by same alleged deficient practice. All residents who require assistance with ADLs have been reviewed to ensure shaving and/or nail care has been provided.	

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	gave a shower, she washed hair and all body parts unless they (the resident) could assist, she then completed nail care, applied lotion, changed bed linen, and sometimes shaved the residents, if they needed it. During an interview, on 3/9/2023 at 4:12 P. M. CNA 7 indicated Resident 13 does not refuse his showers. She indicated she provided Resident 13 with assistance with ADLs including shaving. 2. The record for Resident 17 was reviewed on 3/6/2023 at 3:00 P.M. Diagnoses included, but were not limited to: dementia without behavioral disturbances, mood disturbances, psychotic disturbances, anxiety, and major depressive disorder. A Quarterly MDS assessment, dated 2/2/2023, indicated total care for bathing, extensive assist of two for bed mobility, transfers, toilet use and personal hygiene. A Care Plan, dated 1/10/2023, indicated the resident required assistance of two staff for bathing, personal hygiene, toileting bed mobility, dressing and locomotion. During an observation, on 3/6/2023 at 11:46 A.M., Resident 17 was sitting in a Broda chair in the dining room, had facial hair on her chin, and a brown substance under her nails on both hands. During an observation, on 3/7/2023 at 9:23 A.M., Resident 17 was up in the common area in a Broda chair , watching TV. She had facial hair on her chin and a brown substance under her nails on both hands. During an observation, on 3/8/2023 at 7:04 A.M.,		3. DON/Designee has educated all nursing staff on the routine resident care policy with a focus on shaving and nail care. 4. DON/Designee will audit 5 residents requiring assistance with shaving and nail care. This will occur 3 x wk x 4 wks, then 1 x wk x 8 wks. DON/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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Resident 17 was up in the common area in a Broda chair, with facial hair on her chin and a brown substance under her nails.

During an observation, on 3/9/2023 at 9:56 A.M., Resident 17 was up in the dining room in a Broda chair with facial hair on her chin and a brown substance under her nails.

During an interview, on 3/9/2023 at 9:50 A.M., CNA 2 indicated when she gave a shower she washed their hair, full body, cleaned their nails, and clipped nails unless the resident was diabetic applied lotion and shaved them. CNA 2 indicated she would also offer to shave residents on days other than shower days if she saw a lot of hair growth. .

During an interview, on 3/9/2023 at 9:56 A.M., CNA 5 indicated if a resident was a total assist, she would wash the whole body, trim nails if not diabetic and report any skin issues.

3. The record for Resident 27 was reviewed on 3/8/2023 at 8:32 A.M. Diagnoses included, but not limited to: type 2 diabetes, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, and post- traumatic stress disorder.

A Quarterly MDS assessment, dated 2/16/2023, indicated Resident 27 was totally dependent for bathing, and extensive assist of two for personal hygiene.

During an observation and interview, on 3/6/2023 at 11:13 A.M., Resident 27 had facial hair and he indicated that he would like to be shaved.

During an observation, on 3/7/2023 at 10:24 A.M.,

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Resident 27 was in the activity room for coffee, he was unshaved.

During an observation, on 3/8/2023 at 11:24 A.M., Resident 27 was sitting in his room in a geri chair, unshaved.

During an observation, on 3/9/2023 at 9:17 A.M., Resident 27 was sitting in the hallway, unshaved.

During an interview, on 3/9/2023 at 9:20 A. M., CNA 3 indicated that when she gave a shower, she washed everything, including hair, brushed teeth and shaved, most of the time. She indicated some (Residents) got shaved by the activity person

During an interview, on 3/9/2023 at 9:38 A.M., the Director of Nursing indicated that she would expect her staff to include full head to toe washing, including hair, nail care, shaving and lotion when bathing/showering a resident. Residents are not shaved every day; they are shaved as part of the shower.

4. The record for Resident 56 was reviewed on 3/8/2023 at 9:05 A.M. Diagnoses included, but not limited to: benign prostatic hyperplasia, heart failure, and vascular dementia without behavioral disturbances.

An Admission MDS assessment, dated 2/27/2023, indicated Resident 56 required extensive assist of 2 staff for personal hygiene, transfers, bed mobility, toileting, and total dependent for bathing.

During an interview and observation, on 3/6/2023 at 9:43 A.M., Resident 56 indicated he would like to be shaved, and have his nails trimmed but they

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(the facility) "don't do that here." He had facial hair growth on his face.

During an observation, on 3/7/2023 at 9:36 A. M., the resident was in a gown sitting in the recliner, unshaved and his fingernails were jagged.

During an observation, on 3/9/2023 at 4:25 P.M., resident was sitting in his recliner sleeping, he was unshaved.

During an observation, on 3/10/2023 at 9:40 A.M., resident was sitting in his recliner, unshaved.

During an interview, on 3/9/2023 at 9:50 A.M., CNA 2 indicated when she gave a shower she washed their hair, full body, cleaned nails, and clipped them, unless the resident was diabetic. She offered shaves on other days if she saw a lot of facial growth.

During an interview, on 3/9/2023 at 9:56 A.M., Certified Nurse Aide 5 indicated that if a resident is total assist she will wash the whole body, trim nails if not diabetic, report any skin issues. She does not do a partial bed bath does complete every day, uses a shampoo cap to wash the hair, and nails if needed.

During an interview on 3/9/2023 at 9:38 A.M., the Director of Nursing indicated she would expect her staff to include full head to toe washing, including hair, nail care, shaving and lotion when bathing/showering a resident. Residents were not shaved every day; they were shaved as part of the shower.5. During an initial tour of the facility, on 3/6/23 at 10: 00 A.M., accompanied by CNA 8, Resident 10 was observed lying in bed with dirty, jagged finger nails on both hands.

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	During an interview with Resident 10, on 3/6/23 at 3:03 P.M. , the resident indicated she preferred bed baths. The record for Resident 10, completed on 3/8/2023 at 4:20 P.M., , indicated the resident's diagnosis, included but were not limited to: hemplegia. The Quarterly MDS (Minimum Data Set) assessment, completed on 2/7/2023 indicated the resident was totally dependent for bathing and personal hygiene. The care plan for Resident 10, initiated on 10/6/2020, indicated the resident was totally dependent for bathing and personal hygiene needs and her fingernails were to be kept short to prevent her from scratching herself. During an interview, on 3/9/2023 at 9:10 A.M., LPN 16, the Unit Manager, indicated the resident received bed baths and in which nail care should be provided. During an observation and interview of Resident 10, on 3/9/23 at 9:41 A.M., accompanied by LPN 12, the resident's nails remained long and jagged. During an interview with LPN 12, on 3/9/2023 at 9:41 A.M., LPN 2 indicated the resident's nails should have been cut as the resident had received a bed bath on 3/7/2023 on the evening shift. On 3/9/2023 at 9:59 A.M. the Regional Nurse provided the policy titled "Nail and Hair Hygiene Services", no date noted, which included the following instructions: "...Nail hygiene services: refers to routine trimming, cleaning, filing but not polishing of undamaged nails, and on an individual bases, care for ingrown or damaged			

