STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 00 B. WING	03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILLOW CROSSING HEALTH & REHABILITATION CENTER	3550 CENTRAL AVE COLUMBUS, IN 47203

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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 IN00402158 and IN00399791. Complaint IN00402158 - No deficiencies related to the allegations are cited. Complaint IN00399791 - No deficiencies related to the allegations are cited Survey dates: March 2, 3, 6, 7, 8, and 9, 2023 Facility number: 000572 Provider number: 155535 AIM number: 100267710 Census Bed Type: SNF/NF: 102 Total: 102 Census Payor Type: Medicare: 17 Medicaid: 73 Other: 12 Total: 102 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 14, 2023.	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alisha Miller	Administrator	03/31/2023

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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	that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure residents that self-administered medications were appropriately assessed for self-administration for 1 of 6 resident observations. (Resident 66) Findings include: During a continuous observation on 03/07/23 at 12:00 P.M., Resident 66 was sitting in her room in her recliner. On top of her night stand, that was next to her chair, were two medication cups nested together. The top cup contained a large flat colored tablet. A CNA (Certified Nurse Aide) came in to serve the resident's lunch tray. When asked, the resident said the tablet was her, "softies," they were for her stomach, but she couldn't remember the name of the tablet. The CNA took the medication cups out to the Nurse's Station and the Dementia Care Coordinator/LPN (Licensed Practical Nurse) 10 indicated the tablet in the medicine cup was a Tums. The resident was not allowed to get her Tums by herself. During an interview on 03/07/23 at 2:52 P.M., on the Dementia Unit, RN 7 indicated no residents on the Dementia Unit were allowed to self-administer medications. If a resident was allowed to self-administer medications, they would have had an assessment completed and it would be in their chart. On 03/09/23 at 11:15 A.M., the medications in the medication cart for the resident were observed with RN 7. The cart lacked the resident's Tums (stomach medication). During an interview on 03/09/23 at 11:16 A.M., RN 8 indicated the resident's Tums had been	F 0554	F554 Requires the facility to ensure resident's that self administer medications are properly assessed. 1. Resident 66 Tums order was discontinued, as per interview with the staff, the resident refuses to take them. 2. All residents have the potential to be affected. Staff was immediately inserviced on not leaving medications at bedside for residents who are unable to properly administer their own medication per MD order. No concerns were noted. See below for corrective measures. 3. The medication administration policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the above procedure. 4. The DON or her designee observe 2 medication passes a day ensuring no medications are left at bedside for residents who cannot take medications correctly per MD order. If resident can take medication per the physician's order, then the self administration policy and procedure will be followed and an order obtained to self administer medication. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100%	03/24/2023

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	discontinued yesterday, 03/08/23. She never left medications at the bedside. The resident was not allowed to self-administer her medications. The resident had been prescribed two Tums tablets each morning. Residents wandered on the Dementia Unit, and it would be unsafe. The EMAR/ETAR (Electronic Medication Administration Record/Treatment Administration Record) for March 2023, was provided by the Regional Director on 03/09/23 at 11:32 A.M. The record contained the following physician's order: - Calcium carbonate (Tums) [OTC] (Over the Counter) tablet, chewable; Amount to administer: 2 tablets, once a day, with a start date of 10/28/22, and a discontinued date of 03/07/23. The record indicated the medication had been administered on 03/07/22. The record lacked a physician's order allowing the resident to self-administer her medications. The current "MEDICATION ADMINISTRATION" policy, with a revised date of 04/2017, was provided by the Corporate Clinical Nurse on 03/09/23 at 10:30 A.M. The policy indicated, "...PURPOSE...To safely administer medications as per physician's orders...Licensed or qualified personnel shall be responsible to follow accepted practices of medication administration as per physicians' orders...All medications are to be given by the person who prepared the dose...Always observe the resident taking their medication(s). Never permit medication to remain in the resident's room. Residents may not self-administer medications unless specifically authorized in writing by the attending physician..."		compliance is obtained and maintained.(See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly **if the audits being conducted are not showing 100% compliance per the regulatory guidance. If 100% compliance is still a concern, the plan of correction will have additional inservice training conducted and additional monitoring added to obtain compliance. The monitoring would continue** daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. 5. The above corrective measures will be completed on or before March 24, 2023.	

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	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 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			

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	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, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to notify the physician related to low blood pressure values for 1 of 23 residents reviewed. (Resident 66) Findings include: The clinical record for Resident 66 was reviewed on 03/07/23 at 9:40 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 01/05/23, indicated the resident was moderately cognitively impaired for daily decision making, decisions were poor, and they required cueing and supervision. The diagnoses included, but were not limited to, Alzheimer's disease, hyperlipidemia, and depression. The EMAR/ETAR (Electronic Medication Administration Record/Treatment Administration Record) for December 2022, February 2023, and March 2023, were provided by the Regional Director on 03/09/23 at 11:32 A.M. The records included, but were not limited to, an open-ended physician's order, with a start date of 10/28/22, for the following:	F 0580	F580 Requires the facility to notify the physician related to low blood pressure values. 1. Resident 66 blood pressures were reviewed with the nurse practitioner and no new orders were obtained. 2. All residents have the potential to be affected. An audit for the last 30 days was conducted to ensure the physician was notified of blood pressures that were out of range of the parameter. No further concerns were noted. See below for corrective measures. 3. The physician orders policy and procedure was reviewed with no changes made. (See attachment C) The staff was inserviced on the above procedure. 4. The DON or designee will review all blood pressures obtained daily to ensure that the physician is contacted on blood pressures out of the range of the parameter set. The DON or her	03/24/2023

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	- Perform Blood Pressure and Pulse Check Once a Day on the 1st of the Month. "Special Instructions" indicated the staff were to notify the medical provider if SBP(Systolic Blood Pressure, the top number) was less than 100, DBP (Diastolic Blood Pressure, the bottom number) was less than 60, or the Pulse was less than 50. The December record indicated the resident's blood pressure was 87/61 and the physician had not been notified. The February record indicated the resident's blood pressure was 94/57 and the physician had not been notified. The March record indicated the resident's blood pressure was 97/67 and the physician had not been notified. During an interview on 03/07/23 at 1:48 P.M., the DON (Director of Nursing) indicated if staff had notified the physician it should have been documented in the Nurse's Notes. The Progress Notes/Nurse's Notes, from admission to present, were provided by the Regional Director on 03/09/23 at 10:40 A.M. The record lacked documentation that the nursing staff had notified the physician of the low blood pressure values. The current "PHYSICIAN ORDERS" policy, dated 10/2014, indicated, "...Facility nursing personnel will ensure clear, accurate and complete physician's orders...Ensure any follow through is completed..." 3.1-5(a)(2)		designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly **if the audits being conducted are not showing 100% compliance per the regulatory guidance. If 100% compliance is still a concern, the plan of correction will have additional inservice training conducted and additional monitoring added to obtain compliance. The monitoring would continue** daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. 5. The above corrective measures will be completed on or before March 24, 2023.	

