STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 00 B. WING	06/09/2023

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PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00409452, IN00401469, IN00402291, and IN00407950. Complaint IN00409452 - No deficiencies related to the allegations are cited. Complaint IN00401469 - No deficiencies related to the allegations are cited. Complaint IN00402291 - No deficiencies related to the allegations are cited. Complaint IN00407950 - No deficiencies related to the allegations are cited. Survey dates: June 5, 6, 7, 8, 9, 2023 Facility number: 000555 Provider number: 155370 AIM number: 100267530 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 7 Medicaid: 49 Other: 8 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 20, 2023.	F 0000	Submission of this Plan of Correction by the facility is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the survey agency. Please accept the following as the facility's credible allegation of compliance.	

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

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F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview and record review, the facility failed to ensure that 1 of 5 residents observed during medication pass had a self administration assessment and order. (Resident 8) Finding includes: On 6/7/23 at 8:03 A.M., QMA (Qualified Medication Aide) 8 was observed leaving Resident 8's medication on the food tray and left the room without watching the resident take the following medications: 1 Loratidine 10 mg (milligrams) 1 Baby Aspirin 81 mg 1 Carvedilol 25 mg 1 Diltiazem HCL ER 240 mg 1 Farxiga tablet 5 mg 1 Furosemide 40 mg 1 Levetiraceta 500 mg 1 Losartan 100 mg 1 Omeprazole 20 mg 1 Preservision capsule 1 Tradjenta 5 mg tablet On 6/8/23 at 9:00 A.M., Resident 8's clinical record was reviewed. Diagnosis included, but was not limited to, hemiplegia and hemiparesis following unspecified cardiovascular disease and heart failure. The current quarterly MDS (Minimum Data Set) assessment, dated 4/18/23, indicated Resident 8	F 0554	A self-administration of medication assessment was completed on resident 8. QMA 8 was individually in-serviced on the self-administration of medication policy and given a verbal warning on the deficient practice. All residents have the potential to be affected by the deficient practice. An audit was conducted to ensure that any resident that is not being observed by the nurse or QMA with medication administration has an appropriate self-administration of medication assessment completed. An in-service was conducted for QMA's and nurses by the DON on the medication administration policy that includes self-administration of medication. An audit tool has been created for the DON to monitor 5 random med passes 5x week for 8 weeks, 5 random med passes 3x/week for 8 weeks and 5 random med passes 1x/week for 8 weeks. Results of the monitoring will be forwarded to QAPI for review and any needed further recommendations.	07/07/2023

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	was cognitively intact. Current physicians orders lacked a self administration order. Current care plan lacked self administration interventions. Clinical record lacked a self medication assessment. During an interview on 6/8/23 at 8:30 A.M., the Administrator indicated Resident 8 did not have a self administration assessment and does not administer medication. During an interview on 6/9/23 at 8:28 A.M., LPN (Licensed Practical Nurse) 15 indicated residents should take medications in front of her. The only time she would leave medication at the bedside if the resident had a self medication order. A current Self Administration Policy effective 10/25/2014, was provided by the Administrator indicated "... if the resident desires to self-administer medication, an assessment is conducted by the interdisciplinary team of the resident... during the care planning process". 3.1-11(a)			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which			

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	results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part,			

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	and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to provide notification of change for 1 of 6 residents reviewed for unnecessary medications. A resident's representative was not notified prior to anti-anxiety or narcotic pain medication as requested by the representative. (Resident 48) Finding includes: Interview on 6/5/23 at 1:31 P.M., Resident 48's daughter (power of attorney) indicated she had spoken with the Director of Nursing (DON), as well as Resident 48's hospice team related to a new prescription of Ativan (an anti-anxiety medication) and Morphine (a narcotic pain medication). She indicated she had requested she be called prior to administration of these medications, as they were prescribed on an as needed basis, and she wanted to speak with staff about implementing other interventions prior to giving the medications. On 6/6/23 at 1:16 P.M., Resident 48's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and COPD (chronic obstructive pulmonary disease). The most recent quarterly MDS (minimum data set) Assessment, dated 5/22/23, indicated Resident 48 was severely cognitively impaired, had experienced behavioral symptoms 1-3 days during the previous 7 days, wandered 1-3 days, required limited assistance of 1 staff for bed mobility, transfers, and eating, extensive assistance of 1 staff for bathing, was totally dependent of 1 staff for bathing, had taken an anti-anxiety medication 7 of 7 days, had not taken an opioid medication, had not experienced pain, and was on hospice.	F 0580	Resident 48's morphine was discharge, care plan updated and the family was notified. Resident 48's daughter was interviewed again about the PRN ativan. She does not wish to be called when given this PRN medication. All residents have the potential to be affected by the alleged deficient practice. An audit of all residents that have had a change in condition in the last 72 hours has been completed to ensure all proper notifications have been made. An in-service has been completed by ADON for all licensed nursing staff and QMA's on notification of change policy. IDT will audit all changes of conditions in clinical morning meetings to ensure timely notification of change of conditions is being completed. An audit tool has been created to monitor timely notification of changes of conditions. The DON will monitor family notification in IDT clinical meeting for all change of conditions 5x week for 8 weeks, 3x week for 8 weeks and 1x/week for 8 weeks. Results of this monitoring will be brought to QAPI monthly for review and any needed recommendations.	07/07/2023

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	Current physician orders included, but were not limited to the following: Morphine Sulfate (Concentrate) Oral Solution 100mg (milligrams)/5ml (milliliters) 0.5 ml by mouth every 15 minutes as needed for shortness of breath/pain. GIVE FOR PAIN ONLY!!!!!!! dose is 0.5ml (10mg) GIVE ONLY IF ACTIVELY PASSING, started 4/21/23. lorazepam (Ativan) 0.5mg every 30 minutes as needed for anxiety/restlessness, started 2/20/23. A current pain care plan, last revised 8/31/22, included, but was not limited to, the following interventions: administer medications per order, dated 8/31/22, evaluate effectiveness of interventions as needed, dated 8/31/22, provide non pharmacological interventions to relieve pain such as: provide a quiet calm environment to promote rest and relaxation, reposition as needed, offer snack and fluids, offer bath/shower, validate feelings and provide reassurance, dated 8/31/22. The care plan lacked information to notify the resident's daughter prior to administration of pain medication. A current anti-anxiety medication care plan, last revised 5/2/23, included, but were not limited to, the following interventions: administer anti-anxiety medications as ordered and monitor for side effects and effectiveness, dated 3/22/23, monitor the resident as needed for safety, dated 3/22/23, monitor and record occurrence of target behavior symptoms such as refusal of care, aggression toward staff, placing self on floor, etc., dated 3/22/23. The care plan lacked information to notify the resident's daughter prior to administration of anti-anxiety medication.			

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	The medication administration record (MAR) from 2/2023 through current indicated the following dates that the as needed Ativan was administered: 2/20/23 3:00 P.M. 2/27/23 9:00 A.M. 3/5/23 11:30 P.M. 3/12/23 11:00 P.M. 3/17/23 8:02 P.M. 3/27/23 8:50 A.M. 3/29/23 7:00 P.M. 3/31 23 1:46 P.M. and 8:30 P.M. 4/3/23 10:00 A.M. and 3:31 P.M. 4/14/23 12:37 P.M. 4/23/23 8:00 P.M. 4/29/23 10:45 A.M. 5/13/23 12:01 A.M. 5/29/23 6:07 P.M. Resident 48's clinical record lacked documentation of notification to daughter prior to administering the as needed Ativan. The MAR from 2/2023 through current indicated the following dates that the as needed Morphine was administered: 4/3/23 3:30 P.M. 4/9/23 9:00 P.M. Resident 48's clinical record lacked documentation of notification to daughter prior to administering the as needed Morphine. Interview on 6/7/23 at 12:42 P.M., RN (Registered Nurse) 21 indicated staff was supposed to notify family prior to administering either Ativan or Morphine to Resident 48. Interview on 6/8/23 at 1:46 P.M., the DON indicated she recalled a conversation with Resident 48's daughter "a long time ago" that she wanted to be notified before Ativan or Morphine was administered to her father. At that time, the			

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	DON indicated there was no documentation of that conversation. On 6/9/23 at 1:30 P.M., a current Change in a Resident's Condition or Status policy, revised 12/2016, indicated "Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) when upon assessment, changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) was noted". 3.1-5(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure residents received supervision and consistent implementation of interventions to prevent falls for 2 of 5 residents reviewed for accidents. Fall interventions were observed out of place, and care plans were not updated following falls. (Resident 40, Resident 48) Findings include: 1. On 6/6/23 at 1:42 P.M., Resident 40's clinical record was reviewed. Diagnoses included, but	F 0689	The fall care plan for resident 40 was reviewed and updated. All fall interventions were put into place. The fall care plan for resident 48 was also reviewed and updated. All fall interventions were put into place. All residents with fall interventions have the potential to be affected by the alleged deficient practice. An audit of all fall care plans and interventions has been completed	07/07/2023

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	were not limited to, dementia and depression. The most recent quarterly MDS (minimal data set) Assessment, dated 3/29/23, indicated a severe cognitive impairment, no behaviors, and was on hospice. Resident 40 required limited assistance of one staff for bed mobility, transfers, and eating, supervision of one staff for toileting, and was totally dependent on one staff for bathing. Resident 40 had two or more falls since the prior assessment with no injury. A current risk for falls care plan, dated 5/18/22, included, but was not limited to, the following interventions: apply non skid strips to floor in front of the recliner, dated 2/8/23, non skid shoes with orthotic brace to be worn at all times while awake, dated 1/9/23, place sign in room "to slow down", dated 2/15/23, walk to dine, dated 11/30/22. A current actual fall care plan, dated 5/23/22, included, but was not limited to, the following interventions: staff to walk resident to and from dining room for meals, dated 11/11/22. From June 2022 through June 2023, Resident 40 experienced the following 28 falls: Fall 1 6/7/22 at 8:45 P.M. Fall was not witnessed. Resident fell in the hallway while "in a hurry/rush" as indicated on the post fall evaluation. Resident was assessed. No other notes about the fall were included. The clinical record lacked an IDT (Interdisciplinary Team) note with an updated care plan intervention following the fall. Fall 2 6/8/22 at 4:49 A.M. Fall was not witnessed. The nurse observed the resident come out of his room with a roll of paper towels in his left hand. As the		to ensure all care planned interventions are still appropriate and in place. An in-service has been completed by the ADON on the accident prevention policy which includes fall interventions. A binder has been placed at each nurse's station with fall care plans and interventions for each resident that has a fall care plan. An audit tool has been created for the ADON to monitor all fall interventions 5x week for 8 weeks, then 3x for 8 weeks, 1x week for 8 weeks. Results of this monitoring will be forwarded to QAPI monthly for review and any needed recommendations.	

