STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155803	A. BUILDING 00 B. WING	11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HAMILTON POINTE HEALTH AND REHAB	3800 ELI PLACE NEWBURGH, IN 47630

(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 and Investigation of Complaints IN00391521, IN00387822, and IN00383534. This visit included a State Residential Licensure Survey. Complaint IN00391521 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00387822 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580 and F776. Complaint IN00383534 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: November 14, 15, 16, 17, 18, 21, 22, 2022 Facility number: 012966 Provider number: 155803 AIM number: 201110390 Census Bed Type: SNF/NF: 78 SNF: 21 Residential: 48 Total: 147 Census Payor Type: Medicare: 11 Medicaid: 57 Other: 17 Total: 62 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shawn Cates	Administrator	12/13/2022

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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	Quality review completed on December 2, 2022.			
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.			

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	(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on observation, interview and record review, the facility failed to notify a resident's family related to the need to alter treatment in 1 of 4 residents reviewed for falls. A resident's family was not notified of a delay for a STAT (immediate) X-Ray order following a fall that resulted in a hip fracture.(Resident G) Findings include: On 11/21/22 at 1:42 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, history of falling, and presence of left artificial hip joint. An MDS (minimum data set) Assessment was not available due to the resident being admitted to the facility on 7/6/22 and discharging 7/10/22. A physician narrative progress note, dated 7/7/22, indicated Resident G was pleasantly confused and the provider was unable to assess the resident's cognition. Nursing notes were reviewed and indicated the following:	F 0580	The facility will ensure this requirement is met through the following corrective measures: 1. Resident G no longer resides at the facility. The facility changed radiology providers following this occurrence. 2. All residents have the potential to be affected. See below for corrective measures. 3. The policy for Notification of Changes in Condition was reviewed and no changes were indicated. Licensed staff will be re-educated on this policy. The DON or his designee will audit 10 random residents per week for 6 weeks and until 100% compliance is achieved, then 10 per month for 6 months and until 100% compliance is maintained, to ensure changes in condition are communicated timely. 4. The findings of these audits/observations will be	12/21/2022

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	On 7/8/22, the resident was found at 11:20 A.M. on the floor of her bedroom by her wheelchair. Resident G showed no signs of pain and was unable to answer when asked about pain. On 7/8/22, the resident was found at 5:25 P.M. laying on her left side on the floor near the nurse's station. Upon assessment, blood was found on the resident's hands, eyebrows, nose and carpet. Bleeding was actively occurring from her left nostril and the bridge of her nose had minimal swelling at that time. Resident G could not state if pain existed. On 7/8/22 at 6:35 P.M., the facility received an order from Resident G's primary physician for a STAT X-Rays of the left hip and left shoulder due to an unwitnessed fall. On 7/8/22 at 6:36 P.M., the contracted mobile radiology service provider was notified of STAT X-Ray orders. On 7/9/22 at 7:30 P.M., Resident G's family called the facility for the X-Ray results. At that time, the facility contacted the contracted mobile radiology service provider back and was told STAT X-Rays would be done in the morning on 7/10/22. On 7/10/22 at 1:02 P.M., Resident G's family came into the facility concerned the STAT X-Rays were not yet completed and requested resident be sent to the ER (emergency room) for evaluation. On 7/10/22, ER records indicated imaging completed during the ER visit identified an acute appearing subtrochanteric proximal left femur fracture. The resident was subsequently admitted to the hospital and had an ORIF (open reduction		presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	and internal fixation) surgical repair of the left periprosthetic femur fracture, and a revision of the femoral component of recent left hip arthroplasty (joint replacement surgery) and was discharged on 7/14/22. On 11/22/22 at 9:53 A.M., a service agreement between the mobile radiology service provider and the facility, dated 12/23/21, was provided by the DON (Director of Nursing) and indicated the mobile radiology service provider shall "provide radiology services for facility patients in accordance with: accepted standards of medical care ... ". It lacked a definition of the timeframe a STAT order should be completed. During an interview on 11/22/22 at 9:00 A.M., the contracted mobile X-Ray service provider was contacted and staff indicated a STAT order should be completed within 2-4 hours. The contracted company is located 182 miles, approximately 2 (two) hours and 54 (fifty-four) minutes away from the facility. During an interview on 11/22/22 at 9:51 A.M., the DON indicated staff would be expected to notify family if mobile X-Ray company did not show up for STAT order. He further indicated family should have been notified before they requested ER visit. During an interview on 11/21/22 at 8:50 A.M., the DON indicated there was not a current policy for a timeframe in which STAT orders need to be completed. He further indicated they go by whatever the company providing the mobile service defines as STAT. On 11/22/22 at 8:27 A.M., a physician/clinician/family/responsible party			