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to follow manufacturer's guidelines related to insulin pen usage for 1 of 20 residents reviewed for quality of care. (Resident 12) Findings include: During a medication administration observation on 03/7/23 at 12:18 P.M., LPN (Licensed Practical Nurse) 2 cleaned the tip of the Novolog insulin pen, applied the needle, held the pen sideways, and primed the pen with two units of insulin. She dialed the pen to the correct sliding scale dose in addition to the routine dose of insulin. She went into Resident 5's room to administer the insulin. She administered the insulin in the back side of the resident's left arm. During an interview on 03/07/23 at 12:22 P.M., LPN 2 indicated she was not as familiar with insulin pens as vials of insulin. She had not been educated on insulin pens. She felt she had been rushed through orientation when she was hired three years ago because Covid was active in the facility. The clinical record for resident 5 was reviewed on	F 0684	F684 Requires the facility to ensure manufacturer's guidelines are followed related to insulin pen useage. 1. Resident 12 insulin pen was primed correctly per package insert to ensure pen was functioning properly. 2. All residents have the potential to be affected. An inservice was immediately given to the Nurses/QMA regarding the need to properly prime an insulin pen prior to injecting insulin to a resident. No further concerns were noted. See below for corrective measures. 3. The Novolog package insert was reviewed regarding how to prime an insulin pen. (See attachment D) The staff was inserviced on the above procedure 4. The DON or designee will observe two nurses or qualified medication aides a day to ensure insulin pens are properly primed per manufacturer's package insert. The DON or her designee	03/24/2023

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	03/09/23 at 3:16 P.M., A Quarterly MDS (Minimum Data Set) assessment, dated 01/23/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, heart failure, hypertension, diabetes, anxiety, and depression. During an interview on 03/09/23 1:23 P.M., the DON (Director of Nursing) indicated the nursing staff were reeducated in February of this year on insulin pen usage and medication storage. The current Novolog package insert, with a revised date of 32021, was provided by the DON on 03/09/23 at 10:40 A.M. The insert indicated, "...Before each injection...Turn the dose selector to select 2 units. With the needle pointing up, tap the cartridge gently...to make any air bubbles collect at the top...Press the button all the way in...A drop of insulin should appear at the needle tip..." During an interview on 03/09/23 1:23 P.M., the DON indicated she was unaware of a specific policy for insulin pens. 3.1-47(a)(1)		will utilize the nursing monitoring tool daily times four weeks, then weekly times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly **if the audits being conducted are not showing 100% compliance per the regulatory guidance. If 100% compliance is still a concern, the plan of correction will have additional inservice training conducted and additional monitoring added to obtain compliance. The monitoring would continue** daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. 5. The above corrective measures will be completed on or before March 24, 2023.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with			

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	professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide appropriate hand hygiene and glove usage related to wound care for 2 of 3 residents reviewed for pressure ulcers (Residents 82 and 22). Findings include: 1. During an observation on 03/08/23 at 11:31 A.M., LPN (Licensed Practical Nurse) 2 and CNA Certified Nurse Aide) Student 14 entered Resident 82's room and informed her they would be providing wound care. LPN 2 washed her hands, donned gloves, removed the old dressing from the resident's coccyx. She cleansed the wound with normal saline, patted the wound dry, placed ointment on the adhesive bandage, and placed the bandage on the wound. The clinical record for Resident 82 was reviewed on 03/06/23 at 12:45 P.M. A quarterly MDS (Minimum Data Set) assessment, dated 02/02/23, indicated the resident was cognitively intact. The diagnoses included but were not limited to hypertension, heart failure, renal insufficiency, anxiety, depression, diabetes, and dementia. The resident requires extensive assistance of 2 staff members for most ADLs. The resident had one Stage II (partial loss of dermis) pressure ulcer.	F 0686	F686 Requires the facility to ensure staff provides proper hand hygiene and glove useage related to wound care. 1. Resident 82 and 22 dressing was reapplied using correct hand hygiene and glove useage. 2. All residents have the potential to be affected. The nurse was immediately inserviced on proper hand hygiene and glove useage during a wound treatment. No further concerns were noted. See below for corrective measures. 3. The dressing-clean technique policy and procedure was reviewed with no changes made. (See attachment E) The staff was inserviced on the above procedure. 4. The DON or designee will observe two dressing changes a day ensuring the nurse is following proper hand hygiene and glove usage per policy. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance	03/24/2023

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	2. During an observation on 03/08/23 at 1:54 P.M., LPN 2 and LPN 17 entered Resident 22's room and explained they were going to provide wound care. LPN 2 washed her hands, donned gloves, and removed the dressing from the resident's buttocks. She cleaned the wound with normal saline, placed a small amount of ointment on the adhesive bandage and covered the wound with the bandage. LPN 2 removed her gloves, donned a new pair of gloves, removed the old dressing from the resident's left heel. She cleaned the wound with normal saline, applied an ointment to the bandage and placed the bandage on the heel. During an interview on 03/08/23 at 2:09 P.M., LPN 2 indicated she should have preformed hand hygiene and changed her gloves after removing the old dressing and prior to cleaning wound. The clinical record for Resident 22 was reviewed on 03/06/23 at 1:16 P.M. A Quarterly MDS assessment dated 01/06/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, a stroke, hypertension, heart failure, renal insufficiencies, obstructive uropathy, aphasia, and schizophrenia. The resident is totally dependent on staff for bed mobility and transfers, and required the assistance of 2 staff members for ADLs (Activities of Daily Living). The resident had a Stage II pressure ulcer on her left buttocks and left heel. The current facility policy titled, "DRESSING - CLEAN TECHNIQUE" was provided by the ADON on 03/08/23 at 3:16 P.M. The policy indicated "...Remove soiled dressing and discard...Remove gloves, wash hands, and put on a pair of clean gloves..." 3.1-40(a)(2)		is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly **if the audits being conducted are not showing 100% compliance per the regulatory guidance. If 100% compliance is still a concern, the plan of correction will have additional inservice training conducted and additional monitoring added to obtain compliance. The monitoring would continue** daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. 5. The above corrective measures will be completed on or before March 24, 2023.	

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to follow interventions after a fall for 1 of 3 residents reviewed for accidents. (Resident 85) Findings include: During an interview on 03/07/23 at 9:53 A.M., the Dementia Care Coordinator/LPN (Licensed Practical Nurse) 10 indicated Resident 85 had a lot of falls recently where the staff couldn't keep her off the floor. They had tried a lot of different interventions. She was supposed to wear hipsters and they only had one pair at the time due to supply issues. The resident was not wearing the hipsters at that time due to them being wet and waiting for them to be returned from laundry. During an observation on 03/07/23 at 1:54 P.M., Resident 85 was walking in the hallway. The resident had on regular pants and no hipsters in place. During an observation and interview on 03/07/23 at 4:05 P.M., the resident was walking in the dining room. CNA (Certified Nurse Aide) 12 observed Resident 85 and indicated she did not have her hipsters in place.	F 0689	F689 Requires the facility to follow interventions after a fall. 1. Resident 85 order for hipsters was discontinued due to the resident's refusal. 2. All residents have the potential to be affected. Fall interventions for the last 30 days were reviewed to ensure interventions were in place and being followed. No further concerns were noted. See below for corrective measures. 3. The fall prevention program policy and procedure was reviewed with no changes made. (See attachment F) The staff was inserviced on the above procedure. 4. The DON or designee will review 3 residents fall intervention per the plan of care and ensure the interventions are in place and being followed. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance	03/24/2023

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	During an observation and interview on 03/08/23 at 2:14 P.M., the resident was in the dining room walking around. CNA 13 indicated she was unsure if the resident had her hipsters on as she did not get her dressed that morning, CNA 5 had assisted her. CNA 13 assisted the resident into the bathroom and confirmed she did not have her hipsters in place. During an interview on 03/08/23 at 2:18 P.M., CNA 5 indicated the resident hipsters were not available to put on her that morning as laundry had not returned them from the previous day. He had asked laundry about them and they had told him they would keep and eye out for them. During an interview on 03/09/23 at 11:26 A.M., the Housekeeping Supervisor indicated when washing, drying, and returning clothes to the resident's would take about 2 hours. She believed Resident 85's hipsters were to be handwashed only and they had not seen them. During an interview on 03/08/23 at 10:44 A.M., CNA 15 indicated she was made aware of a resident's preferences and interventions from the nurse on duty and the CNA pocket sheet. On 03/08/23 at 2:09 P.M., RN 7 provided the, undated, CNA pocket sheet. There was no indication that Resident 85 was to wear hipsters. The clinical record for Resident 85 was reviewed on 03/06/23 at 2:26 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 02/16/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, non-Alzheimer's dementia and hypertension.		is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly **if the audits being conducted are not showing 100% compliance per the regulatory guidance. If 100% compliance is still a concern, the plan of correction will have additional inservice training conducted and additional monitoring added to obtain compliance. The monitoring would continue** daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. 5. The above corrective measures will be completed on or before March 24, 2023.	