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	nurse walked ahead of the resident, another resident alerted the nurse that Resident 40 had fallen. Resident 40 then indicated to the nurse "I'm ok. I've fallen so many times. I'm ok." The clinical record lacked a post fall evaluation or an IDT note with an updated care plan intervention immediately following the fall. Fall 3 6/15/22 at 11:20 A.M. Fall was witnessed. Resident was sitting in a chair in the dining room participating in an activity. The resident reached to the right to catch a ball and landed on the floor on the right side. Resident was assisted back into the chair. The post fall evaluation indicated reason for fall was poor safety awareness and a reacher was provided, but the new intervention was not added to the falls care plan. The falls care plan was updated on 6/17/22 to include intervention resident to have on non skid socks on bilateral feet when in bed. Fall 4 6/24/22 at 1:48 P.M. Fall was witnessed. Resident was walking in the hallway and his left leg gave out. The resident indicated "My leg just gave out. I am fine". The post fall evaluation indicated "fell without appropriate footwear". No new intervention was suggested or added to the falls care plan. Fall 5 7/16/22 at 3:00 P.M. Fall was witnessed. Resident lost balance in the dining room. The nurses note indicated resident had a brace to leg that was supposed to be worn, but resident refused the brace. A post fall evaluation indicated resident refused brace to leg, but did not suggest or initiate a new intervention in the falls care plan.			

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	Fall 6 7/19/22 at 7:45 A.M. Fall was witnessed. Resident lost balance while walking in the hallway, landed onto knees, and was able to stand independently. Resident was encouraged to use safety rails that were in the hallway. A post fall evaluation indicated resident continued to refuse brace to leg, and staff to encourage use. No new intervention was suggested or added to the falls care plan. Fall 7 7/22/22 (unknown time) Fall was unwitnessed. An IDT fall note indicated resident fell resulting in laceration to middle of forehead (required sutures) and skin tear to left upper extremity. Water was noted on the floor. Intervention was to spot check the resident's floor three times a day for one week. The falls care plan was updated with the new intervention. The clinical record lacked a post fall evaluation for the fall. Fall 8 8/10/22 at 12:50 P.M. Fall was unwitnessed. Resident fell in his room and was found lying on his right side, bleeding from the forehead. Resident was sent to the ER. The clinical record lacked other notes related to the fall. No new intervention was suggested or added to the falls care plan. Fall 9 8/15/22 at 9:30 A.M. Fall was witnessed. Resident lost balance in the hallway and fell while carrying a tray. A post fall evaluation indicated to obtain an order for therapy evaluation. Clinical record updated. Fall 10 9/8/22 at 5:00 P.M. Fall was witnessed. While			

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	sitting in the dining room, resident leaned too far in a chair and slid out the front. No new intervention was suggested or added to the falls care plan. Fall 11 9/15/22 at 9:00 A.M. Fall was witnessed. Resident was in restroom during morning care and lost balance. Resident bumped his right elbow resulting in two skin tears. No new intervention was suggested or added to the falls care plan. Fall 12 10/13/22 (time unknown) An IDT fall note indicated fall was witnessed. Resident came out of his room to place a tray on the floor outside the doorway. When leaning forward, resident fell and landed on the right side. A skin tear was noted to the right elbow and resident hit the right side of his head. Immediate intervention was to evaluate the splint for the left foot. No new interventions were added to the falls care plan. A post fall evaluation was not completed after the fall. Fall 13 11/1/22 at 5:40 P.M. Fall was witnessed. Resident was walking in the hallway, entered another resident's room, lost balance, and landed on the floor. No new intervention was immediately added to the falls care plan. Fall 14 11/3/22 at 12:50 P.M. Fall was witnessed. Resident was walking in the hallway towards the dining room and lost balance. Landed on the left shoulder and side. The falls care plan was updated 11/11/22 to include intervention: Fall on 11/1/22 and 11/3/22, new intervention for staff to walk resident to and from dining room for meals.			

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	Fall 15 11/29/22 at 5:05 P.M. Fall was witnessed. Resident was walking in the hallway using safety rail, turned quickly and landed on the floor. Resident's forehead was bruised. A new intervention to "walk to dine" was added to the falls care plan on 11/30/22 (same intervention that was added on 11/11/22). Fall 16 12/6/22 at 7:50 P.M. Fall was witnessed. Resident was walking from his room to the nurses station, became unsteady and lost balance. The immediate intervention was to assist resident to and from room. A new intervention to refer to orthotics to ensure brace is properly fitting was added to the falls care plan on 12/7/22. Fall 17 12/8/22 at 9:00 A.M. Fall was witnessed. Resident lost balance while exiting room and turning the corner into the hallway. Resident fell onto the right side. Immediate intervention was to encourage resident to not rise rapidly. No new intervention was added to the falls care plan. Fall 18 1/7/23 at 1:00 P.M. Fall was witnessed by spouse. Resident heard a noise in the hallway, attempted to get out of a chair, and landed onto his left side. An IDT fall note, dated 1/11/23, indicated resident was encouraged to transfer self slowly to prevent further falls, and the new intervention was to keep the resident free of injuries. A new intervention for non skid shoes with orthotic brace to be worn at all times while awake was added to the falls care plan on 1/9/23. Fall 19 2/7/23 at 6:58 A.M. Fall was unwitnessed.			

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	Resident was found in his room laying on his back by the recliner. The resident indicated at that time he had slipped out of the chair while trying to stand up. The new intervention was to add non skid strips in front of the recliner. The falls care plan was updated on 2/8/23. Fall 20 2/13/23 at 1:55 P.M. Fall was witnessed by son. Resident attempted to transfer self from chair to standing position. When resident pivoted, he lost balance and fell to the floor. A new intervention to place sign in room "to slow down" was added to the falls care plan on 2/15/23. Fall 21 2/23/23 at 4:45 P.M. Fall was unwitnessed. Resident was leaving bedroom with arms full, lost balance in the doorway and fell. The post fall evaluation indicated resident refused leg brace. No new intervention was suggested or added to the falls care plan. Fall 22 3/6/23 at 7:32 A.M. Fall was witnessed. Resident was walking in the hallway when staff indicated to resident "we need to put on your brace". Staff attempted to reach resident as resident pivoted and he lost balance and fell. A post fall evaluation was not completed following the fall. An IDT fall note indicated the new intervention was to have day shift staff check on him first thing coming onto shift and assist with putting on his brace. The falls care plan was updated with the new intervention. Fall 23 4/7/23 unknown time. An incident note dated 4/7/23 at 2:00 P.M. indicated "Resident on buttocks on floor sitting in front of recliner. Small			

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	0.2cm (centimeter) skin tear noted to L (left) elbow ... Resident states "I was trying to catch myself from falling and grabbed rocking recliner and it slid away and I fell to the floor". A post fall evaluation was not completed following the fall. The clinical record lacked an IDT note related to the fall. No new intervention was suggested or added to the falls care plan. Fall 24 4/7/23 unknown time. An incident note dated 4/7/23 at 5:42 P.M. indicated "Resident propelled self down hall and tried standing in doorway to room. Lost balance and fell to buttocks. Small 0.5cm skin tear noted to R (right) forearm ... Educated to not stand up unattended at this time". A post fall evaluation was not completed following the fall. The clinical record lacked an IDT note related to the fall. No new intervention was suggested or added to the falls care plan. Fall 25 4/7/23 unknown time. An incident note dated 4/7/23 at 5:47 P.M. indicated "Assisted resident to dining room for meal time. As staff turned to get trays from cart resident stood up and fell to the floor, landing on buttocks ... ". A post fall evaluation was not completed following the fall. The clinical record lacked an IDT note related to the fall. No new intervention was suggested or added to the falls care plan. Fall 26 4/10/23 at 7:00 P.M. Fall was unwitnessed. The CNA (Certified Nurse Aide) observed the resident sitting against the wall on the floor. The resident indicated he was trying to sit down in his wheelchair, but put his foot on the wheel which caused him to fall off of the wheelchair. The resident indicated he hit his head. The falls care			

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	plan was updated with intervention for anti rollback device to the wheelchair, notify hospice of falls, and request medication review. Fall 27 4/21/23 at 11:43 A.M. Fall was unwitnessed. Resident was found sitting on the floor in the hallway outside of his room. A skin tear was noted to the left arm. The resident indicated "I slid off the edge of my bed and scooted to the hallway". An IDT fall note indicated to place gripper strips beside the bed for better traction. The falls care plan was updated with the new intervention on 4/24/23. Fall 28 6/6/23 at 12:45 P.M. Fall was witnessed by spouse. Resident was transferring from the wheelchair to the recliner, lost balance, and sat on the floor. An IDT fall note indicated a new intervention "education provided to wife to alert staff when assistance is needed but also non-compliance care plans in place r/t (related to) resident getting up per self aeb (as evidenced by) frequent falls" The falls care plan was not updated with a new intervention. Interview on 6/7/23 at 12:31 P.M., CNA 7 indicated Resident 40 had been provided with a wheelchair, but would still get up and down which was how most of the falls occurred. She indicated Resident 40 would come out of his room for meals, but required staff assistance to get to the dining room. Interview on 6/7/23 at 12:47 P.M., RN (Registered Nurse) 21 indicated he was unaware of anything that might have contributed to Resident 40's falls, but it could have to do with self transferring from the bed to wheelchair. RN 21 indicated staff should check on Resident 40 frequently.			

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	Interview on 6/9/23 at 10:16 A.M., Resident 40's wife indicated to her knowledge, there had never been a sign in his room to "slow down". At that time, a "slow down" sign was not observed in the room or the bathroom. Skid strips were observed several feet in front of the recliner, but none were observed directly in front of it. Resident 40 did not have on a leg brace, which was observed sitting on a dresser. Interview on 6/9/23 at 10:32 A.M., CNA 3 indicated she remembered Resident 40 having help signs in his room at one time, but was not sure why they were not currently in the room. She indicated the resident probably took them down. 2. During an interview on 6/5/23 at 1:21 P.M., Resident 48's daughter indicated his glasses were missing "for a while", and he suffered a vision issue without them. She indicated he thinks he sees things that were not there because he couldn't make them out, and believed that his vision issue contributed to several falls he had related to not being able to align himself correctly to sit. She indicated staff was aware of the missing glasses. On 6/6/23 at 1:16 P.M., Resident 48's clinical record was reviewed. Diagnosis included, but was not limited to, dementia. The most recent quarterly MDS Assessment, dated 5/22/23, indicated a severe cognitive impairment, and was on hospice. Resident 48 required limited assistance of one staff for bed mobility, transfers, and eating, extensive assistance of one staff for toileting, and was totally dependent of one staff with bathing. The MDS indicated adequate hearing and vision with no hearing aids or corrective lenses, and unsteady transfers, but able			

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	to stabilize without staff assistance. Resident 48 had one fall since the prior assessment with no injury. Current physician orders included, but were not limited to, the following: May consult and be seen by the audiologist, cardiologist, dentist, eye care physician, podiatrist, psychiatrist, or wound care specialist for evaluation and treatment, dated 8/31/22. A current risk for falls care plan, dated 8/31/22, included, but was not limited to, the following interventions: apply hipsters, dated 2/20/23, resident will be provided with non skid footwear, dated 8/31/22. Falls included the following: Fall 1 11/11/22 at 5:47 P.M. Fall was unwitnessed. Resident was found on his knees in the dining room trying to get himself back up. A dining room chair was pulled out next to him. The resident indicated "I just tripped". At the time the daughter was notified, she indicated to staff the resident's glasses were missing and because he can't see well, it may have contributed to the fall. A post fall evaluation indicated poor vision as a contributor to the fall. A nurses note dated 11/11/22 at 5:50 P.M. indicated "Will follow up with eye doctor for appointment so res (resident) can get new glasses". Also to ensure dining room chairs were pushed in after meals. A new intervention was added to the falls care plan on 11/29/22 to assist resident with frequent and routine toileting in between meals and bedtime. Fall 2 A progress note dated 12/1/22 at 8:15 A.M. indicated therapy alerted staff to room and			

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	resident was found laying on the floor. Staff indicated he was last seen in his bed 10 minutes prior. Resident found to have a skin tear on the right forearm. An IDT note dated 12/2/22 at 11:53 A.M. indicated resident was found naked in the floor by therapy staff, while 10 minutes prior had been seen fully clothed in bed. Resident was unable to tell staff what had happened. The new intervention was to have resident up at the nurses station while awake or have him in the day room by the nurses station. The falls care plan was updated with interventions to check resident's location frequently and routinely when out of bed, dated 12/1/22 and low bed when in bed, dated 12/2/22. Fall 3 12/28/22 at 1:00 P.M. Fall was unwitnessed. Resident was found on the floor of another resident's room on his knees. An IDT fall note, dated 12/30/22, indicated the new intervention following fall was to ensure resident remained safe with all other fall interventions in place. The falls care plan was not updated with a new intervention. Fall 4 2/20/23 at 9:55 A.M. Fall was unwitnessed. Resident was up in the dining room, turned in the doorway, lost balance, and landed on buttocks. Resident had just returned from being assisted with toileting. An IDT fall note dated 2/27/22 indicated the new intervention was to place hipsters (adaptive briefs designed to minimize potential damage due to falls) on the resident to prevent injury. The falls care plan was updated with the new intervention on 2/20/22. Fall 5 3/28/23/at 11:05 A.M. Fall was witnessed.			