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	notification for change in condition policy, revised February 2022, was provided and indicated the facility must immediately inform the resident or resident representative when there is a need to alter treatment. This Federal tag relates to Complaint IN00387822. 3.1-5(a)(3)			
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 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			

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	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; (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			

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	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 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 record review and interview, the facility failed to provide transfer/discharge notice to the resident upon transfer to the ER (emergency room) for 2 of 6 residents reviewed for hospitalizations. Residents were not provided with transfer/discharge notice. (Residents 20, Resident 91) Findings include:	F 0623	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. The residents had returned to planned destination when identification of the deficient practice occurred. 2. All residents have the potential	12/21/2022

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	1. On 11/16/22 at 1:44 P.M., Resident 20's clinical record was reviewed. Diagnosis included, but were not limited to, cellulitis of right lower limb, cellulitis of left lower limb, and chronic venous hypertension with ulcer of lower extremity. The most recent admission MDS (minimum data set) Assessment, dated 10/26/22, indicated Resident 20 was cognitively intact. A hospital discharge note indicated Resident 20 had been hospitalization from 11/7/22 to 11/9/22 for right lower extremity cellulitis, mild hypokalemia, mild hypomagnesemia, hypertension, hyperlipidemia, and diabetes mellitus. Resident 20's clinical record lacked information that the notice of transfer or discharge form was provided to the resident on 11/7/22. During an interview on 11/21/22 at 1:25 P.M., the DON (Director of Nursing), indicated the transfer or discharge form could not be located for Resident 20's ER visit on 11/7/22. 2. On 11/16/22 at 3:14 P.M., Resident 91's clinical record was reviewed. Diagnoses included, but were not limited to, malignant neoplasm of lung, COPD (chronic obstructive pulmonary disease), and diabetes mellitus type II. The most recent quarterly MDS, dated 10/3/22, indicated resident was cognitively intact. On 9/21/22, nurse's notes indicated the resident complained of shortness of breath and requested to be sent to the ER (emergency room). The resident returned to the facility on 9/26/22. During an interview on 11/21/22 at 1:25 P.M., the DON indicated there was no documentation of		to be affected. All resident who are currently at the hospital were audited to ensure transfer/discharge/bedhold forms were completed and a copy provided to the residents. 3. The Admission/Transfer/Discharge policy was reviewed and no changes were indicated. Licensed staff will be re-educated on this policy. The SSD or his designee will audit all discharges to ensure copies were provided 5 times a week for 6 weeks and until 100% compliance is achieved, then weekly for 6 months and until 100% compliance is maintained. 4. The findings of these audits/observations will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	transfer notice given to the resident or representative for the transfer to ER on 9/21/22. During an interview on 11/21/22 at 9:36 A.M., LPN 9 indicated that transfer notice should be given if a resident is transferred to the ER for evaluation. On 11/22/22 at 8:27 A.M., a current Admission, Transfer, Discharge Policy, revised 10/31/22, was provided and indicated "Before a facility transfers or discharges a resident, the facility must: Notify the resident and 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". 3.1-12(a)(6)(A)			
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and			