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	nails... 1. Routine Nail Hygiene: a. Residents will have routine nail hygiene and hair hygiene as part of the bath or shower." On 3/9/2023 at 11:08 A.M., the Regional Nurse provided a policy titled, "Routine Resident Care", undated, and indicated the policy was the one currently used by the facility. The policy indicated "... b. Routine care by a nursing assistant includes but is not limited to the following: i. Assisting or provides for personal care 1. bathing, 2. dressing, 3. eating and hydration, 4. toileting...." 3.1-38(3)(E)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.			
	Based on observation, interview and record review the facility failed to identify and assess the use of an AFO (ankle foot orthosis) splint for 1 of 3 residents reviewed for splint use and range of motion issues. (Resident 3) Findings include: During an observation, on 3/6/2023 at 12:20 P.M., Resident 3 was sitting up in her wheelchair in the dining room wearing an AFO splint to her left	F 0684	F684 Quality of Care Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and	04/06/2023

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	lower leg. The record was reviewed on 3/6/2023 at 2:30 P.M. Diagnosis, included but were not limited to acquired deformity of left lower Alleghenies and hemiparesis following cerebral infarction affecting left non-dominant side. and Type 2 diabetes mellitus with diabetic neuropathy. An order for the AFO splint had been discontinued 2/9/2019. During an observation, on 3/7/2023 at 10:00 A.M., the resident was sitting up in her wheelchair in her room wearing an AFO to her left lower leg. A care plan, dated 1/24/2023 indicated the resident was to wear a left AFO daily each shift when out of bed. During an observation and interview, on 3/8/2023 at 11:15 A.M., the resident was sitting up in her wheel chair at the nurses station and the resident indicated she has been wearing the brace for a while, she thought she got it (AFO) when she got her diabetic shoes. During an interview, on 3/9/2023 at 12:20 P.M., Occupational Therapist 10 indicated the resident was not on their case load at this time, and nursing would be managing the resident's AFO. During an observation and interview, on 3/9/2023 at 12:55 P.M., the Director of Nursing (DON) indicated she was not aware of the resident wearing an AFO on her left lower leg. The DON removed the AFO to Resident 3's left lower extremity The DON indicated the resident's left heel was dry, scaly, soft to touch and brown in color. There was no drainage noted. During an interviewed, on 3/9/2023 at 4:00 P.M.,		executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Resident 3 was not harmed by the alleged deficient practice. Resident 3 has been assessed for the use of an AFO splint. 2. All residents who require the use of an AFO have the potential to be affected by same alleged deficient practice. All residents requiring the use of an AFO have been reviewed to ensure identification and assessment are complete. 3. DON/Designee has educated all nursing staff on physician order policy with an emphasis on following physician orders. 4. DON/Designee will audit AFO use and assessment for 2 residents. This will occur 3 x wk x 4 wks, then 1 x wk x 8 wks.	

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	the Wound Nurse Practitioner (NP) indicated the resident's left heel did not appear to have a pressure ulcer on her heel although it was some what soft. During an interview, on 3/10/2023 at 2:55 P.M., the DON indicated she could not locate a policy regarding managing residents with assist devices including AFOs. 3.1-37		DON/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	
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 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 ensure hand splints were applied for 1 of 4 residents reviewed for limited range of motion. (Resident 27) Finding includes:	F 0688	Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of	04/06/2023

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	The record for Resident 27 was reviewed on 3/8/2023 at 8:32 A.M. Diagnoses included, but were not limited to: type 2 diabetes, hemiplegia and hemiparesis following cerebral infarction affecting left dominant side, and post- traumatic stress disorder. A Physician Order, dated 12/7/2022, indicated the facility was to apply a splint to the left hand before bed and remove the splint in the morning and/or if it becomes uncomfortable. A Care Plan, dated 12/7/2022, indicated the resident had hemiplegia related to a stroke, had a left lower extremity knee contracture and was to have a splint to the left hand. The left hand splint was to be applied at bedtime and removed in the morning. During a resident interview, on 3/6/2023 at 9:22 A.M., Resident 27 indicated he used to wear a splint to his left hand but they no longer put it on. No splint was visible in the room. During an observation, on 3/8/2023 at 5:25 A.M., the resident was sleeping, and he had no hand splint on his left hand. During an observation and interview, on 3/8/2023 at 5:29 A.M., CNA 4, indicated she worked all three shifts, and she had worked at the facility for the past eight months and the resident had never had a hand splint on his left hand. CNA 4 opened his nightstand drawers and in the bottom drawer were two types of splints, one for the fingers and a full hand splint. The CNA indicated she had never seen either of these worn by the resident. During an interview, on 3/9/2023 at 10:11 A.M.,		Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Resident 27 was not harmed by the alleged deficient practice. Resident 27 has been audited to ensure placement of hand splint as ordered. 2. All residents with the use of a hand splint have the potential to be affected by same alleged deficient practice. All residents using a hand splint have been reviewed to ensure application of the hand splint as ordered. 3. DON/Designee has educated all nursing staff regarding physician order policy with an emphasis on following physician orders. 4. DON/Designee will audit splint application for 3 residents requiring the use of hand splint. This will occur 3 x wk x 4 wks, then 1 x wk x 8 wks. DON/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	the MDS Nurse indicated that they did not have a restorative nursing program. On 3/8/2023 at 9:00 A.M., a policy regarding splint usage was requested, but one was not provided. 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, record review and interviews, the facility failed to implement interventions to prevent recurrent falls for 1 of 4 residents (Resident 13) and failed to ensure hot water temperatures were maintained at a safe level for 1 of 4 halls. Finding includes: 1. The record for Resident 13 was reviewed on 3/7/2023 at 3:45 P.M. Diagnoses included, but not limited to: Parkinson's, chronic obstructive pulmonary disease, peripheral vascular disease, atrial fibrillation and post-traumatic stress disorder. The record indicated that he had a fall on 1/26/2023, 3/5/2023 and 3/12/2023. A Care Plan, dated 10/17/2020, and current, indicated the residennt was at risk for falls related to Parkinson's and muscle weakness. There was	F 0689	Free of Accident Hazards/Supervision/Devices Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices.	04/06/2023