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	Resident attempted to sit on the couch in the dining room, missed, and landed on buttocks. The resident was fatigued and tired related to poor sleep the night before. The falls care plan was updated on 3/29/23 to include intervention staff re-education for fall prevention measures. The clinical record lacked documentation that Resident 48 had been to the eye care specialist for new glasses. On 6/7/23 at 9:07 A.M., Resident 48 was observed sitting in the dining room. He did not have glasses on and was not wearing hipsters. Resident 48 was wearing nonskid socks, but with the slick side down on the left foot. Resident 48 was then observed to get up and walk out of the dining room unassisted. On 6/7/23 at 12:25 P.M., Resident 48 was observed sitting in the dining room. He was not wearing hipsters. At that time, CNA 7 indicated Resident 48 should always have on gripper socks, and did wear hipsters for a while, but staff stopped using them. She indicated she was unsure why the hipsters were stopped, but maybe because he could not get his pants down. Interview on 6/7/23 at 12:43 P.M., RN (Registered Nurse) 21 indicated Resident 48's glasses were locked up in the medication cart, and had been there as long as he had been working at the facility (about 3 weeks). At that time, Resident 48's eyeglasses were observed in the top drawer of the medication cart. RN 21 indicated residents that took off their glasses, laid them down, and walked away from them, had their glasses put into the medication cart for safe-keeping. Interview on 6/8/23 at 9:43 A.M., the Social			

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	Services Director (SSD) indicated an optometrist came into the facility every 6 months, and the last visit was in May, 2023, but Resident 48 was not seen. At that time, the SSD indicated residents on hospice were generally not seen by optometry unless they were having a concern and needed to be seen. She indicated she was not aware that Resident 48 needed new glasses, and would need to be added to the list for the next visit. On 6/9/23 at 8:00 A.M., a current Fall Prevention policy, dated 10/22/22, was provided and indicated "Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls". 3.1-45(a)			
F 0690 SS=G Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives			

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	one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure that appropriate treatment and services were provided to prevent urinary tract infections (UTI) that resulted in hospitalizations for 1 of 2 residents reviewed for Urinary Catheter and UTI. This failure resulted in 11 UTIs which resulted in 5 hospital admissions and treatment with 12 antibiotics over the past year. (Resident 21) Finding includes: On 6/7/23 at 10:13 A.M., CNA 14 and CNA 19 were observed to provide catheter care for Resident 21. Both staff entered the room and put on gloves. Two basins of water and folded washcloths were observed prepared on a bedside table. CNA 19 moved the bed to the side by grasping the footboard. CNA 19 shut the door. CNA 19 obtained a trash bag from supplies on bed side table. CNA 19 raised the bed using the handheld bed remote and then moved the call light off of the bed. CNA 19 and CNA 14 pulled	F 0690	1. The facility has taken the following corrective action(s) to address those residents and areas specifically identified as affected: A. CNA 14 and CNA 19 have been provided 1:1 training and education regarding catheter care. This training included a return demonstration to evidence competency. B. R21 is scheduled to see his urologist on 6/28/23 for further assessment and subsequent interventions and approaches to prevent further incidences of UTI. This resident's plan of care shall be updated as warranted after this physician visit. 2. The facility has identified residents with catheters as having the potential to be at risk for this alleged deficient practice.	07/07/2023

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	Resident 21's blanket down to his ankles. At that time Resident 21 only had on a brief. The catheter bag was observed lying at the foot of the bed with a dark yellow liquid inside it. CNA 19 and CNA 14 then removed Resident 21's brief. Without changing gloves, CNA 19 placed a washcloth in the basin on right side, grasped Resident 21's penis in her left hand and cleaned the meatus with the washcloth in her right hand. Using the same washcloth, CNA 19 cleaned down the shaft of the penis. Using the same washcloth, CNA 19 moved the catheter tubing and penis aside and cleaned Resident 21's testicles. CNA 19 disposed of the washcloth in the open trash bag. CNA 19 obtained a new washcloth, put it in the water basin, and, holding the top of Resident 21's penis and grasping the catheter tubing between her left thumb and pointer finger, cleaned down the tube. CNA 19 disposed of the washcloth in the open trash bag and obtained a new washcloth. CNA 19 cleaned around the meatus and around the testicles, then disposed of the washcloth in the open trash bag. CNA 19 obtained another washcloth, put it in the water basin, and cleaned around the meatus, around the testicles and thighs, and then grasped the tip of the penis and catheter tubing in her left hand and cleaned down the tubing. CNA 19 obtained a dry washcloth and patted Resident 21's genital area dry. CNA 19 removed the catheter bag from the bed and clipped it to the bars on the lower right side of the bed. CNA 19 obtained a tube from a basin of supplies. She indicated it was an antifungal cream. CNA 19 applied the cream to her left pointer finger and smeared it all over Resident 21's testicles. CNA 19 indicated to CNA 14 that they would leave Resident 21 without a brief on to "air out". CNA 14 pulled the blanket over Resident 21. CNA 19 and CNA 14 pulled Resident 21 up in bed. CNA 14 used the handheld bed remote to lift Resident		3. Measures and systematic changes the facility has taken to correct this alleged deficient practice and ensure it does not recur include: A. Licensed nurses have been educated and trained regarding: § Documenting reasons for antibiotic use; § Documenting Foley Catheter output; § Documenting Foley Catheter flushes; § Documenting Foley catheter and urinary bag changes; and § Following physician orders and documenting on the MAR and TAR administration of medications and treatments respectively. B. C.N.A.s have been educated and trained regarding the facility's policies and procedures for catheter care. This training included a post-training competency to evidence understanding. C. The IP nurse has been in-serviced regarding the importance of reviewing the use of antibiotics 2-3 days after antibiotics are initiated to determine if the resident is on the most appropriate antibiotic(s), dose, and route of admission. 4. The facility has implemented	

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	21's feet and head up and lower the bed. CNA 19 emptied the two water basins. At that time CNA 19 and CNA 14 removed their gloves and performed hand hygiene using soap and water. CNA 19 put on new gloves and emptied the catheter bag of a dark yellow liquid. CNA 19 indicated she emptied 900 mL (milliliters) of fluid into the toilet. CNA 19 then emptied more dark yellow liquid from the catheter bag and indicated she emptied another 200 mL from the catheter bag. CNA 19 removed her gloves and performed hand hygiene. On 6/7/23 at 8:40 A.M., Resident 21's clinical record was reviewed. Resident 21 was admitted on 6/9/21. Resident 21's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus, chronic kidney disease, systemic lupus erythematosus, retention of urine, and major depressive disorder. The most recent annual MDS (Minimum Data Set) Assessment, dated 3/2/23, indicated the resident was cognitively intact, had an indwelling catheter, was always incontinent of bowel, required extensive assistance of two plus staff for toileting and bed mobility, and required total assistance of two plus staff for bathing. A Catheter Assessment, dated 2/28/23, indicated permanent placement due to urinary retention. Current orders included, but were not limited to: Catheter care to be done each shift two times a day, initiated 5/4/23. Flush F/C (foley catheter) with 60 mL (milliliters) of NS (normal saline) Q (every) day at bedtime, initiated 7/6/22. Foley Catheter output every shift two times a day,		the following Quality Assurance Plan to monitor on-going facility performance and compliance with this requirement: A. The DON and/or appointed designee(s) shall perform random observations of a minimum of two C.N.A.s performing catheter care weekly. Observations shall evaluate compliance with infection control procedures and compliance with the facility's procedures for catheter care. This shall be ongoing for a minimum of sixty (60) days and may be extended as warranted until sustained compliance is achieved. Noted problems shall be addressed immediately and identified patterns/trends of non-compliance shall be reported to the Quality Assurance Committee for further action(s). B. The DON and/or appointed designee(s) shall perform random chart audits of residents with catheters. I minimum of two audits shall be completed weekly. These audits shall review that nursing catheter charting includes: § Documenting reasons for antibiotic use (if applicable); § Documenting Foley Catheter output; § Documenting Foley Catheter flushes;	

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	initiated 6/16/22. Change Foley catheter every 14 days at bedtime, initiated 5/24/23. Previous orders included, but were not limited to: Nurse to chart the use of cipro (ciprofloxacin, an antibiotic medication) for UTI. Chart urine characteristics, pain, burning at foley site, fever, lethargy every shift from 7/21/22 to 7/31/22. Ceftriaxone Sodium Solution Reconstituted 1 GM (gram) IM (intramuscularly) at bedtime for UTI from 9/2/22 to 9/8/22. Amoxicillin-Pot Clavulanate Tablet 500-125 MG (milligrams) by mouth three times a day for bacterial infection from 11/19/22 to 11/28/22. Nurse to chart the use of amoxicillin (an antibiotic medication) for uti. Chart output, color of urine, sediment, fluid intake, catheter care, pain, burning at catheter site, pain in abdomen every shift from 11/20/22 to 11/28/22. Cipro tablet 250 MG by mouth two times a day for UTI from 12/15/22 to 12/22/22. Bactrim DS Oral Tablet 800-160 MG by mouth two times a day for UTI from 2/2/23 to 2/9/23. Fosfomycin Tromethamine Oral Packet 3 GM by mouth in the morning every 3 days for UTI from 2/8/23 to 2/14/23. Augmentin Oral Tablet 500-125 MG by mouth three times a day for UTI-Klebsiella from 2/23/23 to 3/5/23. Ertapenem Sodium Injection Solution		§ Documenting Foley catheter and urinary bag changes; and § Following physician orders and documenting on the MAR and TAR administration of medications and treatments respectively. This shall be ongoing for a minimum of ninety (180) days and may be extended as warranted until sustained compliance is achieved. Noted problems shall be addressed immediately and identified patterns/trends of non-compliance shall be reported to the Quality Assurance Committee for further action(s).	

