STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155262	A. BUILDING 00 B. WING	05/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF SULLIVAN NURSING FACILITY, THE	505 W WOLFE ST SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: May 8, 9, 10, 11, and 12, 2023. Facility number: 000163 Provider number: 155262 AIM number: 100291380 Census Bed Type: SNF/NF: 38 SNF: 3 Total: 41 Census Payor Type: Medicare: 2 Medicaid: 25 Other: 14 Total: 41 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 22, 2023.	F 0000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exits or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a			

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

LeAnn Petit | Executive Director | 06/01/2023

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

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	representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge;			

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	(iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure			

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	In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on interview and record review, the facility failed to ensure the representative of the Office of the State Long-Term Care Ombudsman was notified of the hospital transfer and/or discharge for 1 of 3 residents reviewed for hospitalization (Residents 39). Finding includes: During an interview, on 5/9/23 at 10:26 a.m., Resident 39 indicated she had been transferred to the hospital a couple of months ago for an UTI (urinary tract infection, a common infection which happened when bacteria, often from the skin or rectum, entered the urethra, and infected the urinary tract). Resident 39's record was reviewed on 5/11/23 at 1:52 p.m. Diagnosis included, but was not limited, urinary tract infection (UTI). An annual Minimum Data Set (MDS) assessment, dated 3/16/23, indicated the resident was cognitively intact and required limited assistance of one person for toilet use. Census information indicated the resident was hospitalized from 3/1/23 to 3/3/23.	F 0623	**F623 Ombudsman notification** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident 39 continues to reside at this facility. The area ombudsman was notified on May 12, 2023 of resident 39's transfer/ discharge in March of 2023. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** An audit of transfer/ discharges for the last six months was completed on May 30, 2023, and the area ombudsman was notified of these on May 30,2023. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Social Service Director was	06/04/2023

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	A nursing progress note, dated 3/1/23, indicated Resident 39 was admitted into the hospital for a urinary tract infection. The note lacked documentation the representative of the Office of the State Long-Term Care Ombudsman was notified of the transfer to the hospital. A nursing progress note, dated 3/3/23, indicated Resident 39 had returned to the facility from the hospital. The resident was alert and oriented to person, place, and time, with speech clear. The resident transferred per assist of one staff to a chair without difficulty. The note lacked documentation the representative of the Office of the State Long-Term Care Ombudsman was notified of the transfer to the hospital. On 5/12/23 at 1:34 p.m., the Social Services Director (SSD) indicated she was unable to find any March 2023 documentation of notification to the representative of the Office of the State Long-Term Care Ombudsman for the transfer and discharge to the hospital. On 5/12/23 at 8:46 a.m., the Director of Nursing (DON) provided and identified an undated document as a current facility policy titled, "The National Long-Term Care Ombudsman Resource Center - Copies of Transfer/Discharge Notices to the Ombudsman Program." The policy indicated, "...As of November 28, 2016, according to section 483.15(c)(3)(i) of the new regulations, a facility must send a copy of the written transfer or discharge notification to the representative of the Office of the State Long-Term Care Ombudsman...." 3.1-12(a)(6)(A)		educated during the survey process on May 12, 2023 of the facility policy for notifying the local ombudsman of transfer and discharges. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The Administrator or designee will monitor compliance with F623 and audits will be completed as follows. Weekly times four weeks, then monthly times five months. The monitoring will take place for no less than 6 months. If the facility is within 95% compliance at the end of 6 months the monitoring will be stopped. Audit findings will be documented and discussed at the morning IDT meeting as well as monthly QAPI meeting for further review and corrective action. **By what date the systemic changes for each deficiency will be completed**. Completion date : 6-4-2023	

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F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, record review, and interview the facility failed to revise a care plan for 1 of 12 residents reviewed for care plans (Resident 26). Finding includes: On 5/10/23 at 2:20 p.m., Resident 26 was observed	F 0657	**F657** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident 26's care plan was reviewed on May 11th by the IDT	06/04/2023