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	an intervention, dated 3/6/2023 to evaluate the resident for an urinary tract infection and labs. During a resident interview, on 3/6/2023 at 11:04 A.M., he indicated he rolled out of bed two days ago and they did not do anything to prevent it from happening again There was no documentation regarding any assessment or laboratory tests for Resident 13, after his fall on 3/5/2023. The resident fell again on 3/12/2023. During an interview, on 3/13/2023 at 11:04 A.M., the Director of Nursing indicated a Urinalysis and/or other labs were not completed in response to the resident's fall on 3/5/2023. On 3/13/2023 at 11:31 A.M., the Director of Nursing provided a policy titled, "Fall Prevention and Management", dated 5/25/2021, and indicated the policy included instructions for the IDT team to review the care plan, identify the interventions and put new interventions in place. 2. During the environmental tour of the facility, with the Maintenance Supervisor and the Administrator, on 3/8/2023 between 10:20 - 11:20 A.M., the following was observed: The hot water temperature for Room 209 was 122.5 degrees Fahrenheit. During the initial tour of the facility, conducted on 3/6/2023, indicated the resident in bed A was able to ambulate and utilizing the bathroom by herself. The hot water temperature for Room 214 was 122.2 degrees Fahrenheit. During the initial tour of the facility, conducted on 3/6/2023, two alert male residents in wheelchairs indicated they were able		1. Resident 13 was not harmed by the alleged deficient practice. Resident 13 interventions have been completed as ordered. No residents were harmed by the alleged deficient practice of hot water temperatures being out of range. 2. All residents who have had a fall in the past 30 days have the potential to be affected by the same alleged deficient practice. All residents who have had a fall in the past 30 days have been reviewed to ensure appropriate interventions have been completed. Water heater was adjusted by outside service provider to maintain acceptable water temperatures. 3. DON/Designee has educated interdisciplinary team regarding the fall prevention and management policy with an emphasis on interventions. ED/Designee has educated maintenance director and assistant regarding guidance tool with an emphasis on safe water temperatures.	

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	to wheel themselves into the bathrooms. The Administrator indicated the hot water heater had recently been replaced. The Maintenance Supervisor indicated the hot water temperatures were supposed to be maintained between 100 - 120 degrees Fahrenheit. Review of the documentation of biweekly hot water temperature recordings from December 2022 through present indicated the hot water temperatures were usually between 115 - 119 degrees Fahrenheit on the 200 hall. A policy titled, "Water Temp Procedure" provided by the Director of Nursing on 3/13/2023 at 4:07 P.M. included the following: "1. Hot water temperature meets regulatory requirements (document per facility policy) ...3. IN (Indiana) 100 - 120 F (Fahrenheit)...."3.1-45(a)		4. DON/Designee will audit implementation of fall interventions for all residents with a fall. This will occur in clinical meeting for 12 wks. DON/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved. Maintenance Director/Designee will audit completion of hot water temperatures weekly for 12 weeks. Maintenance Director/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting.	
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 that all respiratory equipment was available, labeled and dated at the bedside for immediate use. This	F 0695	Respiratory/Tracheostomy Care and Suctioning Preparation and execution of this	04/06/2023

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	deficient practice affected 1 of 2 residents reviewed for respiratory care. (Resident 3) Findings includes: During an observation and interview on 03/06/23 at 11:44 AM, Resident 3's tracheostomy site was clean and dry. There was no suction machine located in the resident's room. The resident indicated if she needed it, the staff would bring one to her. During an observation on 03/08/23 at 09:28 AM, Resident 3 was sitting up in her chair. There was no suction machine noted in her room. The record for Resident 3 was reviewed on 3/8/23 at 9:47 A.M. Diagnosis, included but were not limited to: Chronic Respiratory failure, Hypoxia or Hypercapnia. Physician's orders, dated 11/29/2023 included "...suction canister and catheters in room at all times..." During an interview, with the Regional nurse on 3/9/2023 at 2:45 P.M., she indicated they should have provided resident 3 with a suction machine. She indicated she was unsure how long the resident was without having a suction machine in her room. A policy and procedure, provided by the Regional Nurse Consultant, on 3/13/2023 at 1:15 P.M., included instructions for oxygen use but there was no policy specific to respiratory equipment required in resident rooms when a resident had a tracheotomy. 3.1-47(a)(4)		plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Resident 3 was not harmed by the alleged deficient practice. Resident 3 room has been assessed to ensure all respiratory equipment is available, labeled and dated at the bedside for immediate use. 2. All residents who use respiratory equipment have the potential to be affected by same alleged deficient practice. All residents using respiratory equipment have been reviewed to ensure respiratory equipment is available, labeled and dated at the bedside for immediate use. 3. DON/Designee has	

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			educated all licensed nurses on the supplemental oxygen policy with a focus on dating equipment. 4. DON/Designee will audit equipment for 3 residents using respiratory equipment. This will occur 3 x wk x 4 wks, then 1 x wk x 8 wks. DON/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review and interviews, the facility failed to ensure 1 of 1 residents receiving dialysis was transported timely for a treatment. (Resident B) Finding includes: The record for Resident B was reviewed on 3/7/2023 at 3:00 P.M. Resident B was admitted to the facility with diagnoses, including but not	F 0698	Dialysis Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and	04/06/2023

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	limited to: diabetes mellitus, end stage renal disease, hypertensive chronic kidney disease, , dependence on renal dialysis, obesity, chronic kidney disease stage 4, acquired absence of left foot, right above the knee amputation and long term use of insulin. The most recent Minimum Data Set (MDS) assessment for Resident B, completed on 2/1/2023 for a quarterly review, indicated the resident was completely alert and oriented, required extensive staff assistance of two for bed mobility, transfers, toileting and bathing. The resident required extensive staff assistance of one staff for wheelchair locomotion and personal hygiene needs and utilized a mechanical lift for transfer needs. In addition, the resident's need for dialysis as a special treatment was marked. The current physician orders included an order for the resident to receive dialysis treatments at a local dialysis center on Monday, Wednesday and Friday at 6:00 A.M. The current care plans for Resident B included a plan to address the resident's chronic stage 4 kidney disease. The interventions included: "...dialysis as ordered." A nursing progress note, dated 2/20/2023 at 5:33 A.M. indicated Resident B was unable to be transported to her dialysis due to not having a clean hoyer sling available to transfer her. The staff indicated they had offered her a used sling but the resident refused. During an interview with alert and oriented Resident B, conducted on 3/7/23 at 11:51 A.M., the resident indicated she often have to wait for a clean sling. The resident indicated they utilized a		executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Resident B was not harmed by the alleged deficient practice. An audit has been performed to ensure resident has been transported to dialysis in a timely manner for treatment. 2. All residents who receive dialysis have the potential to be affected by same alleged deficient practice. All residents receiving dialysis have been audited to ensure transportation to dialysis occurred in timely manner. 3. DON/Designee has educated all licensed nurses regarding the hemodialysis care and monitoring policy. 4. DON/Designee will audit 4 residents dialysis for transport to dialysis. This will occur 3 x wk x 4 wks, then 1 x wk x 8 wks.	