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	Reconstituted 1 GM intravenously one time a day for UTI from 3/6/23 to 3/9/23. Levaquin Oral Tablet 750 MG by mouth at bedtime for UTI from 5/5/23 to 5/12/23. Macrobid Oral Capsule 100 MG by mouth two times a day for UTI from 5/23/23 to 5/30/23. Ertapenem Sodium Injection Solution Reconstituted 1 GM intravenously one time a day for UTI from 5/25/23 to 6/4/23. Resident 21 had the following UTIs: Occurrence 1. On 7/17/22 a progress note indicated Resident was not feeling well and urine was dark yellow with sediment and foul order. On 7/18/22 a UA (urinalysis) and C&S (culture and sensitivity) was obtained. A lab report, dated 7/20/22, indicated Escherichia Coli was detected. A progress note, dated 7/21/22, indicated the resident was started on ciprofloxacin (an antibiotic medication) for UTI. A lab report, dated 7/20/22, indicated ciprofloxacin was resistant (ineffective) to Escherichia Coli. The MAR (medication administration record) from 7/2022 and 8/2022 indicated the resident received ciprofloxacin from 7/20/22 to 8/3/22. Occurrence 2. On 8/25/22 a progress note indicated Resident was having pelvic pain and urine was dark yellow with foul order. The note also indicated that a UA was sent. On 8/26/22 a progress note indicated "Resident complaining of urinary leakage around tip of penis, noted approx. 100ml cloudy yellow urine in bedside drainage bag. Noted a moderate amount of urine in brief. Resident reports tenderness to			

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	left lower quadrant (Abdomen), tender with palpation, slight distension noted. Removed coude catheter, tip intact, and successfully reinserted an 18fr 30ml coude foley catheter, with immediate urine return, cloudy yellow, 100ml, to drainage bag. By end of procedure, another 300ml collected to drainage bag. Resident reported relief from catheter change, and bladder distension resolved. Will continue to monitor". A review of the census indicated that Resident 21 was admitted to the hospital from 8/26/23 to 9/2/23. A progress note on 9/2/22 indicated that the resident returned from the hospital where he was treated for a UTI with an order for ceftriaxone sodium (an antibiotic medication). The MAR from 9/2022 indicated the resident received ceftraixone sodium from 9/2/22 to 9/8/22. Occurrence 3. On 10/15/22, a progress note indicated "F/C (foley catheter) leaking at this time. Resident total bed change. Removed Coduet [sic] French size 18F/10 ml at this time. Resident tolerated well. Inserted Coduet [sic] French size 18F/10 ml with no return of urine and large amount thick blood surrounding external cath. Insertion of Coduet [sic] attempted by second nurse at this time with success and returned of this mucus and medium blood clot noted. Urine clear amber in color". A progress note, dated 10/17/22, indicated the resident was admitted to the hospital for a UTI. A progress note, dated 10/20/22, indicated the resident returned to the facility. Occurrence 4. On 11/15/22, a progress note indicated Resident complained of bladder pain and burning. MD was notified and order given to send the Resident to the ER (emergency room) for evaluation and treatment.			

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	On 11/18/22, a progress note indicated Resident returned to the facility. A progress note, dated 11/19/22, indicated the resident was receiving antibiotics for a UTI. The MAR from 11/2022 indicated the resident received Amoxicillin-Pot Clavulanate (an antibiotic medication) from 11/19/22 to 11/28/22. Occurrence 5. On 12/13/22, a progress note indicated Resident's urine was yellow and cloudy with a strong foul odor. On 12/14/22, a UA and C&S was obtained. A lab report, dated 12/15/22, indicated multiple potential uropathogens present in the specimen indicating probable contamination and a recollection was recommended. The clinical record lacked documentation of recollection or follow up lab reports. A progress note, dated 12/15/22, indicated the MD (medical doctor) ordered ciprofloxacin (an antibiotic medication) for UTI. The MAR from 12/2022 indicated the resident received ciprofloxacin from 12/15/22 to 12/22/22. A progress note, dated 12/27/22, indicated a new order for Macrobid 50 MG once daily prophylactically for recurrent UTI. The MAR for 12/2022, 1/2022, 2/2022, and 3/2022 indicated the resident received Macrobid (an antibiotic medication) from 12/27/22 to 3/2/23. Occurrence 6. On 1/8/23, a progress note indicated that Resident had cloudy yellow urine with strong foul odor and the resident was receiving prophylactic antibiotics for chronic UTI. On 1/10/23, a progress note indicated that Resident had yellow urine with foul odor and sediment, and the resident was receiving Macrobid prophylactically for chronic UTI. The clinical record lacked documentation of MD			

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	notification. Occurrence 7. On 2/1/23, a progress note indicated the Resident was transferred to the hospital. On 2/2/23, a progress note indicated the Resident was transferred back to the facility with an order for Bactrim to treat UTI. The MAR from 2/2022 indicated the resident received Bactrim (an antibiotic medication) from 2/2/22 to 2/9/22, Occurrence 8. On 2/14/23, a progress note indicated Resident had amber urine with foul odor. On 2/16/23, a progress note indicated the IP (Infection Preventionist) nurse reviewed UA results with WBC (white blood cells) and bacteria noted. Culture in progress with resident on prophylactic Macrobid daily. A lab report, dated 2/18/23, indicated Klebsiella Pneumoniae was detected. On 2/20/23, a progress note indicated an order was received for IV Pipeacill/Tazob (an antibiotic medication). On 2/22/23, a progress note indicated the Resident refused IV placement because he was tired of "getting stuck". On 2/23/23, a progress note indicated a new order for oral augmentin (an antibiotic medication) was received. A lab report, dated 2/18/23, indicated Klebsiella Pneumoniae carried an intermediate classification (response rates may be lower). On 2/24/23, a progress note indicated Resident, resident's wife, and IP nurse met for a care conference to discuss treatment. Wife and Resident agreed to continue with oral antibiotics and hold off on IV antibiotics at that time. On 2/25/23, a progress note indicated Resident was observed with temperature of 102.0 degrees Fahrenheit. An order was received to transfer the			

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	resident to the hospital for evaluation. On 3/2/23, a progress note indicated the Resident returned to the facility from the hospital where he was treated for acute pyelonephritis (kidney infection) with orders for IV antibiotics. The MAR for 3/2023 indicated the resident received Ertapenem Sodium (an antibiotic medication) from 3/3/23 to 3/9/23. Occurrence 9. On 4/6/23, a progress note indicated the Resident complained of pain in the bladder, was confused, and urine was amber in color with sediment present. MD notified and order given for UA and C&S if indicated. A lab report, dated 4/8/23, indicated Klebsiella Pneumoniae and Providencia Stuartii detected. On 4/8/23, order received for IV Amikacin. The MAR for 4/2023 indicated the resident received Amikacin Sulfate (an antibiotic medication) from 4/9/23 to 4/15/23. Occurrence 10. On 5/2/23, a progress note indicated Resident was confused and complained of burning. NP (nurse practitioner) notified and orders received for UA and C&S. A lab report, dated 5/6/23, indicated Klebsiella Pneumoniae was detected. Levofloxacin (an antibiotic medication) was ordered for UTI on 5/5/23. A lab report, dated 5/6/23, indicated Klebsiella Pneumoniae was resistant (ineffective) to levofloxacin. The MAR for 5/2023 indicated the resident received levofloxacin from 5/5/23 to 5/11/23. Occurrence 11. On 5/17/23, a progress note indicated Resident was confused and verbally expressed pain. NP notified and orders given for UA and C&S. A lab report, dated 5/19/23, indicated			

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	Enterococcus Faecalis and Klebsiella Pneumoniae were detected. On 5/19/23, a progress note indicated the NP was notified of UA and C&S results. A progress note, dated 5/21/23, indicated a PICC (peripherally inserted central catheter) was placed. On 5/22/23, a progress note indicated Resident continued to have confusion and NP contacted for orders. On 5/23/23, a progress note indicated orders were received for Macrobid (an antibiotic medication) for UTI. It also indicated resident complained of bladder pain. A lab report, dated 5/19/23, indicated Klebsiella Pneumoniae was resistant (ineffective) to Macrobid. A progress note, dated, 5/24/23, indicated that Resident attended an appointment with a urologist and a new order for IV antibiotics was received. The MAR for 5/2023 and 6/2023 indicated the resident received Ertapenem Sodium (an antibiotic medication) from 5/26/23 to 6/2/23 and Macrobid from 5/23/23 to 5/30/23. The TAR (treatment administration record) for July 2022 indicated the following: Foley catheter output every shift two times a day was not completed on 7/5, 7/10, 7/11, 7/16, 7/21, 7/23, 7/24, and 7/25. Nurse to chart cipro use for uti was not completed on 7/24 day shift. Flush foley catheter 60 mL NS (normal saline) daily at bedtime was not completed on 7/10, 7/18, and 7/24. The TAR for August 2022 indicated the following: Foley catheter output every shift two times a day			

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	was not completed on 8/1, 8/2, 8/3, 8/15, and 8/16. Flush foley catheter 60 mL NS daily at bedtime was not completed on 8/15. The TAR for September 2022 indicated the following: Foley catheter output every shift two times a day was not completed on 9/2, 9/8, 9/14, 9/24, and 9/25. Flush foley catheter 60 mL NS daily at bedtime was not completed on 9/22. The TAR for October 2022 indicated the following: Foley catheter output every shift two times a day was not completed on 10/11 and 10/23. The TAR for November 2022 indicated the following: Foley catheter output every shift two times a day was not completed on 11/13, 11/14, and 11/26. Nurse to chart every shift the use of amoxicillin for uti was not completed on 11/25 night shift. Flush foley catheter 60 mL NS daily at bedtime was not completed on 11/3, 11/7, and 11/20. Change Foley catheter and urinary bag at bedtime every 30 days for urinary retention was not completed on 11/7. The TAR for December 2022 indicated the following: Foley catheter output every shift two times a day was not completed on 12/3, 12/4, 12/12, 12/14, 12/17, 12/22, and 12/25. Flush foley catheter 60 mL NS daily at bedtime			

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	was not completed on 12/13, 12/18, and 12/22. The TAR for January 2023 indicated the following: Foley catheter output every shift two times a day was not completed on 1/4, 1/9, and 1/30. Flush foley catheter 60 mL NS daily at bedtime was not completed on 1/14. The TAR for March 2023 indicated the following: Foley catheter output every shift two times a day was not completed on 3/2, 3/7, and 3/22. Flush foley catheter 60 mL NS daily bedtime was not completed on 3/14. The TAR for April 2023 indicated the following: Foley catheter output every shift two times a day was not completed on 4/3, 4/16, 4/17, 4/23, 4/25, and 4/29. The TAR for May 2023 indicated the following: Foley catheter output every shift two times a day was not completed on 5/15. During an interview on 6/8/23 at 10:21 A.M., the DON (Director of Nursing) indicated that blank spaces in the MAR and TAR meant the treatment and/or medication was not provided. She further indicated that she expected all orders to be followed. During an interview on 6/7/23 at 2:24 P.M., CNA (Certified Nursing Aide) 4 indicated that when providing catheter care, gloves should be changed and hand hygiene performed after touching dirty items such as a remote, blanket, or table and before touching the resident or catheter tubing.			