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	to be asleep in her bed, no floor mat was observed on the floor by her bed. On 5/22/23 at 9:02 a.m., Resident 26 was not observed to be in her room, no floor mat was observed on the floor by her bed and was not seen anywhere in her room. Resident 26's record was reviewed on 5/10/23 at 10:28 a.m. The profile indicated the resident's diagnoses included, but were not limited to, heart failure (a condition in which the heats doesn't pump as well as it should), type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), hemiplegia and hemiparesis (these are similar in that they describe weakness on one side of your body), and hypertension (elevated blood pressure). A quarterly Minimum Data Set (MDS) assessment, dated 4/7/23, indicated the resident had severe cognitive deficit and required a 2 person assist with bed mobility, dressing, toileting, and transfers. A care plan, dated 3/30/21 and revised on 02/21/23, indicated the resident was at risk for falls due to her history of falls, due to ambulation with assisted devices, muscle weakness, unsteadiness on feet, and diabetes mellitus. Interventions included, but were not limited to, mat to floor at bedside bed. Review of progress note, dated 2/15/23 at 6:52 a.m., indicated Resident 26 was found lying on the floor in her room. The resident indicated she tried to get to the wall to reach the grab bar at the foot of her bed. Review of interdisciplinary team (IDT) note, dated		team and updated to reflect current interventions. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Careplans for all residents with falls within the last 90 days have been reviewed as of June 1, 2023 and accurately reflect care given. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Resident care changes will be reviewed in morning IDT meeting and careplans will be reviewed and if needed updated at that time. The DON or designee has educated nurse staff on the policy for updating care plans on or before June 3,2023. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The director of nursing or designee will monitor compliance related to F657 , Audit tools will be completed weekly times 4 weeks, then monthly times 5 months. The	

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	2/21/23 at 11:38 a.m., indicated Resident 26 was observed to be lying on the floor at the side of her bed by staff. The resident was trying to reach the grab bar on the wall at the end of her bed. Mats were placed at bedside. During an interview, on 5/10/23 at 3:01 p.m., LPN 4 indicated staff had removed the floor mat to Resident 26's room about month ago, she was unsure as to why it was removed and no longer being used as a fall intervention. During an interview on 5/10/23 at 3:05 p.m., CNA 9 indicated the mat was no longer being used in Resident 26's room as a fall intervention, she indicated it had been about month since it was used, and she was unsure as to why it was removed. During an interview on 5/11/23 at 11:26 a.m., the Director of Nursing (DON) indicated the IDT met and reviewed Resident 26's record and had decided to remove the floor mat as a fall intervention. The DON was unable to provide any documentation of that review. She further indicated the care plan should have been updated to reflect the removal of the floor mat. On 5/11/23 at 1:30 p.m., the Unit Manager 19 provided an undated document titled, "Baseline Care Plan Assessment/Comprehensive Care Plans," and indicated it was the policy currently being used by the facility. The policy indicated, "...9. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health psycho-social issues. 10. The MDS/Care Plan Coordinator staff will attend the morning meetings where in in-depth review of the 24-hour report(s) are reviewed...they will then see that the		monitoring will take place for no less than 6 months. If the facility is within 95% compliance at the end of 6 months the monitoring will be stopped. Audit findings will be documented and discussed at the morning IDT meeting as well as monthly QAPI meeting for further review and corrective action. **By what date the systemic changes for each deficiency will be completed**. Completion date : 6-4-2023	

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	care plans for residents are revised and updated as necessary...." 3.1-35(d)(2)(B)			
F 0690 SS=D 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 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			

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	services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure a suprapubic urinary catheter (a type of indwelling catheter inserted directly into the bladder) drainage bag was prevented from contact with the floor for 1of 2 residents reviewed for urinary catheter/urinary tract infection (Resident 8). Findings include: During a random observation, on 5/8/23 at 2:50 p.m., Resident 8 was sitting in his wheelchair in his room. His urinary catheter drainage bag was placed in a dignity bag (a solid color bag used to cover a clear urinary drainage bag) and the bag was observed to be in contact with the floor. The urinary catheter bag had not been secured by the hook onto the resident wheelchair and had been just set inside the dignity bag. During a random observation, on 5/9/23 at 11:23 a.m., the resident was sitting in his wheelchair in his room. His urinary catheter drainage bag was placed in a dignity bag and the bag was observed to be in contact with the floor. The urinary catheter bag had not been secured by the hook onto the resident wheelchair and had been just set inside the dignity bag. As the resident turned his wheelchair, the dignity bag, which contained his urinary catheter drainage bag, was observed to slide on the floor with the movement of the wheelchair. Resident 8's record was reviewed on 5/11/23 at 10:04 a.m. The profile indicated the resident's diagnoses included, but were not limited to, stage 3 chronic kidney disease (mild to moderate	F 0690	**F690** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Upon notification on May 11,2023 the director of nursing assured the catheter bag was in proper place and functioning. All nursing staff were in serviced on or before June 3rd, 2023 on proper placement of catheter bags and tubing. Resident 8 was given a new dignity bag on May 11th, 2023. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents with catheter bags were reviewed on May 11, 2023, and no deficiencies were identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Catheter bags will be monitored by the Director of nursing or designee for proper placement of catheter bag and tubing. All nursing staff were in serviced on or before June 3rd, 2023, on proper placement of	06/04/2023