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	"blue" sling. The resident indicated there were not enough slings to go around. The resident indicated she missed a dialysis treatment due to there were no clean slings available so the resident could be transferred to her wheelchair to leave for her dialysis appointment. The resident indicated the nursing staff offered her a "used" sling but the resident refused to be transferred with a sling used for someone else because she was afraid there was "poopy and pee pee" on it. The resident indicated the Administrator had telephoned the dialysis center and told them the resident refused her dialysis treatment. During an interview with RN 20, on 3/10/23 at 12:30 P.M. , she indicated she remembered the incident with Resident B missing her dialysis treatment due to no clean sling available. RN 20 indicated at the time, nursing staff did not have a key to access the laundry room to look for clean lift slings and after searching the building, no unused sling could be located for Resident B. RN 20 indicated she had offered a used sling to Resident B but she refused. Review of the facility policy and procedure, titled, "Hemodialysis Care and Monitoring" provided by the Regional Nurse Consultant on 3/6/2023 at 3:10 P.M. included the following: "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 concern for our residents, staff and visitors. Residents may require hemodialysis in he event of critically low kidney function...Residents will be transported to a specialized center for hemodialysis. Scheduling of dialysis will be through the dialysis centers based on their availability...."		DON/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	This Federal tag relates to Complaints IN00402462 and IN00402173 3.1-37(a)			
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, record review and interviews, the facility failed to document and communicate behavioral triggers to prevent re-traumatization for 1 of 1 residents reviewed for post traumatic stress disorder. (Resident 45) Finding includes: Resident 45 was observed on 3/6/2023 at 11:00 A.M., seated in her wheelchair in her room. The resident was dressed in a hospital gown, had disheveled hair and was able to answer routine questions. There was a large pile of what looked like used and clean briefs, books, papers and hygiene items on he floor in her room. The record was reviewed on 3/7/2023 at 2:30 P.M. Resident 45 was admitted to the facility with diagnoses, including but not limited to: adult failure to thrive, , low back pain, adjustment disorder with mixed anxiety and depressed mood, personality disorder, major depressive disorder and post traumatic stress disorder.	F 0699	Trauma Informed Care Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Resident 45 was not harmed by the alleged deficient practice. Resident 45 care plan has been updated to ensure	04/06/2023

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	A quarterly MDS assessment, dated 1/18/2023, indicated displayed feeling down, depressed or hopeless, trouble falling and/or staying asleep, sleeping too much, feeling tired or having little energy, feeling bad about herself- or that you are a failure or have left yourself or your family down, trouble concentrating on things, such as reading the newspaper or watching television, moving or speaking so slowly that other people could have noticed. - or being so fidgety or restless that you have been moving around a lot more than usual and had verbally abusive behaviors and other behaviors. The current care plan regarding the resident's PTSD (Post Traumatic Stress Disorder) did not indicate any specific triggers related to her PTSD diagnosis. During an interview with the Social Services Designee, on 3/13/23 at 2:39 P.M. she indicated she did not know what "triggers" Resident 45 had for her PTSD diagnoses and the record failed to identify any triggers related to her diagnosis. Although the facility had documentation employees had been inservices in 2022 regarding Post Traumatic Stress Disorder, the Regional Nurse Consultant indicated on 3/14/2023 at 10:10 A.M., the facility had no policy or procedure in regards to providing care to residents diagnosed with PTSD.		behavioral triggers to prevent re-traumatization have been documented and communicated. 2. All residents who have PTSD have the potential to be affected by same alleged deficient practice. All residents with PTSD have been reviewed to ensure care plans have been updated with behavioral triggers. 3. DON/Designee has educated the clinical team regarding plan of care overview policy with an emphasis on resident centered care. 4. DON/Designee will audit PTSD care plans for 3 residents with diagnosis of PTSD to ensure behavioral triggers in place. This will occur 3 x wk x 4 wks, then 1 x wk x 8 wks. DON/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			
	Based on observation, record review and interviews, the facility failed to ensure adequate monitoring was documented in regards to multiple orders for antibiotic eye drops for 1 of 2 residents reviewed for antibiotic medications. (Resident C) Finding includes: Resident C was admitted to the facility with diagnoses, including but not limited to: hemiplegia and hemiparesis. During an interview with Resident C, on 3/6/2023 at 9:48 A.M., he indicated he had experienced a	F 0757	Drug Regiment is Free from Unnecessary Drugs Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law.	04/06/2023

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	recent stroke that had affected his balance and his hearing on the left side and his eye on the left side. The resident was noted to be wearing prescription eye glasses and his left eye was not opening as far as his right eye. A physician's order, dated 2/17/2023 included the following antibiotic eye drop: "Ciloxan Ophthalmic Solution 0.3 % (Ciprofloxacin HCl (Ophth)) Instill 1 drop in left eye every 4 hours for right eye redness for 7 Days" A nursing progress note, dated 2/27/2023 at 5:00 P.M. indicated the following: "Returned from Dr's appointment at 4 PM. New order received: Polymyxin B sulfate 1 mg/ml 10 ml, Instill 1 drop at left eye every 6 hrs. Duration pending for clarification as office is already closed." Another nursing progress note, dated 3/1/2023 at 1:14 P.M., indicated the following: "Returned from appt with eye dr and new order received to d/c polytrim and start ofloxacin and gentamicin every other hour in the left eye. Pt to get a drop in left eye every hour alternating between gentamicin and ofloxacin. Pt to been seen for follow up in 2 days" The physician's orders included the following: "Ofloxacin Ophthalmic Solution 0.3 % (Ofloxacin (Ophth))Instill 1 drop in left eye every 2 hours for eye infection until 03/16/2023" and a second order for antibiotic eye drops, dated 3/6/2023 for "Gentamicin Sulfate Ophthalmic Solution 0.3 % (Gentamicin Sulfate (Ophth)) Instill 1 drop in left eye every 2 hours for eye infection until 03/16/2023" There was no documentation in the clinical record		The facility cordially requests paper compliance regarding alleged deficient practices. 1. Resident C was not harmed by the alleged deficient practice. Resident C is no longer resides at this facility. 2. All residents who receive antibiotics have the potential to be affected by same alleged deficient practice. All residents receiving antibiotics in the past 10 days have been reviewed to ensure orders have been updated with adequate monitoring and documentation. 3. DON/Designee has educated all licensed nurses on the infection monitoring policy with an focus on infection monitoring. 4. DON/Designee will audit follow up documentation for 3 residents receiving antibiotics. This will occur 3 x wk x 4 wks, then 1 x wk x 8 wks. DON/Designee will report on audits monthly to the	

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	of any kind of assessment of the infectious process for Resident C's eyes. Resident C did discharge on 3/8/2023. During an interview with the Director of Nursing, conducted on 03/13/23 at 2:01 P.M. she indicated when an order (for an antibiotic) was received and put in PCC (the facility's electronic charting system) an order to monitor for signs and symptoms of the infection should have also been put in PCC and nursing would then document regarding the infection.. Review of the facility policy and procedure, titled "Infection Monitoring", provided by the Regional Nurse Consultant on 3/14/2023 at 10:00 A.M.,included the following: "...Infection monitoring is accomplished by the following including but not limited to: a. Shift to shift reporting/rounding b. Review of vital sign or change in condition alerts from nursing assistant and/or EHR c. Morning meeting d. Review of Stop and Watch alerts each shift e. Nursing judgement f. During AD care....II. The unit nurse will ...b. Follow up with vital sign assessments including temperature, blood pressure. pulse and respirations i. Additional assessments may be required based upon the area of infection...III. Infection Preventionist (IP) will: a. Monitor the resident symptoms for surveillance reporting.... Although the policy listed several ways infectious symptoms could be monitored there was no direct instructions on how the assessment was to be documented. 3.1-48(a)(3)		interdisciplinary team for a total of 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	
F 0758 SS=D	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN			