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	A Fall Report, dated 01/18/23, indicated the resident had an unwitnessed fall in her room. There were no injuries noted. The resident's Care Plan for Falls, with a start date of 12/21/22, indicated an intervention, dated 01/19/23, was for the resident to wear hipsters while out of bed. The March 2023 EMAR/ETAR (Electronic Medicaiton Administration Record/Electronic Treatment Administration Record) indicated the resident's hipsters were unavailable on 03/07/23 from 2:30 P.M. through 10:30 P.M., due to being in the laundry. The current facility policy titled, "Fall Prevention Program", dated 10/2014, was provided by Corporate Clinical Nurse on 03/09/23 at 11:45 A.M. The policy indicated, "...To identify residents who are at risk for falls and subsequently implement appropriate, individualized fall preventions interventions...Unit Managers/Charge Nurses are responsible to ensure interventions are implemented as discussed..." 3.1-45(a)(2)			
F 0692 SS=E Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable			

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	parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to provide supplements per the physician's order for a resident with weight loss, implement interventions for weight loss, monitor meal intakes, and follow the Registered Dietician's recommendations for 4 of 5 residents reviewed for nutrition. (Residents 36, 79, 82, and 66) Findings include: 1. During a continuous observation on the Dementia Unit on 03/02/23 from 12:20 P.M. through 12:48 P.M., Resident 36 was asleep in her bed. Her lunch tray was sitting on her over the bed table. The tray was untouched, her 2% milk and ice cream were unopened, no staff entered the room. During an observation on 03/02/23 at 12:49 P.M., the Dementia Care Coordinator/LPN (Licensed Practical Nurse) 10 entered the resident's room and walked back out. She had not woken the resident up. During an interview on 03/02/23 at 12:50 P.M., the Dementia Care Coordinator/LPN 10 indicated	F 0692	F692 Requires the facility to provide supplements per the physician's order for a resident with weight loss, implement interventions for weight loss, monitor meal intakes and follow Registered Dietician recommendations. 1. Resident 36, 82 and 66 were placed on SWAT. Their supplement orders were reviewed and adjusted accordingly per the nurse practitioner after his review. Resident #79 RHC. 2. All residents have the potential to be affected. Weights and meal intakes were reviewed on all residents at this time. Residents were placed on SWAT who had a significant weight loss and supplements were added. No further concerns were noted. See below for corrective measures. 3. The Supplement Use and Indication. SWAT, Dietician Recommendations, and Meal Consumption policy and	03/24/2023

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	when the resident was asleep the staff would try and wake her up. She was very hard of hearing, so it made it difficult. The resident liked to sleep during the day. During an observation on 03/02/23 at 2:37 P.M., Resident 36's lunch tray was sitting on her over the bed table. The ice cream was melted and warm. The carton of 2% milk was warm to the touch. The resident was sleeping. During an observation and interview on 03/06/23 at 12:52 P.M., the resident was sitting on the side of her bed eating lunch. She indicated the lunch was all right and it was the "same ole, same ole." She had a carton of 2% milk on the tray that was unopened. During an observation on 03/07/23 at 9:43 A.M., Resident 36 was asleep in her bed. A breakfast tray was sitting on the over the bed table. Her scrambled eggs and danish were half eaten. There was an empty bowl of what appeared to be oatmeal, and an empty coffee cup. An empty carton of 2% milk was sitting next to a half full glass of milk. The resident's meal ticket laying on the tray indicated she was to get whole milk. The clinical record for Resident 36 was reviewed on 03/06/23 at 1:18 P.M. A Significant Change MDS (Minimum Data Set) assessment, dated 02/06/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, dementia, anemia, hypertension, renal insufficiency, diabetes, anxiety, and depression. The resident had weight loss and was not on a physician prescribed weight loss regimen. The resident's weights were as followed:		procedure were reviewed with no changes made. (See attachment G, H, I, and J) The staff was inserviced on the above procedure. 4. The DON or designee will review all weekly and monthly weights to ensure any resident having a significant weight loss be placed on SWAT immediately and supplements started per physician's order. A resident with weight loss will have their supplements adjusted accordingly based on weights and meal consumption by the physician. The supplement orders will be communicated to the dietary supervisor so she can add them to the resident's meal card. The recommendations of the registered dietician will be reviewed upon each visit and will be followed as well. The Corporate Nurse consultant will review the recommendations to ensure they are addressed and followed after the dietician's visit. The DON or her designee will also observe one meal service a day ensuring supplements are being offered per the physician's order and that meal consumptions are being documented accurately. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See	

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	- 130.1 pounds on admission 08/02/22, - 126.2 pounds on 08/09/22, - 121.2 pounds on 08/16/22, - 118.3 pounds on 08/23/22, - 121.0 pounds on 09/05/22, - 124.1 pounds on 10/05/22, - 120.1 pounds on 11/04/22, - 119.7 pounds on 11/11/22, - 119.2 pounds on 11/18/22, - 119.5 pounds on 11/25/22, - 115.0 pounds on 12/08/22, - 109.9 pounds on 01/05/23, - 113.2 pounds on 02/03/23, and - 115.5 pounds on 03/08/23. During an interview on 03/08/23 at 11:14 A.M., the DON (Director of Nursing) and Corporate Clinical Nurse indicated the resident was not on SWAT (Skin and Weight Assessment Team) since she had taken charge of the facility. She had never removed any SWAT forms from the binder. The resident's weights were stable until December. If she had an order for whole milk, then she should have been getting it on her tray. During an interview on 03/08/23 at 1:35 P.M., the DON indicated she was able to find the resident's SWAT form from the overflow documents and she felt at the end of February the resident weights were stable, so she discontinued her from SWAT. The super cereal (supplement to increase weight) was started in December of 2022, and they should have started a different intervention in January when her weight was down 5 pounds. A SWAT assessment, with a start date of 10/05/22, indicated the following: - 10/05/22, a weight of 124.1 pounds. The MD,		attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly **if the audits being conducted are not showing 100% compliance per the regulatory guidance. If 100% compliance is still a concern, the plan of correction will have additional inservice training conducted and additional monitoring added to obtain compliance. The monitoring would continue** daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. 5. The above corrective measures will be completed on or before March 24, 2023.	