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	(iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on record review and interview, the facility failed to provide Bed Hold notice to resident upon transfer to the ER (emergency room) for 2 of 6 residents reviewed for hospitalizations. Residents were not provided with Bed Hold notice. (Residents 20, Resident 91) Findings include: 1. On 11/16/22 at 1:44 P.M., Resident 20's clinical record was reviewed. Diagnosis included, but were not limited to, cellulitis of right lower limb, cellulitis of left lower limb, and chronic venous hypertension with ulcer of lower extremity. The most recent admission MDS (minimum data set) Assessment, dated 10/26/22, indicated Resident 20 was cognitively intact. A hospital discharge note indicated Resident 20 had been hospitalization from 11/7/22 to 11/9/22 for right lower extremity cellulitis, mild hypokalemia, mild hypomagnesemia, hypertension, hyperlipidemia, and diabetes mellitus. Resident 20's clinical record lacked information that a bed hold policy was provided to the resident on 11/7/22. During an interview on 11/21/22 at 1:25 P.M., the	F 0625	The facility will ensure this requirement is met through the following corrective measures: 1. No residents were harmed. The residents had returned to planned destination when identification of the deficient practice occurred. 2. All residents have the potential to be affected. All resident who are currently at the hospital were audited to ensure transfer/discharge/bedhold forms were completed and a copy provided to the residents. 3. The Bedhold/Readmission Policy was reviewed and no changes were indicated. Licensed staff will be re-educated on this policy. The SSD or his designee will audit all discharges to ensure copies were provided 5 times a week for 6 weeks and until 100% compliance is achieved, then weekly for 6 months and until 100% compliance is maintained. 4. The findings of these audits/observations will be presented during the facility's monthly QAPI meetings and the	12/21/2022

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	DON (Director of Nursing), indicated the bed hold policy could not be located for Resident 20's ER visit on 11/7/22. 2. On 11/16/22 at 3:14 P.M., Resident 91's clinical record was reviewed. Diagnoses included, but were not limited to, malignant neoplasm of lung, COPD (chronic obstructive pulmonary disease), and diabetes mellitus type II. The most recent quarterly MDS, dated 10/3/22, indicated resident was cognitively intact. On 9/21/22, nurse's notes indicated the resident complained of shortness of breath and requested to be sent to the ER (emergency room). The nurse's notes further indicated that the resident returned to the facility on 9/26/22. During an interview on 11/21/22 at 1:25 P.M., the DON indicated there was no documentation of a bed hold policy being given to the resident or representative for the transfer to ER on 9/21/22. During an interview on 11/21/22 at 9:36 A.M., LPN 9 indicated that a bed hold policy should be given if a resident is transferred to the ER for evaluation. On 11/21/22 at 3:00 P.M., a current Bed Hold/Readmission Policy, revised 10/22, was provided and indicated "The facility will notify the resident and resident representative at the time of admission and again, during an event of hospital transfer or therapeutic leave of its bed-hold and return policies. The notice of facility bed hold policy will comply with State and Federal laws and rules. 3.1-12(a)(25) 3.1-12(a)(26)		plan of action adjusted accordingly.	

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F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview, and record review, the facility failed to revise comprehensive care plans for 1 of 3 residents reviewed for nutrition, 1 of 31 residents reviewed for advanced directives, and 2 of 6 residents reviewed for care planning. Care plans were not updated to reflect correct code status, when an antibiotic was completed, when a resident resolved a urinary tract infection, and was not updated to reflect a significant weight	F 0657	The facility will ensure this requirement is met through the following corrective measures: 1. Residents 88, 353, 4 and 63 care plans were reviewed and revised accordingly. 2. All residents have the potential to be affected and care plans will be reviewed and revised	12/22/2022