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Bldg. 00	Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's			

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(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
	medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on observation, record review and interviews, the facility failed to ensure there were adequate indications and monitoring of use for psychotropic medications for 1 of 5 residents reviewed for unnecessary medications. (Resident 70) Finding includes: The record for Resident 70 was reviewed on 3/7/2023 at 2:50 P.M. Resident 70 was admitted to the facility with diagnoses, including but not limited to: , dementia with other behavioral disturbance, vascular dementia with other behavioral disturbance, major depressive disorder, single episode, post traumatic stress disorder, insomnia, anxiety disorder, Adult personality and behavior disorder, , visual hallucinations, and cognitive communication deficit The current physician's orders for medication included the antipsychotic medication, Quetriapine Fumarate 50 mg orally in the morning and 100 mg at bedtime for vascular dementia with behavioral disturbance. In addition, the resident received the antiepileptic medication, Divalproex Sodium Oral Tablet Delayed Release 500 MG (Divalproex Sodium) 500 mg orally three times a day for Vascular dementia with behavioral disturbance. Review of the current care plans for Resident 70,	F 0758	Free from Unnecessary Psychotropic Meds/PRN Use Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Resident 70 was not harmed by the alleged deficient practice. Resident 70 orders have been updated to ensure presence of adequate indications and monitoring for psychotropic medications. 2. All residents who receive	04/06/2023

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	revised on 2/15/2023 included plans to address the possible adverse side effect of both the Divalpoex Sodium and the Quetriapine Fumarate, but there was no plan to identify for which behavior the resident was receiving the medications and no non pharmalogical intervention to address such behaviors. During an interview with the Social Service Designee, conducted on 3/13/2023 at 2:30 P.M. she indicated she was not aware of what specific behaviors Resident 70 had displayed which required the use of the Divalpoex Sodium or the Quetripine Fumarate. The SSD indicated she and others from the IDT (Interdisciplinary team) worked together to initiate the care plans regarding behaviors. The SSD indicated the resident had not been evaluated by the facility's psychiatric nurse practitioner but was scheduled to be seen later this month. Review of the facility policy and procedure, titled, "Antipsychotic Second Clinical Review" provided by the Regional Nurse Consultant on 3/13/2023 at 10:55 A.M. included the following: "...The purpose of this policy is to provide guidance for directing the appropriate use of antipsychotic medications for residents in this facility as defined in the Centers for Medicare and Medicaid Services (CMS) federal regulations (F 758) by using a second nurse reviewer for psychotroptic medication orders. The second nurse reviewer will be in at a (sic) supervisory level above the nurse taking the order. The role of the second nurse reviewer is to evaluate the need for the medication based upon the resident's medical record to meet regulatory standards for the medication...Residents will not receive antipsychotic medications which are not clinically indicated to treat a specific condition. Diagnosis		psychotropic medications have the potential to be affected by same alleged deficient practice. All residents receiving psychotropic medications have been reviewed to ensure adequate indications and monitoring for use are in place. 3. DON/Designee has educated all licensed nurses on the antipsychotic second clinical review policy with an emphasis on indications and monitoring. 4. DON/Designee will audit 3 residents receiving pyschotropic medications. This will occur 3 x wk x 4 wks, then 1 x wk x 8 wks. DON/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	alone does not warrant the use of antipsychotic medications. An interdisciplinary team (IDT) approach will be utilized for review of resident receiving antipsychotic medications for appropriate use and risk /benefit considerations....II. Appropriate use of antipsychotic medications includes but is not limited to: a. Behavioral symptoms that present a danger to the resident or others b. Expressions or indications of distress that cause significant distress to the resident c. When the use of multiple non-pharmacological approaches have been attempted, but did not relieve the symptoms which are presenting a danger or significant distress d. Treat an enduring (non-acute, chronic or prolonged) condition such as: i. Bipolar disorder ii. Huntington's Disease iii. Schizophrenia iv. other. III. New Admission a. Residents that are admitted to the facility on an antipsychotic medication will be reviewed for the following, including but not limited to: i. Preadmission screening for mental illness and intellectual disabilities ii. the attending physician and the consulting pharmacist will re-evaluate the use of the antipsychotic medication upon admission. 1. The physician and pharmacist will collaborate on whether the resident will continue on he medication and/or is a dose adjustment would be appropriate to reduce the dose 2. The facility will obtain immediate care orders form the phys... VI. Documentation to support use of antipsychotics in his setting includes: ...a. Prescriber is required to document use, goals and on-going assessments b. Nursing staff is required to document supportive symptoms c. An assessment prior to initiating or increasing an antipsychotic medication for enduring conditions, including the resident's symptoms an therapeutic goals which must be clearly and specifically identified and documented...."			

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	There was no documentation the facility's policy had been followed regarding an administrative nurse review of the medication order, specifically identifying behavioral issues supportive of the continued use of the medication and there was no plan to address the resident's behaviors. 3.1-48(a)(3) 3.1-48(a)(4)			
F 0759 SS=E Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;			
	Based on observation, interview and record review, the facility failed to ensure it was free of a medication error rate of greater than 5% for 1 of 7 residents observed during medication pass. Two medication errors were observed during 25 opportunities. This resulted in a medication error rate of 8 percent. (Resident 20) Finding includes: The record for Resident 20 was reviewed on 3/10/2023 at 9:29 A.M. A Physician Order, dated 12/10/2021, included but were not limited to: Albuterol Sulfate HFA Aerosol Solution 90 MCG/ACT, 2 puffs inhale orally four times a day. A Physician Order, dated 12/11/2021, included, but were not limited to: Mometasone Furoate Aerosol Powder Breath Activated 220 MCG/INH, 1 puff orally two times a day for breathing	F 0759	Free of Medication Error Rt 5 Percent of More Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Resident 20 was not	04/06/2023

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	treatment. During an observation on 3/8/2023 at 7:16 A.M., the Registered Nurse (RN) 9 handed Resident 20 the albuterol inhaler and the resident administered the medication per self. She gave herself a puff, then she was handed the other inhaler Mometasone Furoate. There was no wait time between the inhalation, only one puff of albuterol was observed, and the resident was not given water to rinse her mouth and spit out. She was immediately given a cup of water and her oral pills ,which she took. During an interview, on 3/8/223 at 7:18 A. AM., RN 9 indicated the resident gave herself 2 puffs of the albuterol and she was uncertain of the wait time between inhalers or the need to instruct the resident to rinse their mouth after the inhaler medication administration. On 3/9/2023 at 11:08 A.M., the Regional Nurse provided a policy titled, "Medication Administration", revised 1/5/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...h. Inhalers i. A minimum period of one minute is suggested between puffs of same inhalers 1. Follow manufacturers recommendation for specific types of inhalers ii. Space two (2) different medication at five (5) minutes intervals, iii. Administer bronchodilators first, or as ordered iv. Rinse mouth after steroid inhaler...." A professional resource from Medline plus indicated there should be a one minute time frame in between inhaled medications and steroids doses, in additions there were instructions to rinse the mouth and spit the water out after inhalation doses.		harmed by the alleged deficient practice. Family and physician notified of medication error and resident assessed with no negative findings. 2. All residents receiving inhaler medications have the potential to be affected by same alleged deficient practice. All residents using inhalers have been reviewed to ensure medications are being administered without error. 3. DON/Designee has educated all licensed nurses on the medication administration policy. 4. DON/Designee will audit administration of inhalers for 3 residents. This will occur 3 x wk x 4 wks, then 1 x wk x 8 wks. DON/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	