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	During an interview on 6/9/23 at 10:05 A.M., the IP (Infection Preventionist) Nurse indicated new gloves should be put on before starting catheter care. She indicated that CNA's are not evaluated for catheter care competency. During an interview on 6/8/23 at 1:54 P.M., the IP Nurse indicated that she looks at antibiotic use daily for indications of use, susceptibility, side effects, and end dates. She indicated that she reviews all antibiotics whether they are prescribed in or out of facility. She indicated the antibiotics prescribed to Resident 21 on 7/20/22 and 5/5/23 were not appropriate for organism detected. At that time, the IP Nurse provided the facility tracker and Resident 21 was identified on September 2022 to May 2023 forms. On 6/9/23 at 9:59 A.M., a current Catheter Care policy, dated 11/28/22, was provided by the Administrator, and indicated steps to catheter care included, but were not limited to, "Perform hand hygiene. Don gloves ... Gently grasp penis. Using circular motion, cleanse the meatus with a clean cloth moistened with water and perineal cleaner (soap). With a new moistened cloth, starting at the urinary meatus moving down, cleanse the shaft of the penis. With a new moistened cloth, starting at the urinary meatus moving outward, wipe the catheter making sure to hold the catheter in place so as to not pull on the catheter. Pat area with towel". On 6/7/23 at 12:44 P.M., a current Administration of Medications policy, dated 10/15, was provided by the Administrator, and indicated "each dose administered shall be properly recorded on the resident's Mediation administration record or in the treatment administration record immediately following the administration by initial the box			

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	indicated for the medication given". On 6/5/23 at 11:30 A.M., a current Antibiotic Stewardship Program policy, dated 11/2017, was provided by the Administrator, and indicated "the facility will review the use of antibiotic 2-3 days after antibiotics are initiated to answer ... is the resident on the most appropriate antibiotic(s), dose, and route of admission". 3.1-41(a)(2)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to ensure attempt for management of pain was provided for 1 of 1 residents reviewed (Resident 28). Finding includes: During an interview on 6/8/23 at 10:57 A.M., Resident 28 indicated they were experiencing pain following a recent surgery on 5/11/23, had told staff on multiple occasions they were experiencing pain, and had not received any treatment for the pain in weeks. During an interview on 6/8/23 at 1:45 P.M., the DON (Director of Nursing) indicated that Resident 28 had a positive drug screen on 5/23/23, and the facility physician had discontinued all narcotics, but Resident 28 should still be receiving	F 0697	Resident 28 pain care plan was updated and an order for Tylenol was obtained. All residents with pain have the potential to be affected by the alleged deficient practice. An audit of all residents TAR over the last 72 hours has been completed to ensure any resident reporting pain has a pain care plan and intervention place. An in-service has been completed by DON for all nursing and QMA staff on the facility's pain management policy. A question has been added to customer service rounding that includes "are	07/07/2023

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	alternative pain management treatment. On 6/8/23 at 1:55 P.M., Resident 28's clinical records were reviewed. Diagnoses included, but were not limited to, chronic pain, fracture of right humerus, and encounter for orthopedic aftercare. The most recent admission MDS (Minimum Data Set) Assessment, dated 3/20/23, indicated resident was cognitively intact, required extensive assist of 2 staff for bed mobility, transfer, and toileting. Resident 28 was not on a scheduled pain medication regimen, had received as needed pain medications, and experienced pain frequently. The MDS indicated opioids had been given 6/7 days from the lookback period. The most recent care plan dated 3/14/23 addressed acute pain. Interventions included, but were not limited to, anticipate need for pain relief and respond immediately and administer analgesia. The active orders lacked treatments for pain management. Resident 28's TAR (treatment administration record) indicated that on the following days their pain was assessed and recorded 5/23/23 Pain level 5/10 (day) ; 7/10 (night) 5/24/23 Pain level 7/10 (night) 5/25/23 Pain level 8/10 (night) 5/28/23 Pain level 2/10 (day) ; 7/10 (night) 5/29/23 Pain level 7/10 (night) 6/5/23 Pain level 3/10 (night) 6/6/23 Pain level 7/10 (night) 6/7/23 Pain level 7/10 (night) 6/8/23 Pain level 3/10 (day) ; Pain level 9/10 (night) The clinical record lacked treatment of pain for pain levels assessed.		we managing your pain?" Customer service rounding is reviewed daily in a.m. morning meeting. An audit tool has been created for the DON to monitor all reports of pain to ensure pain interventions have been put in place to address reported pain. The TAR and customer service rounds will be reviewed 5x week for 8 weeks, 3x week for 8 weeks and 1x week for 8 weeks to ensure all reported pain has an appropriate intervention in place to address pain. Results of this monitoring will be reviewed in QAPI and any needed recommendations made.	

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	On 6/9/23 at 1:30 P.M., the Administrator provided a current policy on pain management dated 12/16. The current policy included, but was not limited to, "The purposes of this procedure are to help the staff identify pain the resident, and to develop interventions that are consistent with the resident's goals and needs. The pain management program is to provide comfort to the resident. "Pain management" is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident. Pain management interventions shall address the underlying cause of the resident's pain. If pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated". 3.1-37(a)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155370	A. BUILDING 00 B. WING	06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PREMIER HEALTHCARE OF NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631

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	(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure completed staffing sheets were posted daily for 5 of 5 days during the survey. Finding includes: On 06/05/23 at 9:10 A.M., a nurse staffing sheet was observed across from the front desk hanging on the wall, dated 6/5/23. The sheet included, but was not limited to, the following information: Shift hours for RN (Registered Nurse), LPN (Licensed Practical Nurse), CNA (Certified Nursing Assistant), and QMA (Qualified Medication Aide) Total number of RN, LPN, CNA, and QMA for each shift Total hours of RN, LPN, CNA, and QMA for each shift The sheet did not specify which actual hours were	F 0732	No ill effects occurred due to the alleged deficient practice. No residents were affected by the alleged deficient practice. An in-service has been completed by the DON for the night shift nursing staff and scheduler on posting the Nurse Staffing with all required information. The nurse staffing sheet has been modified to include alternate shift times. An audit tool has been created to monitor the Daily Nurse Staff Posting 5x week for 8 weeks, 3x week for 8 weeks, 1x week for 8 weeks. Results of this monitoring will be brought to QAPI for review	07/07/2023

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	worked by each discipline during the specified shift when the total hours were not equal to the number of staff. On 06/06/23 at 8:24 A.M., a nurse staffing sheet was observed across from the front desk hanging on the wall, dated 6/6/23. The sheet included, but was not limited to, the following information: Shift hours for RN, LPN, CNA, and QMA Total number of RN, LPN, CNA, and QMA for each shift Total hours of RN, LPN, CNA, and QMA for each shift The sheet did not specify which actual hours were worked by each discipline during the specified shift when the total hours were not equal to the number of staff. On 06/06/23 at 10:30 A.M., copies of nurse staffing sheets, dated 6/5/23, 6/6/23, 6/7/23, 6/8/23, and 6/9/23, were provided by the DON (Director of Nursing). The sheets included, but were not limited to, the following information: Shift hours for RN, LPN, CNA, and QMA Total number of RN, LPN, CNA, and QMA for each shift Total hours of RN, LPN, CNA, and QMA for each shift The sheet did not specify which actual hours were worked by each discipline during the specified shift when the total numbers were not equal to the number of staff. During an interview on 06/09/23 at 10:49 A.M., the Administrator indicated that she was unable to determine the actual number of nursing staff in the building at any given time just by looking at the posted nurse staffing sheet. She indicated there was no policy regarding posted nurse staffing.		and any further needed recommendations.	

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F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to ensure appropriate social services were provided to meet the resident's needs for 1 of 4 residents reviewed for vision and dental services. (Resident 48) Finding includes: On 6/5/22 at 10:03 A.M., Resident 48 was observed sitting in the dining room. He was not wearing eyeglasses or dentures. Interview on 6/5/23 at 1:18 P.M., Resident 48's daughter indicated Resident 48 was currently eating without his dentures, as they had been in the nurses cart since 9/2022. She indicated speech therapy was supposed to work with him wearing the dentures, but to her knowledge had not done so yet. She further indicated his glasses were missing and staff was aware, but had not assisted to replace them. On 6/6/23 at 1:16 P.M., Resident 48's clinical record was reviewed. Diagnosis included, but was not limited to, dementia. The most recent quarterly MDS (minimum data set) Assessment, dated 5/22/23, indicated Resident 48 was severely cognitively impaired and was on hospice. Resident 48 had adequate vision with no corrective lenses, no broken or loosely fitting dentures, and required limited assist of one staff with bed mobility, transfers, and eating, extensive assist of one staff with toileting, and was totally	F 0745	Resident 48's glasses were not missing. Resident 48's glasses were given to him to wear. Resident has been given his dentures to wear. The MDS and care plan have been updated to include the glasses and dentures. Resident's daughter has been contacted and refused any consultant care from in-house vision or dental care due to not wanting to pay for the service. Resident is hospice and would be responsible for the bill. All residents have the potential to be affected by the deficient practice. An audit of all residents that wear glasses and dentures has been completed to ensure each resident has possession of the them and the care plans and the MDS are accurate. An audit of all consents for these outside services has also been completed to ensure residents consenting to these services have received these services. All residents declining services will have a note put into the chart that services have been declined. An in-service has been completed	07/07/2023

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	dependent on one staff with bathing. Current physician orders included, but were not limited to: Regular diet, mechanical soft texture, regular/thin consistency, double portions with gravies on ground meats, dated 4/25/23. May consult and be seen by the audiologist, cardiologist, dentist, eye care physician, podiatrist, psychiatrist, or wound care specialist for evaluation and treatment, dated 8/31/22. Discontinued orders included, but were not limited to: Regular diet, pureed texture, regular/thin consistency, ordered 9/23/22 and discontinued 10/21/22. Progress notes included, but were not limited to the following: A dietary note, dated 9/16/22, indicated resident's family had brought in resident's dentures and may consider diet change after he had his teeth. A dietary note, dated 9/16/22, indicated Speech Therapy reported may trial for diet change now that resident had dentures. Therapy notes, dated 9/24/22, indicated "Patient refused to allow donning (wearing) of dentures d/t (due to) behaviors this date, nursing reports patient has been anxious all day. Patient noted to display decreased mastication (chewing)/bolus prep on trial soft mech soft and required mod/max verbal cues to reduce rate of presentation as well. Caregiver education/training pertaining to reducing distractors (sic) during oral intake and reminders to slow pace as well as continued attempts at denture placement". Resident 48		by the Administrator for the Social Service Director on making sure services are available to assure medically related emotional and social needs of the resident are met and maintained on an individual basis. An audit tool has been created for the SSD to monitor all consents and services of new and current residents in the facility. All new consents and declinations will be reviewed upon admission 5x week for 8 weeks, 3x week for 8 weeks, 1x/week for 8 weeks. Also, all resident rosters of consultant services will be reviewed upon the consultant entering the facility to compare with the consent list to ensure no one is missed for services that have a consent on file. This monitoring will take place for every vision and dental consultant that comes in for 6 months.	