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	dietician and family are aware of the decreased weight, - 11/04/22, a weight of 120.1 pounds and down four pounds. Shakes continued, twice a day with super cereal and whole milk, - 11/11/22, a weight of 119.7 and down 0.4 pounds, - 11/18/22, a weight of 119.2 and down 0.5 pounds. The dietician reviewed the resident on 11/15/22 and the MD was aware, - 11/25/22, a weight of 119.5 and up 0.3 pounds with no new orders, - 12/09/22, a weight of 115 and down 3.5 pounds. A new order to add Boost, a nutritional supplement, at 2 P.M. and cheese sandwich at dinner, - 01/06/23, a weight of 109 pounds and down 5 pounds. Supercereal at breakfast, - 01/13/23, weight refused, - 01/20/23, weight refused, - 02/03/23, weight of 113.2, - 02/10/23, weight of 112.9, and - 02/17/23, weight of 112.0, the weight was stable and would continue with monthly weights. The physician's orders included, but were not limited to,: - an open-ended order with a start date of 08/23/22, for supercereal at breakfast, - an open-ended order with a start date of 08/23/22 for whole milk with meals, - an open-ended order with a start date of 12/09/22 for a cheese sandwich with dinner daily, - an open-ended order with a start date of 08/25/22 for health shake, twice a day, and - an open- ended order with a start date of 12/09/22 for boost shake once a day. The clinical record lacked documentation that a new intervention was in place on 01/06/23 when			

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the resident weight decreased from 115 pounds to 109 pounds or a that the resident had refused to be weighed on 01/13/23 and 01/20/23.

2. The clinical record for Resident 79 was reviewed on 03/06/23 at 1:57 P.M. A Quarterly MDS assessment, dated 01/12/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, anemia, hypertension, pneumonia, UTI (urinary tract infection) in the last 30 days, non-Alzheimer's dementia, anxiety, and malnutrition.

The resident's weights were as followed:

- 134.0 pounds on 08/04/22,
- 136.0 pounds on 09/02/22,
- 135.6 pounds on 10/04/22,
- 136.0 pounds on 11/04/22,
- 147.0 pounds on 12/08/22,
- 149.2 pounds on 01/10/23,
- 121.5 pounds on 02/08/23,
- 118.5 pounds on 02/17/23, and
- 117.5 pounds on 03/06/23.

The physician's orders included, but were not limited to,:

- an open-ended physician's order, with a start date of 02/03/23 to be up in the dining room for all meals,
- an open-ended physician's order, with a start date of 02/23/23 for a house shake with lunch,
- an open-ended physician's order, with a start date of 02/23/23 for ice cream with dinner, and
- an open-ended physician's order, with a start date of 02/23/23 for super cereal with breakfast.

The Meal Ticket for Resident 79 was provided by

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	the Dietary Manager on 03/08/23 at 3:07 P.M. The meal tickets for breakfast, lunch, and dinner, lacked documentation of the prescribed supplements that were to be added to the resident's meal trays. The March 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Medication Administration Record) indicated the resident had received the supplements for breakfast, lunch, and dinner. During an interview on 03/08/23 at 3:05 P.M., the DON indicated the resident had a decline in her health. The resident would thrive when she went to the dining room but had been refusing to get up. The resident was on SWAT and weekly weights. She was started on SWAT on 02/08/23. She had supplements in place. During an interview on 03/09/23 at 11:17 A.M., CNA Student 14 indicated the resident had verbal behaviors at times towards staff. She refused to get out of bed and didn't eat very well. She was unsure if the resident was to have supplements as it was not listed on her CNA sheet. The resident liked to snack throughout the day and the family would provide her with snacks she liked. She would eat those better than her meal sometimes. The current facility policy titled, "Supplement Use and Indications", dated 05/2018, was provided by the Corporate Clinical Nurse on 03/09/23 at 1:05 P.M. The policy indicated, "...Residents with increased nutritional needs will receive additional food items and commercially prepared supplements as necessary..." 3. The clinical record for Resident 82 was reviewed on 03/06/23 at 12:45 P.M. A quarterly MDS assessment, dated 02/02/23, indicated the resident			

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	was cognitively intact. The Diagnoses included, but were not limited to, hypertension, heart failure, renal insufficiency, UTI in the last 30 days, anxiety, depression, diabetes, and dementia. The resident had one stage II pressure ulcer (partial loss of dermis). The resident's weights were as followed: - 238.5 pounds on 08/22, - 223.0 pounds on 11/22, - 227.0 pounds on 12/02/22, - 227.8 pounds on 01/06/23, - 188 pounds on 02/07/23, - 186 pounds on 02/14/23, and - 185 pounds on 02/22/23. The physician's orders included, but were not limited to,: - an open-ended physician's order, with a start date of 02/23/23 for house shake with lunch, - an open-ended physician's order, with a start date of 02/23/23 for ice cream with dinner, and - an open-ended physician's order, with a start date of 02/23/23 for supercereal with breakfast. The Meal Ticket for Resident 82 was provided by the Dietary Manager on 03/08/23 at 3:07 P.M. The meal tickets for breakfast, lunch, and dinner, lacked indication the resident was to have any supplements. The March 2023 EMAR/ETAR indicated the resident had received the supplements for breakfast, lunch, and dinner. During an interview on 03/09/23 at 8:34 A.M., QMA (Qualified Medication Aide) 3 indicated if a resident has super cereal for breakfast it's			

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probably indicated on their meal ticket and she would ask the CNA (Certified Nurse Aide) if the resident had eaten the super cereal and then she would mark it as such in the EMAR/ETAR
.
During an interview on 03/09/23 at 8:39 A.M., CNA 4 indicated supercereal is a high calorie oatmeal, if a resident was supposed to get it, it would be documented on their meal ticket.

During an interview on 03/08/23 at 2:40 P.M., the DM (Dietary Manager) indicated if the Registered Dietitian makes a recommendation, a copy of that recommendation was placed on her desk until the physician signed the orders. If supercereal, ice cream and house shakes are ordered for a resident it would be written on their meal ticket. Dietary Aides would not know to place an item on a meal tray unless it's written on the meal ticket. She was unaware Resident 82 had orders for supercereal, house shakes, or ice cream.
4. During an observation and interview on 03/02/23 at 12:42 P.M., Resident 66, resided on the locked Dementia Unit, was sitting in her recliner in her room eating lunch. She indicated she was saving her dessert for "the kids". The resident's eyes were sunken, and she was thin and bony.

The clinical record was reviewed on 03/07/23 at 9:40 A.M. A Quarterly MDS assessment, dated 01/05/23, indicated the resident was moderately cognitively impaired for daily decision making, decisions were poor, and they required cueing and supervision. The diagnoses included, but were not limited to, Alzheimer's disease and depression. The resident had weight loss and was not on a planned weight loss program. She was 60 inches tall and weighed 80 pounds.

The complete Care Plan was provided by the DON

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	on 03/07/23 at 3:30 P.M. The Nutrition Care Plan, dated 12/08/22, indicated the resident had diagnoses of depression, Alzheimer's disease, and was anemic (lacking enough healthy red blood cells to carry adequate oxygen to body tissues). She had progressive down trending weight changes and an abnormal BMI (Body Mass Index). The interventions included, but were not limited to, monitoring weight and intake. The ADL (Activities of Daily Living) binder that contained paper Meal Consumption Records for the residents for March 2023 were provided by LPN (Licensed Practical Nurse) 10 on 03/07/23 at 10:40 AM. The records for meal consumption lacked documentation for the following dates and meals: - Breakfast on March 2, 3, 4, and 5, 2023, - Lunch on March 2, 3, 4, and 5, 2023, and - Supper on March 4, 2023. During an interview on 03/08/23 at 11:13 A.M., CNA 5, usually worked on the Dementia Unit, indicated they documented meal intakes on paper charts in the ADL (Activities of Daily Living) binder. On the Dementia Unit all residents were monitored for intake and output, intake meaning food and fluids. A Dietary Progress Note written by the RD (Registered Dietician), dated 01/27/23 at 1:43 P.M., was provided by the DON on 03/07/23 at 11:26 A.M., and indicated the resident's meal consumption was fair at times and the resident continued to have weight loss. Staff were to weigh the resident weekly and to monitor the resident's po (by mouth) intake. The resident had the following weights, in the past, on the following dates:			

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	155535	A. BUILDING 00 B. WING	03/09/2023

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- On "10/22" the resident weighed 86.3 pounds.
- On "12/22" the resident weighed 84 pounds.
- On "01/23" the resident weighed 79.8 pounds.