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	3.1-48(c)(1)			
F 0761 SS=E 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 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, record review and interview, the facility failed to place open dates on medication for 1 out of 2 carts reviewed for medication storage and labeling. This deficient practice affected 9 residents. (Residents 2, 8, 30, 36, 37, 55, 64, 69 and 74) Finding includes:	F 0761	Label/Store Drugs and Biologicals Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of	04/06/2023

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	The 100-hall medication cart had 7 bottles of opened nasal sprays and 3 inhalers without an open date on the packaging. There was a Symbacort inhaler for Resident 8, with delivery date of 3/1/2023 and no open date. There was an Albuterol inhaler for Resident 74, with a delivery date of 2/23/2023 and no open date. There was an Albuterol inhaler for Resident 30 with no open date There was a Flucotisone nasal spray for Resident 2 with a delivery date of 1/22/2023 and no open date. There was a Flucotison nasal spray for Resident 36 with a delivery date of 9/26/2022 and no open date. There was a Oxymerazoline nasal spray for Resident 69 with a delivery date of 3/3/2023 and no open date. There were two Fluticansone nasal sprays for Resident 55 with a delivery date of 12/10/2022 and 2/11/2023 and no open date on either spray. There was a Fluticansone nasal spray for Resident 37 with a delivery date of 9/12/2022 and no open date. There was a Deep Sea Moisturizer nasal spray for Resident 64 with a delivery date of 1/19/2023 and no open date. During an interview, on 3/8/2023 at 5:52 A.M.,		Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. The facility cordially requests paper compliance regarding alleged deficient practices. 1. Residents 2, 8, 30, 36, 37, 55, 64, 69, 74 were not harmed by the alleged deficient practice. All medication carts been audited to ensure open medications have open dates present. 2. All residents have the potential to be affected by same alleged deficient practice. All residents medications have been audited to ensure open medications have open date present. 3. DON/Designee has educated all licensed nurses on the medication policy with an emphasis on labeling open medications with open date. 4. DON/Designee will audit 2 medication carts for open dates. This will occur 1 x wk x 4 wks,	

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	LPN 21 indicated there should have been open dates on all the boxes. On 3/9/2023 at 11:08 A.M., the Regional Nurse provided a policy titled, "Medication Administration," revised on 1/5/2022, and indicated the policy was the one used currently used by the facility. The policy indicated "...aa. For medications that expire, label the date opened on the label (insulin, irrigation solutions etc.)...." 3.1-25		Then will audit 1 medication cart for open dates. This will occur 1 x wk x 8 wks. DON/Designee will report on audits monthly to the interdisciplinary team for a total of 6 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 6 months with 100% compliance achieved.	
F 0803 SS=D Bldg. 00	483.60(c)(1)-(7) Menus Meet Resident Nds/Prep in Adv/Followed §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph			

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	should be construed to limit the resident's right to make personal dietary choices. Based on observation, record review and interviews, the facility failed to ensure the menus were followed 4 of 83 residents (Residents C, D, 8 and 54) and 3 of 4 residents who attended the resident council meeting. (Residents 36, 39 and 63) Finding includes: 1. During the observation and interview of the meal service, on 3/6/2023 at 11:56 A.M., alert and oriented Resident 8 indicated she was never served the right food per the menu. Observation of her meal tray and food ticket indicated she was supposed to be served Caprices vegetables and was served carrots. She was also supposed to be served pureed rice and was served mashed potatoes. 2. During an observation and interview with Resident 54, on 3/6/2023 at 12:45 P.M., indicated he had not received the correct food items. Review of his meal ticket indicated he was supposed to have received two hamburger patties with grilled onions and gravy, double portions of rice pilaf and Caprise vegetables. He was observed to have only received two plain hamburger patties with gravy, the rice was supposed to be rice pilaf but was just plain rice, he was served carrots. 3. During an interview with alert and oriented Resident C, on 3/6/2023 at 11:00 A.M., he indicated the food was often cold and the menu was not followed. He indicated his diet had been changed from pureed to a mechanical soft but he often still received pureed food and often the menu provided with the meal had not been followed.	F 0803	**Menus Meet Residents Nds/Prep in Adv/Followed** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. No residents were identified as being harmed by the alleged deficient practice. 2. All residents that consume an oral diet have the potential to be affected by the same alleged deficient practice. 3. The Food Service Manager has educated the dietary department on the facility's expectation to adhere to the predetermined menu. The Executive Director has educated the Food Service Manager on the facility's expectation to order the required food products required for the predetermined menus to ensure accuracy of delivered	04/06/2023

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	During an observation of meal service/dining, conducted on 3/6/2023 during the noon meal, Resident C's meal tray was observed. The resident was supposed to have rice and was served mashed potatoes, he was supposed to have Caprise vegetable blend and was served carrots. 4. During an interview and observation of the noon meal on 3/6/2023, with alert and oriented Resident D, he was noted to have received mashed potatoes instead of rice, bread instead of a dinner roll and carrots instead of the Caprise vegetables on the menu. The lunch menu, provided by the Administrator on 3/6/2023 at 1:00 P.M., indicated the menu for 3/6/2023 should have been either Dijon pork loin or hamburger steak with grilled onions, Capri vegetable blend or braised cabbage, Rice pilaf or oven browned potatoes, dinner roll/bread and citrus glazed angel food cake. 5. During the resident council meeting on 3/10/23 at 2:09 PM, 3 of 4 residents in attendance (Residents 36, 39 and 63) indicated the food was often served cold and the items were often not available and menus were not followed. Review of the facility's policy and procedure, titled "Food Quality and Palatability" provided by the Regional Nurse Consultant on 3/13/2023 at 1:44 P.M. included the following: "Procedures: 1. The Dining Services Director and Cook(s) are responsible for food preparation. Menu items are prepared accordingly to the menu, production guidelines, and standardized recipes..."		meals and to notify the Executive Director of unforeseen occurrences that require food substitutions on the menu so that the facility may utilize best efforts to notify residents of menu changes. 4. The Food Service Manager, Executive Director/Designee will audit 10 resident trays of random meals 3 x weekly for 1 month, then 5 resident trays of random meals 2 x weekly x 1 month, then 5 resident trays 1 x weekly x 1 month to ensure menus match foods delivered. The Food Service Manager/Designee will report on audits monthly to the interdisciplinary team for 3 months during QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance achieved.	