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	remained on puree diet. Therapy notes lacked any documentation of denture placement attempts after 9/24/22. The clinical record lacked documentation of a dental consultation or eye specialist consultation. During an interview on 6/7/23 at 12:28 P.M., CNA (Certified Nursing Aide) 3 indicated Resident 48 did not have teeth. She indicated he had dentures, but did not know where they were or who had them. Interview on 6/7/23 at 12:43 P.M., RN (Registered Nurse) 21 indicated Resident 48's dentures and eyeglasses were locked up in the medication cart due to resident taking them off/out, and leaving them places. He indicated he had never seen the resident wearing dentures or eyeglasses. He was unaware of any appointments needed or made for a dentist or eye specialist. Interview on 6/7/23 at 1:00 P.M., the Social Services Director (SSD) indicated she was not aware of any dental or vision concern for Resident 48, and was unaware that his eyeglasses and dentures were in the medication cart. Interview on 6/8/23 at 9:43 A.M., the Social Services Director (SSD) indicated an optometrist came into the facility every 6 months, and the last visit was in May, 2023, but Resident 48 was not seen. At that time, the SSD indicated residents on hospice were generally not seen by optometry unless they were having a concern and needed to be seen. She indicated she was not aware that Resident 48 needed new glasses, and would need to be added to the list for the next visit.			

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	On 6/9/23 at 8:00 A.M., a Director of Social Services job description, last revised 11/2021, was provided and indicated the primary purpose of the SSD was to "assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis" Duties and responsibilities included, but were not limited to, "Plan, develop, organize, implement, evaluate, and direct the social service programs of this facility ... Involve the resident/family in planning social service programs when possible ... Assist in arranging transportation to other facilities when necessary ... Develop preliminary and comprehensive assessments of the social service needs of each resident ... Develop a written plan of care for each resident that identifies social problems/needs of the resident and the goals to be accomplished for each problem/need identified" 3.1-34(a)			
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			

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	§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, interview, and record review, the facility failed to ensure medications were administered appropriately for 1 of 6 residents reviewed for unnecessary medication use. An antianxiety medication and narcotic pain medication were administered without rationale. (Resident 48) Finding includes: Interview on 6/5/23 at 1:31 P.M., Resident 48's daughter (power of attorney) indicated she had spoken with the Director of Nursing (DON), as well as Resident 48's hospice team related to a new prescription of Ativan (an anti-anxiety medication) and Morphine (a narcotic pain medication). She indicated she wanted to speak with staff about implementing other interventions prior to giving the medications. She indicated about a month ago, a staff member had given Ativan and Morphine both without notifying her first. A nurse that was there at that time indicated to her that the staff that administered the medication had indicated "I gave him enough meds to knock over a horse. He'd better find a couch soon". On 6/6/23 at 1:16 P.M., Resident 48's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and COPD (chronic obstructive pulmonary disease). The most recent quarterly MDS (minimum data set) Assessment,	F 0757	The PRN morphine was discharged on resident 48 and Tylenol implemented for pain. The PRN Xanax was discharged on resident 21. The order on the PRN Ativan was changed to include the resident being on hospice services and life expectancy less than 6 months with moderate to severe anxiety, restlessness, and shortness of breath. All residents on PRN anti-anxiety medications have the potential to be affected by the alleged deficient practice. An audit of all PRN anti-anxiety orders has been done to ensure the orders do not extend past 14 days without rationale included in the medical record. An in-service has been completed by the Clinical Consultant for all licensed nursing staff including the DON and ADON on PRN anti-anxiety drugs and orders as related to Federal Tag 757. An in-service has also been completed by the Social Service Director on behavior tracking and the new behavior tracking binders.	07/07/2023

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	dated 5/22/23, indicated Resident 48 was severely cognitively impaired, had experienced behavioral symptoms 1-3 days during the previous 7 days, wandered 1-3 days, required limited assistance of 1 staff for bed mobility, transfers, and eating, extensive assistance of 1 staff for bathing, was totally dependent of 1 staff for bathing, had taken an anti-anxiety medication 7 of 7 days, had not taken an opioid medication, had not experienced pain, and was on hospice. Current physician orders included, but were not limited to the following: Morphine Sulfate (Concentrate) Oral Solution 100mg (milligrams)/5ml (milliliters) 0.5 ml by mouth every 15 minutes as needed for shortness of breath/pain. GIVE FOR PAIN ONLY!!!!!!! dose is 0.5ml (10mg) GIVE ONLY IF ACTIVELY PASSING, started 4/21/23. lorazepam (Ativan) 0.5mg every 30 minutes as needed for anxiety/restlessness, started 2/20/23. Behavior every shift, dated 8/31/22. Evaluate pain level every shift, dated 3/24/23. Nurse to chart any behavior resident has, even if same behavior. Chart multiple times a day if need be, every shift, dated 4/10/23. Acetaminophen tablet 325mg, give 2 tablets every 4 hours as needed for pain, dated 12/25/22. A current pain care plan, last revised 8/31/22, included, but was not limited to, the following interventions: administer medications per order, dated 8/31/22, provide non pharmacological interventions to relieve pain such as: provide a quiet calm environment to promote rest and		All PRN anti-anxiety medication administered will be reviewed in clinical meeting to ensure non-pharmacological interventions are being attempted prior to PRN anti-anxiety administration as well as effectiveness of the medication documented in the clinical record. Each unit now has a behavior tracking binder that is individualized and lists the targeted behavior with care planned non-pharmacological interventions for every PRN anti-anxiety medication. An audit tool has been created for the DON to monitor all administered PRN medications and the behavior tracking book 5x week for 8 weeks, 3x week for 8 weeks and 1x week for 8 weeks. The results of this monitoring will be forwarded to QAPI for review and any needed further recommendations.	

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	relaxation, reposition as needed, offer snack and fluids, offer bath/shower, validate feelings and provide reassurance, dated 8/31/22. A current anti-anxiety medication care plan, last revised 5/2/23, included, but were not limited to, the following interventions: administer anti-anxiety medications as ordered and monitor for side effects and effectiveness, dated 3/22/23, monitor and record occurrence of target behavior symptoms such as refusal of care, aggression toward staff, placing self on floor, etc., dated 3/22/23. The medication administration record (MAR) from 2/2023 through current indicated the following dates that the as needed Ativan was administered: 2/20/23 3:00 P.M. (MAR indicated "other" behavior) 2/27/23 9:00 A.M. (MAR indicated "other" behavior) 3/5/23 11:30 P.M. (MAR indicated no behaviors) 3/12/23 11:00 P.M. (MAR indicated no behaviors) 3/17/23 8:02 P.M. (MAR indicated no behaviors) 3/27/23 8:50 A.M. (MAR indicated combative/hitting/kicking staff/resists care and crying/restlessness/agitated and "other" behavior) 3/29/23 7:00 P.M. (MAR indicated no behaviors) 3/31/23 1:46 P.M. and 8:30 P.M. (MAR indicated combative/hitting/kicking staff/resists care during day shift, and no behaviors during night shift) 4/3/23 10:00 A.M. and 3:31 P.M. (MAR indicated no behaviors all day) 4/14/23 12:37 P.M. (MAR indicated crying/restlessness/agitated) 4/23/23 8:00 P.M. (MAR indicated crying/restlessness/agitated) 4/29/23 10:45 A.M. (MAR indicated combative/hitting/kicking staff/resists care and			

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	crying/restlessness/agitated) 5/13/23 12:01 A.M. 5/29/23 6:07 P.M. The MAR from 2/2023 through current indicated the following dates that that as needed Morphine was administered: 4/3/23 3:30 P.M. (MAR indicated no pain for the shift, but indicated a "7" as pain level at time of administration) 4/9/23 9:00 P.M. (MAR indicated no pain for the shift, but indicated a "10" as pain level at time of administration) The MAR from 2/2023 through current indicated Resident 48 had not been administered acetaminophen for pain. Behavior monitoring from 2/2023 through current indicated the only day Resident 48 had behaviors on the days Ativan was administered was 4/29/23. Behaviors on that date included, but were not limited to, anxiousness and restlessness. Interview on 6/9/23 at 9:05 A.M., CNA (Certified Nurse Aide) 3 indicated Resident 48 was able to indicate to staff what was hurting if he was in pain, but was not able to indicate the pain level on a 1-10 scale. Interview on 6/9/23 at 9:07 A.M., LPN (Licensed Practical Nurse) 25 indicated Resident 48 was able to tell staff he was in pain at times. She indicated it was more likely that staff would be able to visualize that he was in pain than for him to verbalize it. She indicated Resident 48 would not be able to indicate to staff the level of pain on a 1-10 scale. She further indicated staff should try non-pharmacological interventions prior to administering medications for pain or anxiety. She			

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	indicated because Resident 48 was "not a complainer", staff should try to treat pain with acetaminophen first, and only give Morphine if needed. She indicated staff should try walks or redirection for anxiety first before administering Ativan for anxiety. On 6/7/23 at 12:41 P.M., an undated Administration of Medications policy was provided and indicated "When giving PRN medications, narcotic or non-narcotic, the nurse administering must document the following on the Medication Administration Record ... Reason for giving the PRN medication". 3.1-48(a)(3) 3.1-48(a)(4)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN 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;			

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	§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 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 interview and record review, the facility failed to ensure residents were free from unnecessary medications for 2 of 6 residents reviewed for unnecessary medications. Residents had PRN (as needed) anti-anxiety medications that were ordered for greater than 14 days without a rationale included in their clinical record (Resident 21, Resident 48). Findings include: 1. On 6/7/23 at 8:40 A.M., Resident 21's clinical	F 0758	The PRN Xanax was discharged on resident 21. The order for resident 48's PRN Ativan was changed to include the resident being on hospice services and life expectancy less than 6 months with moderate to severe anxiety, restlessness, and shortness of breath. All residents on PRN antipsychotic medications have	07/07/2023

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	155370	A. BUILDING 00 B. WING	06/09/2023

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	record was reviewed. Resident 21 was admitted on 6/9/21. Diagnosis included, but was not limited to, major depressive disorder. The most recent annual MDS (Minimum Data Set) Assessment, dated 3/2/23, indicated Resident 21 was cognitively intact and an anti-anxiety medication was administered for 7 of 7 days during the look back period. Current physician orders included, but were not limited to, the following: Xanax Oral Tablet 0.5 MG (Alprazolam) 0.5 mg by mouth at bedtime for restlessness/tearfulness/anxiousness, dated 4/19/23. Xanax Oral Tablet 0.5 MG (Alprazolam) by mouth every 24 hours as needed for restlessness/anxiousness/tearfulness, dated 4/19/23 with no end date documented. There was no extension of the medication ordered by the physician. The current MAR (medication administration record) from 4/1/23 through 6/7/23 was reviewed and indicated that Resident 21 received 0.5 mg at bedtime nightly and 1 as needed 0.5 mg dose on 5/21/23. A pharmacy review, dated 5/24/23, lacked a last GDR (Gradual Dose Reduction) date, next evaluation date, or comments for the Xanax 0.5mg every 24 hours PRN order. Resident 21's clinical records lacked documentation of a rationale as to why Resident 21 was taking a PRN antianxiety medication beyond 14 days. 2. On 6/6/23 at 1:16 P.M., Resident 48's clinical record was reviewed. Diagnoses included, but		the potential to be affected by the alleged deficient practice. An audit of all PRN anti-anxiety orders has been done to ensure the orders do not extend past 14 days without rationale included in the medical record. An in-service has been completed by the Clinical Consultant for the DON, ADON and all licensed nursing staff on PRN anti-anxiety medication with an emphasis on the 14 day stop dates and needed assessments after those 14 days to ensure the continued need of the medication. An audit tool has been created for the DON to monitor all administered PRN antipsychotics 5x week for 8 weeks, 3xweek for 8 weeks and 1x week for 8 weeks. The results of this monitoring will be forwarded to QAPI for review and any needed further recommendations.	