During an interview on 03/07/23 at 10:26 A.M., the DON indicated the resident was weighed weekly on admission and was stable. She was not currently on SWAT. In regard to the RD note on 01/27/23, when the RD did an assessment, the results are relayed to the staff by RD recommendation sheets which were on paper. The RD failed to communicate that the resident needed to be on weekly weights.

During an interview on 03/07/23 at 11:26 A.M., the DON indicated she had interpreted the RD note that she wanted a weight for the resident the next week, not a weekly weight.

During an interview on 03/02/23 at 11:30 A.M., the Corporate Clinical Nurse indicated residents' weights were documented in the computer under vitals.

The "Vitals" report for weights from the EHR (Electronic Health Record) were provided by the DON on 03/07/23 at 11:26 A.M., and included, but were not limited to, the following weights and BMI (Body Mass Index) values:

- 10/28/22 (Admission Date), the resident weighed 86.3 pounds with a BMI of 16.85,
- 11/25/22 (four weeks after admission), the resident weighed 88 pounds with a BMI of 17.18,
- 12/08/22, the resident weighed 84 pounds with a BMI of 16.4, a weight loss of 4.5% in 13 days, and
- 01/05/23, the resident weighed 79.5 pounds with a BMI of 15.52, and
- 02/03/23, the resident weighed 83.2 pounds with

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	a BMI of 16.25. No further weights were documented for the resident after 02/03/23. The CDC (Centers for Disease Control) guidelines indicate if your BMI is less than 18.5, it falls within the underweight range. The current "DIETICIAN RECOMMENDATION" policy, dated 10/2014, was provided by the Corporate Clinical Nurse on 03/09/23 at 11:45 A.M. The policy indicated, "...PURPOSE...To ensure the nutritional status of each resident is reviewed, as warranted and necessary nutritional recommendations made and followed as deemed appropriate...Administrative nursing staff shall be responsible to ensure said recommendations are communicated to the resident's physician as soon as possible, but no later than three (3) days from receiving said recommendation. Physician response shall be documented and implemented accordingly..." The current "MEAL CONSUMPTION RECORD" policy, dated 10/2014, was provided by the Corporate Clinical Nurse on 03/09/23 at 1:05 P.M. The policy indicated, "...Percentage of meals consumed daily will be recorded on the document designated by the facility...At the end of each meal, resident trays should be observed and percentage of food consumed recorded on Meal Consumption Record..." The current facility policy titled, "Skin & Weight Assessment Team (SWAT)", with a revised date of 4/2019, was provided by the Corporate Clinical Nurse on 03/09/23 at 3:29 P.M. The policy indicated, "...It is the protocol of this facility to aggressively review and address those residents exhibiting significant/insidious weight change or			

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	skin breakdown. These residents will be monitored by SWAT on a weekly basis involving all applicable disciplines in an effort to improve each resident's nutritional status...This team will monitor those residents at nutritional risk and determine the appropriate intervention(s) to best address each resident's needs...Indicators of needed implementation of SWAT monitoring:...All residents weighing 85 lbs. or less...SWAT will address significant weight loss and/or open areas of the skin, to ensure that each resident's needs are addressed individually based on preferences and overall medical conditions...A resident shall continue to be reviewed by SWAT on a weekly basis until one of the following conditions has been met: Weight Loss - Three months at a stable weight..." 3.1-46(a)(1)			
F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to provide the required RN (Registered	F 0727	F727 Requires the facility to provide a required RN on duty 8	03/24/2023

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	Nurse) on duty for eight hours a day for 1 of the 15 days reviewed. Findings include: The "Daily Staffing Assignment" sheets for nursing staff for the survey time period were provided by the DON on 03/08/23. The staffing sheets lacked documentation that there was an RN on duty for eight consecutive hours on Sunday, March 5, 2023. During an interview on 03/09/23 at 10:10 A.M., the DON (Director of Nursing) indicated there was no RN working in the facility on 03/5/23 (Sunday). Recently, an RN changed her schedule and she didn't work weekends anymore and another RN left the facility. On 03/09/23 10:22 A.M., the DON indicated they did not have a facility policy for RNs working in the building, they followed the regulatory guidance. 3.1-17(b)(3)		hours a day. 1. The nursing schedule was reviewed to ensure an RN was scheduled every day for at least 8 hours. 2. All residents have the potential to be affected. The schedule was reviewed for the last 30 days and for the remaining days for the current schedule. No further concerns were noted. See below for corrective measures. 3. The staff was inserviced on the regulatory guidance that an RN must be present in the facility at least 8 hours a day. 4. The DON or designee will review daily the nursing schedule to ensure an RN is staffed at least 8 hours a day. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly **if the audits being conducted are not showing 100% compliance per the regulatory guidance. If 100% compliance is still a concern, the plan of correction will have additional inservice training conducted and additional**	

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			monitoring added to obtain compliance. The monitoring would continue daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. 5. The above corrective measures will be completed on or before March 24, 2023.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.			

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	§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to ensure a resident's medications were available for 1 of 2 residents reviewed for pain management. (Resident 26) Findings include: During an interview on 03/03/23 at 2:20 P.M., Resident 26 indicated her medications were sometimes late, and there have been a few times her medications were not available. The resident's clinical record was reviewed on 03/06/23 at 10:27 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 01/13/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, heart failure, diabetes, anxiety, depression, and chronic pain. The resident's current physician's orders included, but were not limited to, the following: An open-ended order, with a start date of 12/27/22, for Lyrica (a medication that can be used to treat diabetic nerve pain), 125 mg (milligrams) three times a day. The medication was to be administered at 6:30 A.M., 12:00 P.M., and 8:00 P.M.	F 0755	F755 Requires the facility to ensure a resident's medication is available for pain management. 1. Resident 26's Lyrica was ordered and no further dose was missed. 2. All residents have the potential to be affected. A medication audit was conducted to ensure medications were available for administration. No further concerns were noted. See below for corrective measures. 3. The Medication Preparation policy and procedure was reviewed with no changes made. (See attachment C) The staff was inserviced on the above procedure. 4. The DON or designee will review all medication administration records daily to ensure medications are given per the physician's order. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See	03/24/2023

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	The February 2023 EMAR (Electronic Medication Administration Record) was provided by the DON (Director of Nursing) on 03/08/23 at 3:43 P.M. The EMAR indicated the medication was not administered because it was unavailable on the following dates and times: - 02/03/23 at 8:00 P.M., and - 02/04/23 at 6:30 A.M., 12:00 P.M., and 8:00 P.M., and - 02/05/23 at 6:30 A.M., and 12:00 P.M. The pharmacy was notified the medication was not available on 02/05/23. During an interview on 03/08/23 at 1:41 P.M., LPN (Licensed Practical Nurse) 16 indicated if a medication wasn't available, the nurse should notify the pharmacy and check to see if the medication was available in the EDK (Emergency Drug Kit) in the facility. It would depend on the medication, but common medications were usually readily available. If the medication wasn't on hand, the pharmacy would usually be able to send it on the next delivery. Pharmacy delivered medications every night. The clinical record lacked documentation of an attempt to remove the medication from the EDK. The first documented notification to the pharmacy was after the fifth dose of the medication was missed. The current facility policy, titled "Medication Preparation", and dated 10/2014, was provided by the Corporate Clinical Nurse on 03/09/23 at 2:43 P.M. The policy indicated, "...the medication is not available/in supply, the following actions shall be taken...Check availability of the medication in the EDK...If not available in the EDK, contact the		attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly **if the audits being conducted are not showing 100% compliance per the regulatory guidance. If 100% compliance is still a concern, the plan of correction will have additional inservice training conducted and additional monitoring added to obtain compliance. The monitoring would continue** daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. 5. The above corrective measures will be completed on or before March 24, 2023.	