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	loss. (Resident 88, Resident 353, Resident 4, Resident 63) Finding includes: 1. On 11/14/22 at 1:02 p.m., Resident 88 indicated she has had a weight loss and was trying to increase her eating. On 11/16/22 at 9:03 a.m., Resident 88's record was reviewed. Resident 88's diagnosis included, but were not limited to, COVID-19, muscle weakness. A quarterly MDS (Minimum Data Set), assessment, dated 10/24/22, indicated Resident 88's cognition was intact. The MDS was marked for weight loss, not on prescribed wt loss regimen, loss of 5% or more in the last month or loss of 10% or more in last 6 months. Care plans were reviewed and included, but were not limited to, I require a regular diet. Interventions included, but were not limited to: I will receive my diet as ordered. Date initiated 3/22/22. Weights were reviewed for Resident 88 and included the following: 11/4/2022 - 104.0 Lbs 10/3/2022 -104.8 Lbs 9/2/2022- 113.4 Lbs 8/30/2022- 112.3 Lbs 8/23/2022- 113.8 Lbs 8/16/2022- 111.5 Lbs 8/9/2022- 109.8 Lbs 8/3/2022- 110.0 Lbs 7/3/2022- 119.8 Lbs 7/2/2022- 118.0 Lbs 7/1/2022- 117.0 Lbs 6/22/2022- 132.4 Lbs 5/6/2022- 127.0 Lbs		accordingly. 3. The care planning policy was reviewed and no changes were indicated. Licensed staff will be re-educated on this policy. The DON or his designee will audit 5 residents care plans weekly for 6 weeks and until 100% compliance is achieved, then 5 per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits/observations will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	4/11/2022- 138.9 Lbs 4/4/2022 -142.4 Lbs) 3/28/2022- 141.6 Lbs 3/23/2022 -142.4 Lbs 3/22/2022 -140.2 Lbs November physicians orders were reviewed and included, not limited to: Multi vitamin (ordered 3/22/22), Mighty Shake (ordered 7/5/22), Ensure (ordered 7/27/22), Mirtazapine tablet 7.5 milligram give 1 by mouth at bedtime for appetite stimulant (ordered 8/8/22). Progress notes were reviewed and included, not limited to: 8/11/2022 3:20 P.M. Dietary-Nutrition at Risk Narrative: [name of resident] was reviewed in NAR (nutrition at risk). CBW (current body weight) 109.8# (pounds), down ~10# in 30 days. Remeron was started 8/8/22 to aid in improving appetite/intake Regular diet is supplemented with Mighty Shake BID (twice a day) and Choc Ensure qd (every day). Intake is fair. 50-100%. Continue with current POC (plan of care) and weekly monitoring. 8/18/2022 2:15 P.M. Dietary-Nutrition at Risk Late Entry: Narrative: resident was reviewed in NAR by [team members]. CBW 111.5#, which shows increase from last week wt of 109.8 #. Remeron was started 8/8/22 to aid in improving appetite/intake. Regular diet is supplemented with Mighty Shake BID and Choc Ensure qd. Intake is fair. 50-75%. Continue with current POC and weekly monitoring. On 11/16/22 at 10:20 A.M., MDS Coordinator 1 indicated she normally referred residents with weight loss to the Registered Dietitian, and she			

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	did not initiate a care plan for Resident 88's weight loss. 2. On 11/16/22 at 10:49 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, quadriplegia, cerebral palsy, unspecified urinary incontinence, and history of UTI (urinary tract infection). The most recent quarterly MDS (Minimum Data Set) Assessment, dated 9/27/22, indicated resident was cognitively intact and totally dependent on staff for bed mobility, bathing, and toileting. Resident 4's care plans included, but were not limited to, I have an acute urinary tract infection, dated 9/30/22. Interventions included, but were not limited to, "I will receive antibiotic therapy as ordered." Current physician's orders lacked an order for an antibiotic to be used for treatment of UTI. During an interview on 11/14/22 at 9:52 A.M., Resident 4 indicated she did not have a current urinary tract infection. 3. On 11/17/22 at 7:43 A.M., Resident 63's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and calculus of kidney. The most recent admission MDS Assessment, dated 9/6/22, indicated resident was moderately cognitively impaired. Resident 63's care plans included, but were not limited to, I am currently prescribed an antibiotic, dated 10/25/22, and I have an acute urinary tract infection, dated 10/25/22. Current physician's orders were reviewed and lacked documentation of a current antibiotic prescribed for Resident 63.			