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	damage of the kidneys, which make them less able to filter waste and fluid out of the blood), neuromuscular dysfunction of the bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), and retention of urine (a condition when urine cannot empty from the bladder). A quarterly Minimum Data Set (MDS) assessment (a standardized, comprehensive assessment of an adult's functional, medical, psychosocial, and cognitive status), dated 4/18/23, indicated the resident had no cognitive deficit and required a indwelling urinary catheter. A care plan, dated 4/25/23, indicated the resident had a suprapubic catheter, with a goal the the catheter would be maintained and the resident would remain free from catheter related complications such as infection. A physician's order, dated 7/16/21, indicated to ensure catheter bag was below the waist, covered and not touching floor. A progress note, dated 5/1/23 at 1:24 p.m., indicated the resident had complained of bladder pain and pressure the previous night. The resident was having clear yellow urine output with some mucus noted. A physician's order, dated 5/3/23, indicated Cipro (Ciprofloxacin HCl) Oral Tablet (an antibiotic medication which works by killing bacteria that cause infections) 500 milligrams (mg), by mouth two times daily, for 14 days, for Urinary Tract Infection (UTI-common infection that happen when bacteria, often from the skin or rectum, enter the urethra [tube through which urine leaves the body], and infect the urinary tract).		catheter bags and tubing. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The Director of Nursing or designee will monitor compliance with F690. Audits will be completed weekly times 4 weeks, then monthly times 5 months. The monitoring will take place for no less than 6 months. If the facility is within 95% compliance at the end of 6 months the monitoring will be stopped. Audit findings will be documented and discussed at the morning IDT meeting as well as monthly QAPI meeting for further review and corrective action. **By what date the systemic changes for each deficiency will be completed**. Date of completion : 6-4-2023	

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	During an interview, on 5/11/23 at 11:37 a.m., the Director of Nursing (DON) indicated the dignity bag that the urinary catheter bag had been placed in, was torn and, along with the fact that the urinary catheter bag was not hung on the underneath the wheelchair, likely caused the catheter bag to touch the floor. The bag should have been secured to the underneath of the resident's wheelchair. On 5/11/23 at 9:36 a.m., the Regional Nurse Consultant provided an undated document, titled, "Policy and Procedure; Indwelling Urinary Catheterization for Male Resident," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...Note: ...No component of the system to include the catheter/tubing/urinary drainage bag should come into contact with the floor as the floor is considered contaminated." 3.1-41(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure a resident's	F 0695	**F695** **What corrective action will be accomplished for those**	06/04/2023

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	supplemental oxygen concentrator machine was turned on, the oxygen tubing connected to the machine and resident was dated, and the portable supplemental oxygen tubing was not outdated for 1 of 1 resident reviewed for respiratory care (Resident 21). Finding includes: During an observation, on 5/8/23 at 2:09 p.m., Resident 21 was observed lying in bed with undated oxygen tubing running from the oxygen concentrator machine underneath a mat on the floor with a bedside table on top of the mat to the resident via nasal canula on the resident, with the oxygen concentrator machine not turned on. The oxygen tubing connected to the portable oxygen concentrator machine on the resident's wheelchair oxygen tank was dated 4/6/23. On 5/8/23 at 3:30 p.m., Resident 21 was observed lying in bed with undated oxygen tubing running from the oxygen concentrator machine underneath a mat on the floor with a bedside table on top of the mat to the resident via nasal canula on the resident with the oxygen concentrator machine not turned on. The oxygen tubing connected to the portable oxygen concentrator machine on the resident's wheelchair was dated 4/6/23. The Director of Nursing (DON), on 5/8/23 at 3:45 p.m., observed Resident 21 lying in bed with the oxygen concentrator machine turned off, the undated oxygen tubing connected to the resident via nasal canula with the tubing underneath the mat and a bedside table on top of the mat, and the portable oxygen tubing dated 4/6/23. She indicated all oxygen tubing should be changed and dated every seven days, the oxygen concentrator should be turned on when in use,		**residents found to have been affected by the deficient practice;** Immediately on May 8 ,2023 when the director of nursing was notified of the oxygen concentrator being turned off the director of nursing turned it on. At the same time she properly placed the tubing. May 8th , 2023 new tubing was put on the portable oxygen tank as well. Resident 21 continues to reside at the facility and has shown no ill effects, oxygen is being administered according to doctor's orders with appropriate placement of tubing. Tubing is being changed weekly and dated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All other residents with orders for oxygen were audited on May 8 , 2023 to ensure oxygen is being administered according to doctors' orders with appropriate placement of tubing. Tubing is being changed on weekly basis and dated. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff have been inserviced by DON/designee on oxygen	