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	3.1-20(i)(4)			
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.			
	Based on observations, and interviews the facility failed to identify concerns with palatability and temperature of food served for the residents. This deficient practice had the potential to affect 83 of 83 residents. Findings include: During an observation of the meal service, conducted on 3/6/2023 at 11:56 A.M., an insulated meal cart was delivered to the main dining room. From 11:56 A.M. - 12:23 P.M., the cart's doors were wide open and staff were moving covered meal trays in and out of the cart in an attempt to locate meal trays for the residents who were waiting on meals in the dining room. At 12:23 P.M., all of the meal trays left were placed back into the cart, the doors of the cart were shut and the cart was delivered to the 300 hall. The cart was then moved to the 100 hall and finally the 200 hall before all of the meals were delivered, at 1:02 P.M. In addition, at 12:34 P.M. a second cart was delivered to the 300 unit and the process was repeated with the cart leaving the 300 unit and	F 0804	**Nutritive Value/Appear, Palatable/Prefer Temp** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.** 1. No residents were identified as being harmed by the alleged deficient practice. 2. All residents have the potential to be affected by the	04/06/2023

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	being delivered to the 100 unit. During an interview with alert and oriented Resident D, on 3/6/2023 at 3:00 P.M., he indicated his food at lunch was cold when he received it. During an interview with alert and oriented Resident C, on 3/6/2023 at 3:00 P.M., he indicated his lunch meal tasted okay but was cold. During an observation of the meal service, conducted on 3/10/2023 at 11:55 A.M., the food temperatures in the kitchen were noted to be within acceptable ranges. However, an observation of the food temperatures at the point of service on the 200 hall, completed by the FSS (Food Service Supervisor) at 1:01 P.M. indicated the following: Fish=86 degrees Fahrenheit (F), Broccoli=100 F and potatoes 100 F. Observation of the food temperatures at the point of service, on the 100 hall, completed by the FSS at 1:12 P.M. indicated the following: Peas=105 F, Rice=130 F and Chicken=110 F. During an interview, on 3/13/2023 at 2:15 P.M. , the FSS , indicated he was aware of some of the resident's complaining about the food being cold but when he would investigate, he discovered staff were warming the plates of food up in the microwave. He indicated he was unaware the plate warming system was not functioning properly. This Federal tag relates to Complaints IN00391830.3.1-21(a)(2)		same alleged deficient practice. 3. The Executive Director/Director of Nursing have educated the dietary staff, nursing staff, and staff that assist with delivery of meals on the meal delivery process with emphasis on palatability and temperature of food. Several process changes have been made to the meal delivery including new warming pallets and additional staff to distribute meals. 4. The Food Service Director, Executive Director, or designee will check one of the last three trays to be delivered in each hallway once per day. These four temperature audits will occur randomly over three meals served each day. This audit is an ongoing process. The Food Service Manager will bring the results of the audits to the monthly QAPI meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance achieved.	
F 0812 SS=F	483.60(i)(1)(2) Food			

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Bldg. 00	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.			
	Based on observations and interviews the facility failed to ensure kitchen equipment was free of lime build up and dishes were stored to prevent cross contamination. This deficient practice had the potential to affect 83 of 83 residents. Findings include: During an observation and interview on 03/10/23 at 12:39 P.M., with the FSS there was an lime build up on the bottom of the dish rack and prongs on the inside of the dishwasher. The FSS indicated they de-lime the dishwasher every Friday after the last meal of the day. In addition, pots, pans and bowls were stored on the bottom shelf of the kitchen prep tables, in an upside down manner. He indicated the bowls pots and pan should not	F 0812	**Food Procurement, Store / Prepare / Serve - Sanitary** Preparation and execution of this plan of correction does not constitute admission or agreement by this provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. **The facility cordially requests paper compliance regarding alleged deficient practices.**	04/06/2023

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	be located on the bottom rack because of the dirt and debris on the floor. During an observation, on 3/13/2023 at 2:15 P.M. the pots and bowls remained inverted on the bottom shelf and debris remained on the floor underneath the pots/pan and bowls. During an interview on 3/13/2023 at 2:45 P.M. the FSS provided the policy titled " Environment" dated 9/20/2017, and indicated the policy was the one currently used by the facility. The policy indicated"..."All food preparation areas, food service areas, and dining will be maintained in a clean and sanitary condition...Environment: 3. All food contact equipment will be cleaned and sanitized after every use. 4. The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces. 3.1-21(i)(3)		1. No residents were identified as being harmed by the alleged deficient practice. 2. The dish machine has been de-limed each day in the past five days. The water softener was adjusted to cycle more frequently to aide in reducing lime buildup. A barrier was placed on the storage of pots and pans on the drying rack. This barrier allows for drainage during the drying process and facilitates as a barrier from the floor, some seven inches below the bottom rack. Debris was removed from beneath the aforementioned drying rack. 3. Dietary staff were educated by the Food Service manager regarding the increased de-lime process and storage of pots and pans. Staff were also instructed to alert the head cook or Food Services Manager of any concerns in this area that would prohibit successful completion of this improved practice. 4. The kitchen will be audited by routine sanitation rounds three times a week for a minimum of four weeks and then weekly for three weeks. The Executive Director or Administrator in Training will audit once a week to ensure compliance for the aforementioned concerns. Any	

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			indication of noncompliance will require additional changes in the process for compliance. The reports will be reviewed through the QAPI process.	
F 0880 SS=E 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 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;			

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	(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. §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 observation, interview and record review, the facility failed to wear appropriate	F 0880	F880 (D) Infection Prevention and Control	04/06/2023

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	personal protective equipment (PPE) when entering a transmission based precaution (TBP) room (Resident 81) and failed to ensure infection control practices were followed during medication administration and dressing change (Resident 20, 236 and 17). Findings include: 1. During the initial tour of the facility on 3/6/2023 from 9:45 A.M. - 11:15 A.M., Resident 81's door had signage indicating it was a "Red Zone," instructing staff in PPE (Personal Protective Equipment) usage and indicated the resident was on "Droplet" precautions. Resident 81 was readmitted to the facility on with diagnoses, including but not limited to: acute and chronic respiratory failure with hypercapnia and human metapneumovirus. On 3/7/23 at 9:30 A.M., the Regional Nurse Consultant was observed to answer Resident 81's call light. She propped the door open and asked Resident 81 what she needed. After hearing the resident's response, the Administrative nurse then donned an N95 mask, a disposable gown and gloves. The nurse did not wear a face shield and/or eyewear. On 3/8/2023 at 10:40 A.M., two therapy staff were observed donning PPE to enter Resident 81's room. Neither staff member put on a face shield and/or protective eye wear prior to entering the resident's room. On 3/10/23 at 2:40 P.M., a therapist was noted to don an N95 mask, a disposable gown and gloves and enter Resident 81's room. She did not wear a face shield or eye protection.		The facility will ensure personal protective equipment is donned and doffed correctly, hand hygiene, and equipment disinfected is consistently implemented to potentially prevent the spread of Covid-19 and other infections. Resident #81 was placed in droplet precautions on 3/3/2023 upon return from the hospitals for an URI. Resident #81 was assessed by the DON on 3/14/23 and did not have a negative outcome as a result of the deficient practice. Resident # 81 had a negative COVID test on March 3, 2023 and March 6, 2023. There are no additional resident in droplet precautions at this time. This had the potential to affect 83 residents. All residents are monitored daily for signs and symptoms of COVID-19 infections. There have not been any additional cases of COVID -19, there has not been a negative outcome as a result of the deficient practice. Employee #9 and 18 was given education immediately on 3/14/23 by the DON following the observation of the deficient practice. During observations resident # 20 and # 236 required a blood sugar check by RN# 9, the staff member	