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Resident 63's MAR (medication administration record) was reviewed and there were no antibiotics currently being given.

During an interview on 11/21/22 at 1:20 P.M., LPN (Licensed Practical Nurse) 24 indicated they update care plans when they do MDS assessments and nursing staff can update them as needed.

During an interview on 11/22/22 at 8:27 A.M., the DON (Director of Nursing) indicated care plans should be revised as needed when there is a change of condition in a resident.4. On 11/16/22 at 11:59 A.M., Resident 353's clinical record was reviewed. Diagnosis included, but were not limited to, infection following procedure, other surgical site, obstructive and reflux uropathy, and unilateral inguinal hernia. The most recent admission MDS (minimum data set) Assessment, dated 11/12/22, indicated Resident 353 was cognitively intact.

Resident 353's current physician orders indicated a full code status, dated 11/9/22.

An Advance Directives document indicated a Do not resuscitate form was signed by Resident 353 on 11/9/22.

During an interview on 11/15/22 at 10:45 A.M., LPN 5 indicated Resident 353 currently had a full code status in the computer system, but had signed a DNR (do not resuscitate) on 11/9/22. LPN 5 indicated the computer should have been changed to reflect a DNR status.

On 11/21/22 at 2:00 P.M., a current CPR (Cardiopulmonary Resuscitation) policy, revised

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	5/22, was provided and indicated "Facility staff should verify the presence of advance directives or the resident's wishes with regard to CPR, upon admission. This may be done while doing the admission assessment. If the resident's wishes are different than the admission orders, or if the admission orders do not address the resident's code status and the resident does not want to receive CPR, facility staff should immediately document the resident's wishes in the medical record and contact the physician to obtain the order". On 11/21/22 at 3:00 p.m., the Administrator provided the current policy on care planning with a revision date of 10/22. The policy included, not limited to: It is the policy of this facility to develop a comprehensive plan of care that is individualized, and reflective of the resident's goals, preferences, and services that are to be provided to obtain or maintain the resident's highest practical physical, mental and psychosocial well-being. The resident's care plan will contain measurable objectives and timeframes to meet resident's medial, nursing, and psychosocial needs. Care plans will be updated with any changes in the resident orders, care, or services that change the plan of care. On 11/21/22 at 3:00 P.M., a current care plan policy, revised in October 2022, was provided and indicated "Care plans will be updated with any changes in the resident orders, care, or services that change the plan of care" 3.1-35(a) 3.1-35(c)(1) 3.1-35(e)			

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F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.			
	Based on observation, interview, and record review, the facility failed to ensure a resident received care consistent with professional standards of practice to prevent pressure ulcers in 1 of 2 residents reviewed for pressure ulcers. A resident dependent on staff developed a stage II pressure ulcer on the left buttock. (Resident 4) Findings include: On 11/14/22 at 9:52 A.M., Resident 4 was observed laying in her bed unable to reach her "Breathcall" (call light that the resident blows into to alert staff) call light. At that time, the resident indicated that if she can't reach her call light she has to wait on the staff to come back into her room. On 11/15/22 at 9:23 A.M., Resident 4 was observed laying in her bed unable to reach her call light. The call light was observed to have a mouthpiece and was bent up towards the head of	F 0686	The facility will ensure this requirement is met through the following corrective measures: 1. Resident 4 continues to receive treatment and appropriate interventions are being implemented to ensure healing/prevent further skin issues. 2. All residents at risk have the potential to be affected, they have been identified and observed to ensure interventions are implemented. 3. The Skin Integrity and Pressure Injury policy was reviewed and no changes were indicated. Nursing staff will be re-educated on this policy. The DON or his designee will make rounds 5 times weekly on random days and times, to include weekends and after hours shifts,	12/21/2022