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	and the oxygen tubing should not be underneath the mat and bedside table. Resident 21's record was reviewed on 5/10/23 10:30 a.m. Diagnoses included, but were not limited to, heart failure, shortness of breath (SOB), and chronic respiratory failure (stopped breathing). A quarterly Minimum Data Set (MDS) assessment, dated 2/17/23, indicated the resident had a severe cognitive impairment, required extensive assistance of two persons for bed mobility and toilet use, was a total dependence of two persons for transfer and bathing, and received oxygen therapy. A care plan, initiated on 3/27/21 and revised on 11/3/21, indicated Resident 21 had the potential for exacerbation of shortness of breath due to the diagnoses of heart failure, fluid overload, chronic respiratory failure, and morbid obesity, with an intervention included, but was not limited to, administer oxygen as ordered. A physician's order, dated 3/28/2021, indicated oxygen at 4 liters a minute (L/M) (oxygen flow rate) per nasal canula (NC) continuously for SOB. A physician's order, dated 5/12/22, indicated to change the oxygen tubing, humidifier, and clean concentrator filter weekly. On 5/9/23 at 11:18 a.m., the DON provided 3 policies. The first policy identified as a current facility policy was an undated document , titled "Oxygen Therapy." The policy indicated, " ...Purpose: Oxygen is administered to Residents to improve oxygenation and provide comfort to Residents experiencing respiratory difficulties		administration as well as oxygen tubing placement and replacement on May 8th, 2023. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** DON or designee will monitor concentrator use as well as oxygen tubing dates and placement. Audit tools will be completed Weekly times 4 weeks, then monthly times 5 months. The monitoring will take place for no less than 6 months. If the facility is within 95% compliance at the end of 6 months the monitoring will be stopped. Audit findings will be documented and discussed at the morning IDT meeting as well as monthly QAPI meeting for further review and corrective action. **By what date the systemic changes for each deficiency will be completed**. Completion date : 6-4-23	

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	...Policy: Oxygen therapy is administered by licensed staff only as ordered by a physician or as an emergency measure until an order can be obtained. The physician's order will specify the rate of flow of oxygen ...Administering Oxygen: ...4. Apply face mask or nasal cannula as order ...6. Observe frequently to see that: ...Cannula is in proper position and tubing is not kinked ...." The DON provided and identified a second undated document as a current facility policy, titled "Oxygen Administration." The policy indicated, " ...Policy ...It is the policy of this facility to provide oxygen to maintain levels of saturation to residents as needed and as ordered by the attending physician ...Oxygen concentrators are provided to residents with oxygen orders for the purpose of maximizing overall consistency in regulation of oxygen administration in the resident room. E-tanks are available for extended trips ...4. Tubing, humidifier bottles and filters will be changed, cleaned and maintained no less that (sic) weekly and PRN. Each will be labeled with date, time and initiated by staff completing this service to equipment ...." The DON provided and identified a third, undated and untitled, document as a current facility policy. This policy indicated, " ...When transferring a resident out of their room and using a portable concentrator, a NURSE MUST turn off bedside concentrator and turn on portable concentrator and vice versa ....All tubing and humidifier bottles need to be dated when changed out. Tubing should be changed every Thursday ...." 3.1-47(a)(4) 3.1-47(a)(5) 3.1-47(a)(6)			