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	pharmacy to determine earliest delivery...if pharmacy delivery time will cause the ordered medication to be outside acceptable administration time(s), the physician/NP [Nurse Practitioner] should be notified of the unavailable medication and physician/NP orders/instructions followed and documented..." 3.1-25(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 §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 follow the physician's orders related to medication administration hold parameters for cardiac medications for 3 of 8	F 0757	F757 Requires the facility to follow physician's orders related to medication administration related to medication administration hold	03/24/2023

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	residents reviewed for medications (Residents 24, 53, and 70) Findings include: 1. During an observation and interview on 03/02/23 at 3:12 P.M., Resident 24 indicated he had no concerns related to his medications. The resident walked from one side of the room to his chair with a slow but steady gait. The resident's clinical record was reviewed on 03/08/23 at 9:11 A.M. A Significant Change MDS (Minimum Data Set) assessment, dated 12/24/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, cancer, coronary artery disease, hypertension, orthostatic hypotension, diabetes, and renal failure. The resident's current physician's orders included an open ended order, with a start date of 01/03/23, for midodrine (a medication used to treat low blood pressure) 5 mg (milligrams) once a day. The special instructions indicated the medication was to be held for a sbp (systolic blood pressure) < (less than) 100. The medication administration time frame was from 6:30 A.M. to 2:30 P.M. The January, February, and March EMARs (Electronic Medication Administration Record) indicated the medication was not administered on the following dates: - On 01/17/23 the medication was held on due to the resident's condition, - On 01/18/23 the medication was held because the resident's blood pressure was 152/76, and - On 03/08/23 the medication was held because the blood pressure was 151/76.		parameters for cardiac medications. 1. Resident 24, 53 and 70 parameters for their cardiac medications were reviewed with the physician. 2. All residents have the potential to be affected. An audit of all parameter orders for cardiac medications were reviewed for the last 30 days. No concerns were noted. See below for corrective measures. 3. The medication administration policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the above procedure. 4. The DON or her designee will daily review all parameters for cardiac medications to ensure the medication is administered per the physician's order. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly **if the audits being conducted are not showing 100% compliance per the regulatory guidance. If 100% compliance is still a concern,**	

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	The documentation indicated the medication was administered all the other days. There was no documentation of a blood pressure assessment prior to administering the medication. During an interview on 03/08/23 at 1:44 P.M., LPN (Licensed Practical Nurse) 16 indicated the resident received midodrine for his low blood pressures. If the resident's sbp was 120 or above, they would hold the medication. He took other medications for high blood pressure and those medications had different parameters. She didn't give him the midodrine today because his blood pressure was more elevated. They were to assess the resident's blood pressure just before administering the medication and document it in the computer. They could use a blood pressure reading that was within the hour of administration, but anything older than that should be reassessed before giving the medication. The resident's vitals report from 01/01/23 through 03/08/23 was provided by the Regional Director on 03/09/23 at 3:00 P.M. The resident's documented blood pressures were reviewed. The resident's sbp was 98/59 on 01/15/23 at 8:59 A.M. There were no other blood pressure assessments that indicated the sbp less than 100 during that time. During an interview on 03/08/23 at 1:58 P.M., the DON (Director of Nursing) contacted the NP (Nurse Practitioner) by phone for clarification on the midodrine order. The NP indicated the resident should receive the midodrine if his sbp was less than 100. The DON indicated the order should have read hold if the sbp was > (greater than) 100. The order was put in the computer to hold if the sbp was < (less than) 100. The DON indicated		**the plan of correction will have additional inservice training conducted and additional monitoring added to obtain compliance. The monitoring would continue** daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. 5. The above corrective measures will be completed on or before March 24, 2023.	

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	there should be a place in the EMAR to document the blood pressure prior to administering the medication. 2. The clinical record for Resident 53 was reviewed on 03/06/23 at 2:52 P.M. A Significant Change MDS assessment, dated 02/18/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension, diabetes, non- Alzheimer's dementia, and anxiety. An open-ended physician's order, with a start date of 09/23/22, indicated the staff were to administer midodrine 5 mg, twice a day. The medication was to be held if the systolic blood pressure was greater than 100. The January and February 2023 EMAR/ETAR indicated the resident had received the medication when the systolic blood pressure was greater that 100 on the following dates and times: - 01/01/23, the morning blood pressure was 136/76 and the evening blood pressure was 112/55, - 01/02/22, the evening blood pressure was 126/96, - 01/03/23, the morning blood pressure was 121/77, - 01/04/23, the morning blood pressure was 112/58, - 01/05/23, the morning blood pressure was 115/38, - 01/06/23, the morning blood pressure was 124/71, - 01/07/23, the morning blood pressure was 132/68, - 01/08/23, the morning blood pressure was 132/68 and the evening blood pressure was 122/66, - 01/12/23, the morning blood pressure was 146/74 and the evening blood pressure was 130/74, - 01/14/23, the morning blood pressure was 128/66 and the evening blood pressure was 134/72, - 01/17/23, the evening blood pressure was 125/75, - 01/25/23, the morning blood pressure was 130/74, - 02/02/23 the morning blood pressure was 112/64, - 02/04/23, the evening blood pressure was 111/62,			

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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
	- 02/06/23, the evening blood pressure was 121/87, - 02/17/23, the evening blood pressure was 125/63, - 02/18/23, the evening blood pressure was 142/64, - 02/19/23, the morning blood pressure was 112/54 and the evening blood pressure was 112/54, - 02/23/23, the morning blood pressure was 134/86, - 02/24/23, the evening blood pressure was 112/56, - 02/26/23, the evening blood pressure was 116/68, - 02/27/23, the evening blood pressure was 112/57, and - 02/28/23, the morning blood pressure was 131/70 and the evening blood pressure was 112/66. The clinical record lacked indication the medication was held for the above dates and times. A Hypertension Care Plan, dated 08/01/22, indicated an intervention to administer the medications as ordered. During an observation on 03/06/23 at 12:55 P.M., Resident 53 was lying in bed, asleep. 3. The clinical record for Resident 70 was reviewed on 03/06/23 at 3:03 P.M. A Quarterly MDS assessment, dated 01/04/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, end-stage renal disease, anemia, hypertension, and depression. An open-ended physician's order, with a start date of 09/27/22, indicated the staff were to administer lisinopril (an antihypertensive medication) 20 mg, once a day. The medication was to be held if the systolic blood pressure was less than 130. The January, February, and March 2023 EMAR/ETAR indicated the resident had received			

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	155535	A. BUILDING 00 B. WING	03/09/2023