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	the bed. The mouthpiece was pointed down at mattress level. On 11/16/22 at 9:07 A.M., Resident 4 was observed laying in her bed with her call light out of reach. The mouthpiece of the call light was pointed towards the chair on the right side of the resident's bed and lowered to mattress level on right side of bed. At that time, CNA (Certified Nurse Aide) 6 came into the resident's room and resident asked for water. CNA 6 left the room and did not put Resident 4's call light within reach. During an observation on 11/16/22 at 9:17 A.M., a pressure ulcer was found on Resident 4's left buttocks during incontinence care being provided by CNA 6 and QMA (Qualified Medication Aide) 15. On 11/16/22 at 10:17 A.M., CNA 6 left the room to get a pillow. Resident 4's call light was out of reach. During an interview on 11/16/22 at 10:15 A.M., CNA 6 indicated staff were supposed to reposition the resident every two hours and document when they do. On 11/16/22 at 10:21 A.M., CNA 6 completed care for the resident and left the room without putting the call light within reach of the resident. On 11/16/22 10:49 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, quadriplegia, cerebral palsy, and unspecified urinary incontinence. The most recent quarterly MDS (minimum data set) Assessment indicated Resident 4 was cognitively intact and was an extensive assist of 2 (two) staff for bed mobility, totally dependant with assist of 2		for 6 weeks and until 100% compliance is achieved, then 5 times a month for 6 months and until 100% compliance is maintained, to ensure interventions are being implemented. 4. The findings of these audits/observations will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	(two) staff for transfers and toileting, and totally dependant with the assist of 1 (one) staff for eating and bathing. Current physician orders included, but were not limited to, resident to use the "Breathcall" system to call for assistance, initiated on 2/28/22. A current need for assistance with my ADLS (activities of daily living) care plan, revised 12/14/22, included, but was not limited to, the following interventions: I have a "Breathcall" call light that I use my mouth to blow into mouth piece to activate my call light, initiated 2/23/22. Staff will make sure the mouthpiece for Resident 4's call light is within reach each time they leave the room, initiated 2/23/22. A Braden scale assessment, dated 11/12/22, indicated Resident 4 was high risk for developing a pressure ulcer. A wound assessment, dated 11/16/22 at 10:41 A.M., indicated Resident 4 had a stage II facility acquired pressure ulcer measuring 1.0 cm (centimeter) in length, 0.5 cm in width, and 0.1 cm in depth. Current physician's orders included, but were not limited to, the following: turn and reposition resident throughout shift every shift, initiated 10/26/22, and nursing to monitor resident's positioning and may use pillows to assist with pressure relief every shift, initiated 12/3/21. A current risk for developing pressure ulcers related to change in mobility/inability to			

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	reposition, incontinence care plan, revised on 10/14/22, included but was not limited to, the following interventions: I will turn and reposition frequently throughout the shift and ask for assistance as needed, revised on 10/27/22. You will assist me in turning and repositioning at least every two hours and more frequently as needed, initiated on 10/31/22. A current stage II pressure injury to left buttocks related to altered mobility care plan, initiated 11/16/22, included but was not limited to, the following intervention: · You will assist me with turning and repositioning every two hours and more frequently as needed, initiated 11/16/22. On 11/18/22 Resident 4 was continuously observed from 8:02 A.M. to 11:23 A.M. 8:08 A.M. CNA 6 entered room with breakfast tray for resident 8:15 A.M. CNA 6 exited room and went into nourishment room, came out with carton of milk, grabbed a straw from cart, and went back into the room. 8:30 A.M. CNA 6 exited room with bag containing a used incontinence pad and carrying out a food tray 8:37 A.M. staff entered room with daily chronicle 8:44 A.M. CNA 6 entered room and took out another food tray 8:48 A.M. staff entered room with medications 8:51 A.M. staff exited room 9:03 A.M. staff entered room with laundry 10:39 A.M. CNA 6 entered room 10:40 A.M. CNA 6 exited room 10:41 A.M. CNA 6 went back into room with a drink in a white Styrofoam cup 10:42 A.M. CNA 6 exited room			