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F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on record review and interview, the facility failed to monitor side effects/behaviors and failed to develop a care plan for the use of anti-psychotic medication (medication primarily used to manage psychosis) for 1 of 5 residents reviewed for unnecessary medications (Resident 14). Finding includes: Resident 14's record was reviewed on 5/11/23 at 11:43 a.m. The profile indicated the resident's diagnoses included, but were no limited to, type I diabetes mellitus (a chronic condition in which the pancreas [organ with two main functions that helps in digestion and an endocrine function that regulates blood sugar] produces little or no insulin), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), recurrent depressive disorders (a mental health disorder characterized by persistently depressed moor or loss of interest in activities causing significant impairment of daily life), and treatment resistant depression (depressive disorder that does not respond satisfactorily to adequate treatment	F 0740	**F740** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident 14 continues to live at the facility and is in stable condition, the careplan was updated on May 26, 2023 for the use and monitoring of the anti-psychotic medication. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** On May 30, 2023 an audit was completed of all facility residents on anti-psychotic medications to assure compliance, all are careplaned with monitoring for side effects/behaviors in place. **What measures will be put into**	06/04/2023

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	clearly have harder to treat depression). A quarterly Minimum Data Set (MDS) assessment, dated 2/27/23, indicated the resident had moderate cognitive deficit and received antipsychotic and antidepressant (used to treat depressive symptoms) medications. A care plan, dated 5/9/22, indicated the resident had depression. Interventions included, but were not limited to, monitor medication side effects at least daily, provide support and encouragement as needed, and social service to visit as needed. The record lacked a care plan for use of antipsychotic medication. A pharmacy communication form, dated 10/12/22, indicated a need for justification for use of Aripiprazole (antipsychotic medication). The pharmacy indicated the use of a diagnosis of treatment resistant depression was not warranted alone for the use of the antipsychotic medication. The document indicates the clinical condition must also meet the criteria of behavioral symptoms present a danger to the resident or to others. The document was signed and marked agreed by the facility nurse practitioner. A physician order, dated 12/9/22, indicated Aripipazole 10 milligram (mg) one tablet by mouth one time a day. During an interview, on 5/11/23 at 2:50 p.m., Social Service Director (SSD) indicated there should be an order to monitor for side effects related to use of antipsychotic medications. Resident 14's record lacked documentation of an order. She further indicated there should be a care plan in place for the use of antipsychotic medication. She indicated Resident 14 did not have a care plan for the use of		**place and what systemic changes will be made to ensure that the deficient practice does not recur;** The Social Service director has been educated on monitoring side effects / behaviors as well as the requirements for a care plan. Nursing staff were inserviced on or before June 3, 2023. Going forward new orders for anti-psychotic medications will be reviewed in the IDT meeting and careplans as well as monitoring for side effects /behavior forms will be put in place at that time. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** The Administrator or designee will monitor compliance with F740 and audits will be completed as follows. Weekly times four weeks, then monthly times five months. The monitoring will take place for no less than 6 months. If the facility is within 95% compliance at the end of 6 months the monitoring will be stopped. Audit findings will be documented and discussed at the morning IDT meeting as well as monthly QAPI meeting for further review and corrective action.	

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	antipsychotic medication. SSD indicated there was no behavior tracking for Resident 14 because he did not have behaviors. On 5/11/23 at 2:23 p.m., the SSD provided a document, with a revised date of 3/17/16, titled, "Antipsychotic Medication Review", and indicated it was the policy currently being used by the facility. The policy indicated, "...review the care plan for the following information: antipsychotic medication; ...side effects; behaviors; and suggested interventions...Review that behaviors are being monitored and documented on care tracker and/or behavior sheet that is easily accessible to staff...." 3.1-37(a) 3.1-43(a)(1)		**By what date the systemic changes for each deficiency will be completed**. Completion date: 6-4-2023	
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			

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	documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's 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 record review and interview, the facility failed to ensure the pharmacy recommendation was addressed by a physician and the facility failed to ensure the physician's responses to pharmacy recommendations were implemented for 2 of 5 residents reviewed for unnecessary psychotropic medications (Residents 21 and 6). Findings include:	F 0758	**F758** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The pharmacy recommendation for resident 21 was addressed on May 24th with the hospice physician, the pharmacy recommendation for Resident 6	06/04/2023