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	During an interview, conducted on 3/13/23 at 11:15 A.M., with RN 18, the Infection Preventionist, she indicated Resident 81 was in droplet precautions until after 3/10/2023 and staff should have donned the "full" PPE - a gown, gloves, mask and face shield. Review of the facility policy and procedure, titled "Standard Precautions and Transmission Based Precautions" provided by the Regional nurse consultant, on 3/14/2023 at 10:01 A.M., included the following: "...2. Tier 2 Precautions Droplet Precautions...b. Staff will utilize the proper PPE's upon entering the room or cubical area including gloves, mask and eye protection be fore contacting the resident or environment...." 2. The record for Resident 20 was reviewed on 3/10/2023 at 9:29 A.M. Diagnoses included, but not limited to: dementia, severity with other behavioral disturbances, asthma, type 2 diabetes, and anxiety disorder. During an observation, on 3/8/2032 at 6:24 A.M., Registered Nurse (RN) 9 entered Resident 20's room and placed the glucometer on the nightstand without a barrier, wiped the resident's finger with an alcohol prep and waved her hand over the area to dry the resident's finger, applied the resident's blood to the strip and placed the glucometer on the bed, exited the room with gloves on, placed the glucometer on the med cart with no barrier, removed her gloves with no hand hygiene performed, removed insulin from the cart, performed hand hygiene then went into the room and administered insulin with ungloved hands. The glucometer was not cleaned. 3. The record for Resident 236 was reviewed on		demonstrated deficient practice with hand hygiene and potential cross contamination due to not disinfecting the glucometer and using a protective barrier. The residents have no s/s of infection noted in the clinical record and our monitored daily for s/s infection, there has not been a negative outcome as a result of the deficient practice. Resident # 20 required subcutaneous insulin as per physician order. RN #9 administered the insulin to resident #20 without following standard precautions and don/doffing PPE. The resident was assessed by the DON on 3/14/23 with no s/s of infection, there has not been a negative outcome as a result of the deficient practice. At that time the facility had 22 additional residents with glucometer checks per physician orders. All 23 were assessed by the DON on 3/15/23 with no s/s of infections. At that time the facility had 23 additional residents with physician orders for subcutaneous injections. All 13 residents were assessed by the DON on 3/15/23 with no s/s of infections. Employee #9 was given immediate	

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	3/8/2023 at 8:50 A.M. The diagnoses included, but not limited to: type 2 diabetes and dementia without behavioral disturbances. During an observation on 3/8/2023 at 6:29 A.M., RN 9 entered Resident 236's room and placed the glucometer on the nightstand without a barrier, wiped the resident's finger with an alcohol prep, waved her hand over the area to dry, then exited room with gloves on and took an alcohol prep and wiped the end of the glucometer. and placed the glucometer back in the cart drawer without a barrier. During an interview on 3/8/2023 at 6:34 A.M., RN 9 indicated she should have worn gloves when administering insulin, and their process for cleaning the glucometer was to use a sani-wipe for 30 seconds then let it air dry. She should have cleaned the glucometer between residents. She should have not exited the residents' room with gloves on and should not have waved her hand after applying the alcohol prep due to possible/bacteria in the air and should have used a barrier under the glucometer. On 3/8/2023 at 10:12 A.M., the Regional Nurse provided a policy titled, "Injection Subcutaneous," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...1. Prepare for the procedure d. Perform hand hygiene and don gloves...." And policy titled, "Blood Glucose Point of Care Testing," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...II. Perform the procedure a. Gather supplies including clean glucometer, b. Perform hand hygiene, c. Don gloves, d. Turn on machine and place on a hard surface, with a clean barrier under device i. Do not place machine on bed or		education by the DON on 3/14/23 Resident #17 required a dressing change to the heel as per physician orders. During the dressing change RN#9 performed the dressing change without appropriate PPE, donning/doffing and performing hand hygiene. Resident #17 was assessed by the DON on 3/14/23 with no s/s of infection. There has not been a negative outcome as a result of the deficient practice. Resident # 17's wound is now healed. At that time the facility had 1 additional resident which required dressing changes. The resident is followed by the Wound CNP and was assessed on 3/7/2023 with no s/s of infection. Employee #9 was given immediate education by the DON on 3/14/23.	

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	chair, e. Prepare finger to be lanced by having resident wash hands thoroughly with soap and warm water or use an alcohol wipe and allow to air dry before lancing, v. Remove gloves and perform hand hygiene. III. Clean and Store Equipment a. Place a clean barrier under glucometer until disinfected i. Do not place uncleaned glucometer on top of med or treatment cart without a clean barrier under the device. b. Per manufacture guidelines c. Perform hand hygiene prior to disinfecting e. Don gloves, e. Perform cleaning and disinfection procedure f. Remove gloves and perform hand hygiene g. Store in clean dry area...." And policy titled "Cleaning and Disinfection of Glucose Meter," dated 2/24/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...Procedure b. Each medication cart will have at least two (2) glucose meters that are shared by residents. i. One meter may be in use while the other meter is undergoing disinfection with the high-level antimicrobial wipe for wet-contact time per the manufacturers recommendation. ii. A suggested method to obtain proper disinfection times for wet-contact is to wrap the machine in the wipe ensuring that all surfaces remain wet during the contact time period. iii. Place the wrapped meter in a clean cup on the med cart for the appropriate length of time. iv. Allow meter to air dry prior to use, f. ii. Disinfect the glucometer immediately before re-use with an EPA approved wipe. 1. Alcohol wipes are not appropriate for cleaning/disinfecting a used glucometer...." 4. The record for Resident 17 was reviewed on 3/6/2023 at 3:00 P.M. The diagnoses included, but not limited to: dementia without behavioral disturbances, mood disturbances, psychotic disturbances, anxiety, and major depressive disorder.			

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	During an observation on 3/7/2023 at 9:27 A.M., Registered Nurse (RN) 9 performed a dressing change to Resident 17's heel and did not remove gloves and perform hand hygiene after taking off the dressing. She proceeded to apply the treatment and place a new dressing, replace the boot then took the trash to the soiled utility room where she removed her gloves and used hand sanitizer. During an interview on 3/8/2023 at 9:58 A.M., RN 9 indicated when she removed the dressing, she should have removed her gloves and cleansed her hands and don new gloves prior to applying the treatment3.1-18(a)			