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	were not limited to, dementia and anxiety. The most recent quarterly MDS (minimum data set) Assessment, dated 5/22/23, indicated a severe cognitive impairment. Resident 48 had received an antianxiety medication 7 of 7 days during the look-back period. Current physician orders included, but were not limited to: lorazepam (an antianxiety medication) 0.5mg (milligrams) every 30 minutes as needed for anxiety or restlessness, dated 2/20/23. Resident 48's clinical record lacked documentation that the lorazepam was re-assessed every 14 days after it was ordered on 2/20/23. Interview on 6/7/23 at 2:13 P.M., the Administrator indicated that PRN antianxiety medications are supposed to be reviewed every 14 days. She indicated that because no end date was listed in the order, the medication did not get reviewed and was left as an active order. She indicated that there is no official policy regarding PRN Antianxiety Medication Usage; however, she expected the medication to be discontinued after 14 days if it isn't reviewed. 3.1-48(a)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

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	§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 and interview, the facility failed to provide proper storage of medications in 3 of 4 medication carts and 3 of 3 wound/treatment carts. Loose pills were found in the bottom of the medication cart drawers in 2 of 4 medication carts (Cardinal Hall and East Hall). There were improperly labeled bulk medications and over the counter medications in 3 of 3 wound/treatment carts (Wound/ treatment cart for East/Cardinal Hall, Brown Treatment Cart I/M Hall, Big Cart Wound Cart). Findings include: 1. On 6/7/23 at 6:12 A.M., the medication cart in the M Hall was observed to have the following unlabeled medications and bulk medications in a drawer: Nicotine gum. Active liquid protein [Patient Name], date present,	F 0761	The loose pills in the Cardinal Hall medication cart and the East Hall medication cart were disposed of immediately per policy. All bulk and over-the-counter medications without the proper labels were disposed of. All bulk medications in the Cardinal/East Hall wound cart, I/M brown cart, and the "Big Cart" were disposed of. The oxygen tubing, nebulizer tubing, and O2 saturation probe were all disposed of. No residents were affected by the deficient practice. An in-service has been completed by the DON on the facility Drug storage policy. This in-service includes Indiana's regulation on bulk over the counter supplements and drugs. All resident treatments	07/07/2023

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	but no MD (Medical Doctor) listed. 2. On 6/07/23 at 6:47 A.M., the medication cart on the Cardinal Hall was observed to have the following loose pills laying in 2 drawers: 1 green pill. 1 red with #(number) 242 pill. 1 1/2 oblong pill with # l1nvr. 1 small white pill with L #1. 1 large yellow TV # 9702. 3. On 6/7/23 at 7:45 A.M., the medication cart on the East Hall was observed to have the following loose pills laying in 2 drawers: 1 large white pill with # 610. 1 yellow and green capsule with E #91. 1 white capsule with # 216. The medication cart contained the following bulk and over the counter medications without the proper labels: 2 bottles of Active liquid protein date opened no name, MD name, or administration label. 1 box of hydro gel wound dressing, no name, date, MD name or administration label. 1 tube of Ascend Silvadene wound cream, no name, date, MD name, or administration label. 1 tube of phytoplex wound dressing, no name, date, MD name, or administration label. 4. On 6/7/23 at 8:48 A.M., the wound cart from the Cardinal/ East Hall was observed to have the following bulk medications in several drawers: 1 tube of phyoplex guard no label 2 tubes of silicone cream wound barrier no label. 1 tube of Flanders Butt Cream wound care no		will be stored in a zip lock baggie with the proper labeling on the bag. All house stock supplies will be kept in a storage area separate from the resident's individual treatment bags. An audit tool has been created for the DON to monitor all medication and treatment carts 5x week for 8 weeks, 3x week for 8 weeks and 1x/week for 8 weeks. The results of this monitoring will be forwarded to QAPI for further review and any needed recommendations.	

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	label. 1 jar of Silvadene wound care no label. 2 tubes of Diflocin 1% no label. 1 tube of therahoney wound gel no label. 1 tube of dermasyn hydro gel wound no label. 1 bottle of hibicleans antiseptic cleaner no label. 5. On 6/7/23 at 11:00 A.M., the wound carts for I/M Halls were observed to have the following bulk and over the counter medications in several drawers: Brown Cart: 1 tube of phyoplex guard, no label. 1 tube of Destin skin protector, no label. 1 tube of Polysporin, bacitracin antibiotic cream, no label. 1 container of pain relief spray, no label. 1 container of Phyoplex antifungal powder, no label. 1 bottle of skin integrity wound cleaner, no label. 1 tube of Therahoney gel sterile dressing, no label. Big Cart: 1 bottle of Antifungal powder, no label 1 tube of Renewal skin protect, no label 1 bottle of Calamine skin protectant, no label. 1 bottle of Dermasil skin protectant, no label 1 Oxygen saturation probe dated 4/30/23. 2 packages of oxygen tubing dated 3/31/22 and 9/22. 1 package of nebulizer tubing no label for date open. Interview on 6/7/23 at 7:45 A.M., RN (Registered Nurse) 21 indicated there should be no loose medications in the carts and he tries to clean the			

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	carts every so often. He also indicated once discovered the loose pills should be put in the sharps container or drug buster to destroy. Interview on 6/7/23 at 10:52 A.M., DON (Director of Nursing) indicated if there were medications such as creams ordered, the pharmacy would send the medication in a bag with the resident's name and administration labeling. Tubes taken from stock that are laying in the carts would not be used communally, such as taking the tube into the resident rooms. The medication would be placed in medication cup and taken into the resident's room for administration. The medication was not dated when opened because the facility goes through this particular cream or medication quickly. A current "Storage of Medications" policy, with an effective date of 10/25/24, was provided on 6/7/23 at 12:44 P.M. by the Administrator, indicated "... Mac RX dispenses medications in container that meet regulatory requirements. Medications are kept in these containers. Nurses may not transfer medications from from one container to another ... Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart". A current "Labeling of Medications and Biologicals" policy, dated 5/20/23, was provided on 6/9/23 at 10:30 A.M. by the Administrator and indicated "... All medications and biologicals will be labeled in accordance with... current accepted pharmaceutical principles and practices ... labels for each floor/unit's stock medications must include: ... manufacturer's or pharmacy applied label indicating the medications name... directions for use... ... labels for over-the-counter (OTC)			

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	medications must include: ... the original manufacturer's or pharmacy-applied label indicating the medication name... directions for use". 3.1-25(b)(7) 3.1-25(j)			
F 0805 SS=D Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure meals were prepared to meet resident's needs according to the plan of care for 1 of 2 residents reviewed for dental care. A resident was not provided a diet as ordered. (Resident 48) Finding includes: On 6/6/23 at 1:16 P.M., Resident 48's clinical record was reviewed. Diagnosis included, but was not limited to, dementia. The most recent quarterly MDS (minimum data set) Assessment, dated 5/22/23, indicated a severe cognitive impairment. Resident 48 required limited assist of one staff with eating, had no swallowing disorders, and required a mechanical soft diet. Current physician orders included, but were not limited to, the following: Regular diet, mechanical soft texture, regular/thin consistency, double portions with gravies on ground meats, dated 10/21/22.	F 0805	Resident 48 nutrition care plan has been reviewed and updated. All residents have the potential to be affected by the deficient practice. An audit of all dietary orders and tickets has been completed. An in-service has been completed by the Administrator for all dietary staff including the dietary manager on following diet orders. An audit tool has been created for the Administrator to monitor tray tickets with meal trays at breakfast, lunch and dinner for 10 random trays 5x week for 8 weeks, 3x week for 8 weeks, and 1x week for 8 weeks. The results of the monitoring will be forwarded to QAPI for further review and any needed recommendations.	07/07/2023

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	House shake mixed with ice cream at meals. Dietary to mix and provide on tray at meals, dated 3/13/23. A current nutrition care plan, dated 8/31/22, included, but was not limited to, the following interventions: provide house shake mixed with ice cream twice a day with meals, revised 3/17/23, and mechanical soft diet with gravy on meats, thin liquids, and double portions, revised 10/24/22. On 6/7/23 at 9:04 A.M., Resident 48 was served a breakfast tray in the dining room with cereal, bread, eggs, coffee, and milk. The plate did not have double portions of any food item. On 6/7/23 at 12:20 P.M., Resident 48 was observed eating lunch. No double portions were observed on the plate, and the mechanically altered meat was observed without gravy. At that time, CNA (Certified Nurse Aide) 9 indicated there was no gravy on the meat. CNA 9 opened the chocolate shake container that was on the tray and sat it back down on the tray. A container of ice cream was observed sitting on the tray, unopened. The meal card sitting beside Resident 48's plate indicated double portions with gravy on ground meats. During observation of kitchen service on 6/8/23 from 11:00 A.M. until 12:15 P.M., Resident 48's plate was observed to be prepared with a double portion of meat, but a single portion of carrots and a single portion of mashed potatoes. A carton of chocolate shake and a container of ice cream was placed on the tray. At that time, the kitchen manager indicated Resident 48 was sent meals with a carton of chocolate shake and a separate carton of ice cream and the nurses were to mix them.			

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	Interview on 6/9/23 at 9:30 A.M., the Registered Dietician (RD) indicated Resident 48's order for double portions with gravies on ground meats was meant to indicate double portions of all food on the plate, not only the meats. A policy related to following diet orders was requested and not provided. During an interview on 6/9/23 at 1:35 P.M., the Administrator indicated it was the policy of the facility to follow all physician orders, including diet orders. 3.1-21(a)(3)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			

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	Based on observation, interview, and record review, the facility failed to ensure food was stored and served in accordance with professional standards for food service safety, and food was prepared in a sanitary manner for 2 of 2 observations of the kitchen, and 1 of 1 meal preparations observed. Food was open to air in the freezer, holes were observed in the walls of the kitchen, an expired label was observed on a container of flour, and food was touched with soiled gloves. (Main Kitchen) Findings include: During the initial kitchen observation on 6/5/23 at 8:09 A.M., the following was observed: A box of sliced carrots was open to air in the freezer. A tub of flour under a preparation table had a label on the side that indicated use by 5/20/23. The same was observed on 6/8/23 at 12:18 P.M. A basketball sized hole (approximately 12 inches in diameter) was observed in the wall under the oven, with several layers of drywall missing, and concrete with black spots exposed. The same was observed on 6/8/23 at 12:18 P.M. The paint around the electrical box was chipped. The same was observed on 6/8/23 at 12:18 P.M. The paint around the back door was chipped. The same was observed on 6/8/23 at 12:18 P.M. The wall behind the pots and pans rack had chipped paint. The same was observed on 6/8/23 at 12:18 P.M. A finger sized hole (approximately 2 1/2 inches)	F 0812	The box of sliced carrots was thrown out. The flour was also thrown out. The basketball sized hole under the wall was repaired. The finger sized hole under the sink was repaired. The 13 nail heads were removed, and drywall repaired. All the chipped paint was fixed. No residents were affected by this alleged deficient practice. An in-service has been completed by the Administrator for the Dietary Manager and kitchen staff on proper food storage and food safety requirements. An audit tool has been created for the Administrator to monitor food storage, food handling and handwashing in the kitchen 5x week for 8 weeks, 3x week for 8 week and 1x week for 8 weeks. The result of this audit will be forwarded to QAPI for review and any needed recommendations.	07/07/2023