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	1. Resident 21's record was reviewed on 5/10/23 at 10:30 a.m. The profile indicated the resident's diagnoses included, but was not limited to, depression (persistent sadness and a lack of interest or pleasure in previously rewarding or enjoyable activities). A quarterly Minimum Data Set (MDS) Assessment (part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 2/16/23, indicated the resident had a severe cognitive impairment and received an antidepressant medication on a routine basis for depression. A care plan, initiated on 1/10/21 and revised on 11/3/21, indicated Resident 21 had the diagnosis of depression with the potential for signs and symptoms of persistent feelings of sadness or loss of interest, changes in sleep, appetite, energy, and concentration related to mood with interventions included, but were not limited to, give psych medication as ordered and monitor medication side effects at least daily on the psychotropic medication record. A physician's order, dated 10/23/22, indicated Paxil (antidepressant medication) 20 milligrams (mg) tablet, give 1 tablet by mouth daily at bedtime for depression. A pharmacy recommendation, dated 4/9/23, indicated the resident's order for Paxil 20 mg daily for depression was due for review and a dose reduction attempt, and for the physician to document the resident's current mental and behavior status, review the new dose recommended for Paxil 10 mg tablet daily or provide detailed reason(s) that a dose reduction		was addressed on May 30th , 2023 with the psychiatric provider. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Pharmacy recommendations for the past six months have been audited by the DON or designee and all have been addressed with the primary care provider on or before June 3. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The DON/ADON/Social Services Director were educated on the facility process for Pharmacy recommendations on May 11, 2023. Going forward pharmacy recommendations will be monitored by the DON or designee , these will be addressed with the primary care physician and/or psychiatric care provider. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Pharmacy recommendations will be audited by the Administrator or	

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	was contraindicated for Resident 21. The recommendation form lacked documentation of a physician's response and a signature. During an interview, on 5/11/23 at 9:56 a.m., the Director of Nursing (DON) indicated the April 2023 pharmacy recommendation for Resident 21 was not addressed by the physician. 2. Resident 6's record was reviewed, 5/11/23 at 9:21 a.m., diagnoses included, but were not limited to, unspecified dementia, (a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain), unspecified severity with behavioral disturbance, age related cognitive decline (concern of or difficulty with a person's thinking, memory, concentration, and other brain functions beyond what was typically expected due to aging), generalized anxiety disorder (a feeling of fear, dread, and uneasiness), major depressive disorder (a mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life) recurrent with psychotic symptoms (a condition of the mind resulting in difficulties determining what is real and what is not real). A quarterly Minimum Data Set (MDS) assessment, dated 2/1/23, indicated the resident had a severe cognitive impairment and received antipsychotic medications on a daily basis. A physician's orders indicated to administer the antipsychotic medication, Depakote 12.5 milligrams (mg) tablet three times daily (TID) for dementia severity with behavioral disturbances and risperidone 0.5 mg tablet two times daily (BID) for unspecified dementia with unspecified severity		designee and will be performed monthly for 6 months. Any deficiencies will be corrected immediately, and the findings will be documented and discussed at the monthly QAPI meeting for further review and corrective action. **By what date the systemic changes for each deficiency will be completed**. Completion date : 6-4-2023	

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	with behavioral disturbance. A pharmacy recommendation, dated 12/11/22, indicated concerns with the antipsychotic diagnosis and justification for Depakote 125 mg TID. The current diagnosis of restlessness and agitation and was not an acceptable diagnosis per CMS regulations. The pharmacy recommendation was to change the supporting diagnosis to, "...Expression or indications of distress/Behavioral and Psychological Symptoms of Dementia..." Justification was behavioral symptoms presented a danger to the resident or others and was signed by the physician. The medical record lacked documentation the recommendation was entered into the resident's medical record. A pharmacy recommendation, dated 2/8/23, indicated concerns with the antipsychotic diagnosis and justification for Depakote 125 mg TID. The current diagnosis of dementia with behavior was not acceptable per CMS regulations. The pharmacy recommendation was to change the supporting diagnosis to, "...Severe depression refractory to other therapies and or with psychotic features," and was signed by physician. The medical record lacked documentation the recommendation was entered into the resident's medical record. A pharmacy recommendation, dated 2/8/23, indicated the antipsychotic diagnosis and justification for Risperdal 0.5 mg BID of dementia with behaviors was not acceptable per CMS regulations. The pharmacy recommendation was to change the supporting diagnosis to, "...expression or indication of distress behavioral and psychological symptoms of dementia." Justification was behavioral symptoms presented			