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	the medication when the systolic blood pressure was less than 130 on the followings dates: - 01/03/23, the blood pressure was 127/81, - 01/06/23, the blood pressure was 123/67, - 01/10/23, the blood pressure was 108/58, - 01/16/23, the blood pressure was 114/71, - 01/31/23, the blood pressure was 124/70, - 02/01/23, the blood pressure was 97/67, - 02/07/23, the blood pressure was 129/70, - 02/09/23, the blood pressure was 123/69, - 02/11/23, the blood pressure was 121/83, - 02/16/23, the blood pressure was 124/68, - 02/19/23, the blood pressure was 126/85, - 02/25/23, the blood pressure was 121/87, - 02/27/23, the blood pressure was 126/68, - 02/28/23, the blood pressure was 102/80, - 03/01/23, the blood pressure was 107/81, - 03/04/23, the blood pressure was 128/66, - 03/05/23, the blood pressure was 128/66, and - 03/07/23, the blood pressure was 119/87. The clinical record lacked indication the medication was held for the above dates. A Hypertension Care Plan, dated 04/23/21, indicated an intervention to administer the medications as ordered. During an observation on 03/08/23 at 10:41 A.M., the resident was laying in bed. Her call light was in reach and she had no concerns. During an interview on 03/07/23 at 9:57 A.M., the Dementia Care Coordinator/LPN (Licensed Practical Nurse) 10 indicated if a resident's medications had hold parameters prior to administration the nurse would obtain the required vital signs before giving the medication. If the vital signs were outside of the parameters,			

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	then the medication was not to be given and documented in the EMAR/ETAR as to why it wasn't given. The current facility policy titled, "Physician Orders" dated 10/2014, was provided by the Social Service/Activity Consultant on 03/07/23 at 2:56 P.M. The policy indicated, "...Physician's orders are administered upon the clear, complete and signed order of an individual lawfully authorized to prescribe...Facility nursing personnel will ensure clear, accurate and complete physician orders...Transcribe new order onto MAR or TAR, as indicated. Ensure any follow through is completed..." The current facility policy titled, "Medication Administration" with a revision date of 4/2017, was provided by the Corporate Clinical Nurse on 03/09/23 at 10:30 A.M. The policy indicated, "...To safely administer medications as per physicians' order...Licensed or qualified personnel shall be responsible to follow accepted practices of medication administration as per physicians' orders...Always take pulse and B/P [blood pressure] as indicated if ordered prior to giving certain cardiac or antihypertensive drugs..." 3.1-48(a)(6)			
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;			

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

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	Based on observation, interview, and record review, the facility failed to follow the physician's orders related to a GDR (Gradual Dose Reduction) of a psychotropic medication and ensure usage of a PRN (as needed) psychotropic medication was limited to 14 days for 2 of 6 residents reviewed for unnecessary medications. (Residents 24 and 95) Findings include: 1. During an observation and interview on 03/02/23 at 3:12 P.M., Resident 24 indicated he had no concerns related to his medications. The resident's clinical record was reviewed on 03/08/23 at 9:11 A.M. An Admission MDS (Minimum Data Set) assessment, dated 09/23/22, indicated the resident was moderately cognitively intact. The diagnoses included, but were not limited to, cancer, coronary artery disease, diabetes, dementia, anxiety, and depression. The resident received an antipsychotic medication on three of the seven days of the assessment review period. The resident's physician's orders included an order, with a start date of 09/19/22 for risperidone (an antipsychotic medication), 1 mg (milligram) at bedtime, for anxiety. The resident received the medication every evening as ordered. A pharmacy note to the physician, dated 10/10/22, indicated the resident was receiving risperidone for a diagnosis of anxiety. Additional criteria would need to be met for the anxiety diagnosis to justify the use of the antipsychotic medication. The pharmacist recommended the following GDR and discontinuation of the medication: -Reduce the resident's risperidone to 0.75 mg for	F 0758	F758 Requires the facility to follow the physician's order related to a GDR of a psychotropic medication and ensure useage of a prn psychotropic medication was limited to 14 days. 1. Resident 24 GDR was effective with no adverse reaction. Resident 95 prn psychotropic medication was discontinued. 2. All residents have the potential to be affected. An audit was completed to ensure prn psychotropic medications were not given past 14 days. Pharmacy recommendations were reviewed for the last 30 days to ensure physician's orders were transcribed correctly per the recommendation. No concerns noted. See below for corrective measures. 3. The prn medication and physician's orders policy and procedure were reviewed with no changes made. (See attachment L and C) The staff was inserviced on the above procedure. 4. The DON or her designee will review prn medications daily to ensure medications are given per the physician's order. The DON or her designee will review monthly the pharmacy recommendations to ensure the physician order is transcribed correctly per the recommendation. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four	03/24/2023

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	seven days, then to 0.5 mg for seven days, then 0.25 mg for seven days, then discontinue. The physician agreed with the recommendation to gradually reduce and discontinue the medication. The clinical record indicated the resident's last dose of the risperidone 1 mg was received on 10/16/22. The record lacked documentation the resident's medication was tapered and then discontinued as recommended by the pharmacist and ordered by the physician. During an interview on 03/09/23 at 2:40 P.M., the Corporate Social Services Support Staff indicated there was no documentation that the risperidone was tapered as ordered when the medication was discontinued. The medication should have been tapered and discontinued as ordered. 2. During an interview on 03/06/23 at 12:54 P.M., Resident 95 indicated he took medication for anxiety daily. The resident's clinical record was reviewed on 03/08/23 at 9:01 A.M. An Admission MDS assessment, dated 01/24/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, diabetes, stroke, hemiplegia, and anxiety. The resident's current physician's orders included an open-ended order, with a start date of 01/22/23, for alprazolam, 0.25 mg twice a day, as needed for anxiety, for up to two days. The January and February 2023 EMAR (Electronic Medication Administration Records) were provided by the DON on 03/09/23 at 2:16 P.M. The EMAR indicated the resident received the anxiety		weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly **if the audits being conducted are not showing 100% compliance per the regulatory guidance. If 100% compliance is still a concern, the plan of correction will have additional inservice training conducted and additional monitoring added to obtain compliance. The monitoring would continue** daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. 5. The above corrective measures will be completed on or before March 24, 2023.	

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	medication on the following dates and times: - On 01/22/23 at 9:56 A.M., - On 01/24/23 at 2:48 P.M., - On 01/27/23 at 5:44 P.M., - On 01/28/23 at 3:23 P.M., - On 01/29/23 at 7:39 P.M., - On 01/31/23 at 3:25 P.M., - On 02/03/23 at 2:25 P.M., - On 02/04/23 at 9:07 A.M. and at 7:09 P.M., - On 02/05/23 at 10:35 P.M., - On 02/06/23 at 7:59 P.M., - On 02/09/23 at 4:48 P.M., - On 02/11/23 at 4:31 A.M., - On 02/12/23 at 9:31 P.M., and - On 02/13/23 at 12:51 P.M. A pharmacy note to the physician, dated 02/14/23, indicated the resident's PRN order for the alprazolam expired 14 days from the start date. The medication must be discontinued unless the order was extended. The February EMAR indicated the resident continued to receive the PRN medication on the following dates and times: - On 02/14/23 at 11:17 A.M., - On 02/16/23 at 11:48 A.M., - On 02/17/23 at 9:20 A.M., - On 02/18/23 at 6:32 P.M., - On 02/19/23 at 5:02 P.M., - On 02/20/23 at 12:55 P.M., - On 02/22/23 at 5:59 A.M., and - On 02/23/23 at 3:17 P.M. The physician's response to the pharmacy note, dated 02/24/23, was to continue the medication order for the time being due to the resident dealing with social and legal stressors.			