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	was observed in the wall under the sink. The same was observed on 6/8/23 at 12:18 P.M. A 12 inch ruler length area in the wall under the sink was missing paint. The same was observed on 6/8/23 at 12:18 P.M. The area just under the soap dispenser by the sink near the dishwasher had 13 nail-heads sticking out of the wall. The same was observed on 6/8/23 at 12:18 P.M. The wall around the dry storage door had chipped paint. The same was observed on 6/8/23 at 12:18 P.M. During an observation of meal preparation on 6/8/23 at 11:00 A.M., Kitchen Staff 5 was observed to prepare lunch for residents. Kitchen Staff 5 put on a pair of gloves, and while plating the food on all plates, touched all scoop handles that were in the food containers on the steamtable, touched all plates and bases, lids, meal cards, and bowls. With the same gloved hands, the underside of the steamtable counter was touched when the edge was grabbed with fingers underneath the table. Kitchen Staff 5 then touched the food with one hand while scooping food onto plates with the other hand. With visibly soiled gloves, baked potatoes were obtained from the steamtable and placed on plates. Interview on 6/8/23 at 12:18 P.M., the kitchen manager indicated the label on the flour container was not updated when the flour container was filled last, and food should not be open to air in the freezer. On 6/9/23 at 1:30 P.M., a current Handwashing/Hand Hygiene policy, revised			

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	11/2017, was provided, and indicated "The use of gloves does not replace handwashing/hand hygiene". At that time, the Administrator indicated the same policy did cover hand hygiene and glove use in the kitchen. 3.1-21(i)(2) 3.1-21(i)(3)			
F 0881 SS=D Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on observation, interview, and record review, the facility failed to ensure that the appropriate antibiotics were prescribed in 1 of 6 residents reviewed for unnecessary medications. The resident was prescribed antibiotics on 3 occurrences that were resistant (ineffective) to the organism found in the culture and sensitivity (C&S). (Resident 21) Findings include: On 6/7/23 at 8:40 A.M., Resident 21's clinical record was reviewed. Resident 21 was admitted on 6/9/21. Resident 21's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus, chronic kidney disease, systemic lupus erythematosus, and retention of urine.	F 0881	Resident 21 is currently on an antibiotic that has been reviewed and follows the Antibiotic Stewardship Policy. All residents on an antibiotic have the potential to be affected by the alleged deficient practice. An audit of all current residents on antibiotics has been completed to ensure the Antibiotic Stewardship Policy is being followed. An in-service has been done by the DON for all licensed nursing staff and IP nurse on the Antibiotic Stewardship Policy. An audit tool has been created for	07/07/2023

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	The most recent annual MDS (Minimum Data Set) Assessment, dated 3/2/23, indicated the resident was cognitively intact, had an indwelling catheter, was always incontinent of bowel, and an antibiotic medication was administered for 5 of 7 days during the look back period. Previous orders included, but were not limited to: Ceftriaxone Sodium Solution Reconstituted 1 GM (gram) IM (intramuscularly) at bedtime for UTI (urinary tract infection) from 9/2/22 to 9/8/22. Amoxicillin-Pot Clavulanate Tablet 500-125 MG (milligrams) by mouth three times a day for bacterial infection from 11/19/22 to 11/28/22. Cipro tablet 250 MG by mouth two times a day for UTI from 12/15/22 to 12/22/22. Bactrim DS Oral Tablet 800-160 MG by mouth two times a day for UTI from 2/2/23 to 2/9/23. Fosfomycin Tromethamine Oral Packet 3 GM by mouth in the morning every 3 days for UTI from 2/8/23 to 2/14/23. Augmentin Oral Tablet 500-125 MG by mouth three times a day for UTI-Klebsiella from 2/23/23 to 3/5/23. Ertapenem Sodium Injection Solution Reconstituted 1 GM intravenously one time a day for UTI from 3/6/23 to 3/9/23. Levaquin Oral Tablet 750 MG by mouth at bedtime for UTI from 5/5/23 to 5/12/23. Macrobid Oral Capsule 100 MG by mouth two times a day for UTI from 5/23/23 to 5/30/23.		the IP nurse to monitor all new antibiotics for 24 weeks to ensure compliance with the Antibiotic Stewardship Policy. The results of this audit will be forwarded to QAPI for review and any needed further recommendations.	

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	Ertapenem Sodium Injection Solution Reconstituted 1 GM intravenously one time a day for UTI from 5/25/23 to 6/4/23. On 7/17/22 a progress note indicated Resident was not feeling well and urine was dark yellow with sediment and foul order. On 7/18/22 a UA (urinalysis) and C&S (culture and sensitivity) was obtained. A lab report, dated 7/20/22, indicated Escherichia Coli was detected. A progress note, dated 7/21/22, indicated the resident was started on ciprofloxacin (an antibiotic medication) for UTI. A lab report, dated 7/20/22, indicated ciprofloxacin was resistant (ineffective) to Escherichia Coli. The MAR (medication administration record) from 7/2022 and 8/2022 indicated the resident received ciprofloxacin from 7/20/22 to 8/3/22. On 12/13/22, a progress note indicated Resident's urine was yellow and cloudy with a strong foul odor. On 12/14/22, a UA and C&S was obtained. A lab report, dated 12/15/22, indicated multiple potential uro-pathogens present in the specimen indicating probable contamination and a recollection was recommended. The clinical record lacked documentation of recollection or follow up lab reports. A progress note, dated 12/15/22, indicated the MD (medical doctor) ordered ciprofloxacin (an antibiotic medication) for UTI. The MAR from 12/2022 indicated the resident received ciprofloxacin from 12/15/22 to 12/22/22. On 5/2/23, a progress note indicated Resident was confused and complained of burning. NP (nurse practitioner) notified and orders received for UA and C&S.			

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	A lab report, dated 5/6/23, indicated Klebsiella Pneumoniae was detected. Levofloxacin (an antibiotic medication) was ordered for UTI on 5/5/23. A lab report, dated 5/6/23, indicated Klebsiella Pneumoniae was resistant (ineffective) to levofloxacin. The MAR for 5/2023 indicated the resident received levofloxacin from 5/5/23 to 5/11/23. During an interview on 6/8/23 at 1:54 P.M., the IP (Infection Preventionist) Nurse indicated that she looks at antibiotic use daily for indications of use, susceptibility, side effects, and end dates. She indicated that she reviews all antibiotics whether they are prescribed in or out of facility. She indicated the antibiotics prescribed to Resident 21 on 7/20/22 and 5/5/23 were not appropriate for organism detected. At that time, the IP Nurse provided the facility tracker and Resident 21 was identified on September 2022 to May 2023 forms. On 6/5/23 at 11:30 A.M., a current Antibiotic Stewardship Program policy, dated 11/2017, was provided by the Administrator, and indicated "the facility will review the use of antibiotic 2-3 days after antibiotics are initiated to answer ... is the resident on the most appropriate antibiotic(s), dose, and route of admission". 3.1-18(b)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a safe,	F 0921	All deficient environmental	07/07/2023

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	comfortable, and sanitary environment was maintained in 1 of 4 resident halls. Cracks and missing tiles were observed in the floor, the floor was sticky, a toilet paper roll was broken off, window blinds were broken, privacy curtains were torn and missing, and the walls were observed with layers of paint and wall missing. (Secured Hall floor, Secured Hall small dining area, Room 315, Room 312, Room 313, Room 314, Room 309, Room 306, Room 314) Findings include: 1. On 6/6/23 at 9:23 A.M., Room 314 was observed with a bad odor in the room. The call light pull cord in the bathroom was observed with a brown substance on it, the back of the toilet seat was chipping and rusted brown. A string was missing from the right side of the window blinds. The same was observed on 6/9/23 at 10:27 A.M. 2. On 6/6/23 at 9:27 A.M., Room 309 was observed with the window blinds folded on the left side. A cord was sticking out of the wall with the wall plate cracked with a nail sized hole. The caulking behind the sink was cracked, and the area behind the soap dispenser in the bathroom was observed with the outer layer of the wall peeled away. A 12 inch ruler sized area of tile on the floor was missing in front of the air conditioning unit, and the privacy curtain was torn. The same was observed on 6/9/23 at 10:28 A.M. 3. On 6/6/23 at 9:34 A.M., Room 306 was observed with a cable cord outlet cover on the wall missing by the dresser. The air conditioning unit was observed with 2 broken pieces on the top, with sharp edges exposed and the door on the right		conditions were repaired on the secured unit. No residents were affected by the alleged deficient practice. An in-service has been completed by the Administrator for the nursing, housekeeping and Plant Operations Director on maintaining a comfortable environment for residents. An audit tool has been created to monitor the environmental conditions of the Secured Unit 5x week for 8 weeks, 3x weeks for 8 weeks and 1x week for 8 weeks. The results of this rounding will be forwarded to QAPI for review an any needed further recommendations.	

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	was not attached. The bathroom sink was observed with a brown substance buildup around the base of the spout. The same was observed on 6/9/23 at 10:23 A.M. 4. On 6/7/23 at 9:36 A.M., the floor on the secured unit by the soiled utility room was observed with a crack in the tile that extended across the hall. The same was observed on 6/9/23 at 10:25 A.M. At that time, the Maintenance Supervisor indicated there were several areas of the floor on that unit that were missing, and needed to be replaced. 5. On 6/7/23 at 9:42 A.M., Room 315 was observed with a sticky floor, a piece of the tile was missing from the floor in front of the bathroom, the toilet paper holder was broken with a piece not attached and coming off, and the bottom of the call light in the bathroom was observed with a brown substance. The same was observed on 6/9/23 at 10:25 A.M. At that time, the Maintenance Supervisor indicated he was unaware of the toilet paper roll or the brown substance on the call light cord. 6. On 6/7/23 at 9:46 A.M., the wall underneath the two air conditioning units in the small dining area was observed missing the outer layer of paint and wall, with pieces falling off. The same was observed on 6/9/23 at 10:25 A.M. At that time, the Maintenance Supervisor indicated he was aware of the wall, and that it needed to be fixed. 7. On 6/7/23 at 9:55 A.M., Rooms 312, 313, and 315			

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	were observed with no privacy curtain. Each room had 2 residents that resided in the rooms. The same was observed on 6/9/23 at 10:25 A.M. At that time, the Maintenance Supervisor indicated he had not noticed the missing privacy curtains. During the survey, the following anonymous interviews were conducted: The floor was sticky, and there had been a urine odor in the resident rooms. Housekeeping did not clean properly, and had indicated to family it didn't need to be cleaned because the family did it when they came in. The floors were not mopped properly. [Room number] was not cleaned and had a bad odor, as well as the hall. During an interview on 6/9/23 at 11:44 A.M., the Maintenance Supervisor indicated there was no specific policy for maintenance, as he used an app/computer system for all routine maintenance that needed to be done. He indicated staff had been instructed to fill out work orders when non-routine concerns were observed. 3.1-19(f)			