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	a danger to the resident or others. Expressions or indications of distress caused significant distress to the resident. The recommendation was signed by the physician. The medical record lacked documentation the recommendation was entered into the resident's medical record. On 5/11/23 at 10:55 a.m., the Director of Nursing (DON) provided and identified an undated document as a current facility policy titled, "Policy and Procedure- Pharmacy Recommendations." The policy indicated, "...Policy: It is the policy of the facility to monitor medications by pharmacy regime reviewed conducted monthly or more often of indicated. The objective being to ensure that the residents are receiving medications that are effective and safe...Policy: 1. The consultant pharmacist will review resident medications regimens on a monthly basis and as needed...2. Recommendations as a result of the reviews will be provided to the Director of Nursing upon exit interview by the pharmacy consultant. If the DON is not available, the ADON will exit with the pharmacy consultant...3. The DON will coordinate through the nursing department, the notification of physicians of the recommendations received from the pharmacy consultants report. This process will begin within 72 hours of the receipt of the pharmacy consultant's report...6. A response as to the action to be taken regarding the pharmacy consultant's recommendation will be documented within 7 days of the receipt of the recommendation...." 3.1-48(b) 3.1-48(b)(1) 3.1-48(b)(2)			
F 9999				

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	3.1-14 PERSONNEL (p) Initial orientation of all staff must be conducted and documented and shall include the following: (1) Instructions on the needs of the specialized population or populations served in the facility, for example: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) children; or (E) care of cognitively impaired; residents. (2) A review of residents' rights and other pertinent portions of the facility's policy manual. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures and universal precautions. (4) A detailed review of the appropriate job description, including a demonstration of equipment and procedures required of the specific position to which the employee will be assigned. (5) Review of ethical considerations and confidentiality in resident care and records. (6) For direct care staff, instruction in the particular needs of each resident to whom the employee will be providing care. (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education if applicable. (5) Professional licensure, certification, or registration number or dining assistant certificate	F 9999	**F9999** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The employee files for staff members 14, 15, 16, 17 and 18 were updated to contain the required documentations on May 26th, 2023. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** An audit was completed of all current employee files on May 26, 20223. All were reviewed and the required documentation is in place. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** The human resource specialist was educated on 5-12-2023 by the Administrator on mandatory documents for employee files. A checklist will be completed with each new hire for compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	06/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155262	A. BUILDING 00 B. WING	05/12/2023

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	or letter of completion if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with the facility's policy. (10) Date and reason for separation. (r) The employee's personnel record shall be retained for at least three (3) years following termination or separation of the employee from employment. (s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure employee records included all of the required documentation for 5 of 10 employee records reviewed. Findings include:		**assurance program will be put into place; and** The Administrator or designee will monitor compliance with F999 and will be performed as follows. Weekly times 4 weeks, then monthly times 5 months. The monitoring will take place for no less than 6 months. If the facility is within 95% compliance at the end of 6 months the monitoring will be stopped. Audit findings will be documented and discussed at the morning IDT meeting as well as monthly QAPI meeting for further review and corrective action. **By what date the systemic changes for each deficiency will be completed**. Completion date : 6-4-2023	

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	Review of the Employee Records Form (State Form 5440), on 5/12/23 at 10:05 a.m., indicated the following: a. Certified Nursing Assistant (CNA) 14 had a hire date of 3/16/23. Her employee record lacked documentation of a completed physical examination, general orientation, and job-specific orientation. b. Certified Nursing Assistant (CNA) 15 had a hire date of 2/16/23. Her employee record lacked documentation of a job description and job-specific orientation. c. Certified Nursing Assistant (CNA) 16 had a hire date of 3/9/23. Her employee record lacked documentation of job-specific orientation. d. Certified Nursing Assistant (CNA) 17 had a hire date of 4/6/23. Her employee record lacked documentation of job-specific orientation. e. Certified Nursing Assistant (CNA) 18 had a hire date of 3/8/23. Her employee record lacked documentation of job-specific orientation. During an interview. on 5/12/23 at 12:31 p.m., the Human Resources (HR) Specialist indicated, she was sure, there were some items in the employee records that she would not be able to locate. During an interview, on 5/12/23 at 1:42 p.m., the Executive Director (ED) indicated she believed the cause of the lack of documentation in the employee records had to do with the change over from the previous company to the current company. The company policy would be that all employee records would contain the required			

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