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During an interview on 03/09/23 at 1:30 P.M., the DON indicated she and the ADON (Assistant Director of Nursing) usually took turns reviewing newly admitted residents' physician's orders. They would review each order and request clarification on any orders they had questions about. She was unsure why the medication order indicated the medication was to be given for "up to two days". The alprazolam order should have been clarified when the order was reviewed, or shortly thereafter. There should have been a stop date issued for the medication. Pharmacy recommendations were usually addressed by the physician or the NP (Nurse Practitioner) within 48 hours of the recommendation. Sometimes they were addressed sooner, as the NP was in the building often, and available by phone at all times.

The current facility policy, titled "PRN MEDICATIONS", with a revision date of 09/17, was provided by the DON on 03/18/23 at 11:50 A.M. The policy indicated, "...PRN orders for psychotropic drugs shall be limited to 14 days..."

The current facility policy titled, "Physician Orders" dated 10/2014, was provided by the Social Service/Activity Consultant on 03/07/23 at 2:56 P.M. The policy indicated, "...Physician's orders are administered upon the clear, complete and signed order of an individual lawfully authorized to prescribe...Facility nursing personnel will ensure clear, accurate and complete physician orders...Transcribe new order onto MAR or TAR, as indicated. Ensure any follow through is completed..."

3.1-48(a)(6)
3.1-48(b)(2)

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F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to store medications appropriately related to insulin pens for 3 of 3 medication carts reviewed (100 Hall cart, 200 Hall cart, and 300 Hall cart), and for 5 of 12 residents' medications observed. (Residents 82, 39, 36, 41 and 52). Findings include: 1. The 200 Hall Medication Cart was observed on	F 0761	F761 Requires the facility to store medications appropriately related to insulin pens. 1. Resident 82, 39, 36, 41 and 52's Insulin pens had a date open placed on the pens and if expired the pens were discarded. 2. All residents have the potential to be affected. A medication cart audit was completed ensuring all medications that need a date open	03/24/2023

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	03/09/23 at 9:33 A.M., with QMA (Qualified Medication Aide) 3 and contained the following: - a Lantus insulin pen for Resident 82 had an unclear opened date that was 1/2 full. - a Nololog insulin pen for Resident 82 had an opened date of 02/03/23 that was 1/4 full. During an interview on 03/09/23 at 9:34 A.M., the QMA indicated the Lantus pen date was unclear and open dates should be on all medications when they are placed in the medication cart. Insulin pens are good for 30 days. "MEDICATIONS WITH SHORTENED EXPIRATION DATES" was provided by the ADON (Assistant Director of Nursing) on 03/09/23 at 11:51 A.M. "...Lantus Good for 28 days after opening or removing from the refrigerator...Novolog Flexpen Good for 28 days after opening or removing from the refrigerator..." 2. The 100 Hall Medication Cart was observed on 03/09/23 at 10:32 A.M., with LPN (Licensed Practical Nurse) 6 and contained the following: - a Levamir insulin pen with no open date for Resident 39 that was 1/2 full. During an interview on 03/09/23 at 10:33 A.M., the LPN indicated the resident received the medication every night. The insulin pen should have had an opened date written on it, it's good for about 40 days. "MEDICATIONS WITH SHORTENED EXPIRATION DATES" was provided by the ADON (Assistant Director of Nursing) on 03/09/23 at 11:51 A.M. "...Levemir May be kept at		date has one present and all expired medications are discarded. No further concerns. See below for corrective measures. 3. The medications with shortened expiration dates policy and procedure was reviewed with no changes made. (See attachment M) The staff was inserviced on the above procedure. 4. The DON or her designee will complete a medication cart audit to ensure all insulin pens have a date open labeled on the pen and that all pens that are expired are discarded. The DON or her designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly **if the audits being conducted are not showing 100% compliance per the regulatory guidance. If 100% compliance is still a concern, the plan of correction will have additional inservice training conducted and additional monitoring added to obtain compliance. The monitoring would continue** daily times four	

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	room temperature for up to 42 days..." 3. The 300 Hall Medication Cart was observed on 03/09/23 at 11:38 A.M., with RN 7 and RN 8 and contained the following: - a Basaglar insulin pen for Resident 36 with an opened date of 01/30/23 that was 1/2 full. During an interview, on 03/09/23 at 11:39 A.M., RN 7 indicated she didn't think the resident was receiving this medication any longer. The February 2023 EMAR (Electronic Medication Administration Record) was provided by the ADON on 03/09/23 at 4:09 P.M., indicated Resident 36 had an order for Basaglar insulin pen with a start date of 12/21/22 and a discontinue date of 02/23/23. During an interview on 03/09/23 at 4:01 P.M., the ADON indicated any discontinued medication should be removed from the medication cart. The current facility policy titled, "STORING DRUGS" dated 12/2017, was provided by the ADON on 03/09/23 at 11:51 A.M. The policy indicated "...11. Any outdated, contaminated, or deteriorated drugs...must be removed from stock..." 4. The 200 Hall Medication Cart was observed on 02/23/23 at 9:33 A.M., with QMA 3 and contained the following in the top drawer: - a medication cup containing 7 medications with Resident 41's name written on the side. - a medication cup containing 3 medications with Resident 52's name written on the side.		weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. 5. The above corrective measures will be completed on or before March 24, 2023.	

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	During an interview on 03/09/23 at 10:36 A.M., QMA 3 indicated the cups contained the morning medications for the residents. The medications should have not been sitting in the cups. The current facility policy titled, "HEALTH FACILITIES; LICENSING AND OPERATIONAL STANDARDS" was provided by the ADON on 03/09/23 at 11:46 A.M. The policy indicated "...Setting up of doses for more than one (1) scheduled administration is not permitted..." 3.1-25(m)			
F 0812 SS=D 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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(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
	Based on observation and interview, the facility failed to maintain residents' snack refrigerators related to storing staff's food items for 1 of 2 resident snack refrigerators reviewed. (Dementia Unit refrigerator) Findings include: The Nourishment Pantry on the locked Dementia Unit was observed on 03/09/23 at 2:47 P.M., with AA (Activities Assistant) 9. The residents' snack refrigerator contained the following: - A large Styrofoam cup with a lid and a straw labeled with a name identified by AA 9 as an employee's, - A large local restaurant plastic cup of clear liquid with ice, a lid, and a straw with no name or date that was 3/4 full, and - A large red insulated bag located on the bottom shelf that contained a staff members lunch as identified by the Administrator. A nurse identified it as her lunch. During an interview, on 03/09/23 at 2:49 P.M., AA 9 indicated it was the residents' snack refrigerator. Their policy was to label items that were for a specific resident. Staff were supposed to put their things in the break room. The current "Nourishment Pantries" policy, dated 05/2018, was provided by the Administrator on 03/09/23 at 3:20 P.M. The policy indicated, "...No employee food items should be stored with resident's nourishments..." 3.1-21(i)(3)	F 0812	F812 Requires the facility to maintain residents' snack refrigerators related to storing staff's food items. 1. Staff food items were removed from the resident's refrigerator. 2. All residents have the potential to be affected. All resident refrigerator was observed to ensure no staff food was not present in the refrigerator. Staff was immediately inserviced on not storing food in the resident's refrigerator. No further concerns. See below for corrective measures. 3. The Nourishment pantries policy and procedure was reviewed with no changes made. (See attachment N) The staff was inserviced on the above procedure. 4. The DON or her designee will conduct rounds daily ensuring no staff food is stored in the resident's refrigerator. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly **if the audits being conducted are not showing 100% compliance per the**	03/24/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155535	A. BUILDING 00 B. WING	03/09/2023

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			regulatory guidance. If 100% compliance is still a concern, the plan of correction will have additional inservice training conducted and additional monitoring added to obtain compliance. The monitoring would continue daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. 5. The above corrective measures will be completed on or before March 24, 2023.	