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	11:23 A.M. continuous monitoring ceased During an interview on 11/18/22 at 11:23 A.M., Resident 4 indicated the last time CNA 6 came into the room, no encouragement to rotate/reposition was given. During an interview on 11/18/22 at 2:50 P.M., CNA 6 indicated she was not able to complete all tasks she was responsible for during the day. She was usually the only CNA for 18 (eighteen) residents. She had 4-5 (four to five) showers to give in a day, 2 (two) totally dependent residents, and 3 (three) that were 2 (two) staff assist. She had 10 (ten) check and change residents and she was unable to check and change those who required it this morning until after lunch. She was unable to turn residents every 2 (two) hours as needed. She had 2 (two) residents that required a lift, and several other residents who do not require a lift but when weighing residents, it is used because weights tend to be more accurate. She had to wait until she could get help for the lifts because it required 2 (two) staff. During an interview on 11/21/22 at 10:12 A.M., CNA 6 indicated that the call light has to be right in front of Resident 4's mouth before leaving the room because she is totally dependent on staff. On 11/21/22 at 3:00 P.M., a printed turn and reposition log for the past 30 days was provided and indicated that the resident was turned/repositioned at the following times: 10/21/22 9:39 A.M., 5:38 P.M. (two times in 24 hours) 10/22/22 2:10 A.M., 4:18 P.M. (two times in 24 hours) 10/23/22 3:11 A.M., 7:41 A.M., 3:30 P.M. (three times in 24 hours)			

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	10/24/22 12:41 A.M., 5:34 A.M., 11:19 P.M. (three times in 24 hours) 10/25/22 9:01 A.M., 9:25 P.M. (two times in 24 hours) 10/26/22 1:49 A.M., 8:23 P.M. (two times in 24 hours) 10/27/22 12:29 A.M., 9:15 A.M., 8:10 P.M. (three times in 24 hours) 10/28/22 2:47 A.M., 12:48 P.M. (two times in 24 hours) 10/29/22 12:51 P.M., 9:17 P.M. (two times in 24 hours) 10/30/22 2:21 A.M., 12:59 P.M., 4:17 P.M. (three times in 24 hours) 10/31/22 1:59 A.M., 11:21 A.M. (two times in 24 hours) 11/1/22 12:51 P.M., 8:04 P.M. (two times in 24 hours) 11/2/22 5:12 A.M., 7:21 P.M. (two times in 24 hours) 11/3/22 12:52 A.M., 8:25 P.M. (two times in 24 hours) 11/4/22 1:56 P.M., 9:59 P.M. (two times in 24 hours) 11/5/22 12:02 A.M., 12:56 P.M., 8:30 P.M. (three times in 24 hours) 11/6/22 1:23 A.M., 1:32 P.M., 8:12 P.M., 11:19 P.M. (four times in 24 hours) 11/7/22 1:59 P.M., 7:58 P.M. (two times in 24 hours) 11/8/22 4:22 A.M., 9:15 A.M., 8:19 P.M., 10:51 P.M. (four times in 24 hours) 11/9/22 8:39 P.M. (one time in 24 hours) 11/10/22 1:59 P.M., 6:38 P.M. (two times in 24 hours) 11/11/22 12:39 P.M., 7:44 P.M., 11:37 P.M. (three times in 24 hours) 11/12/22 10:51 A.M., 3:09 P.M., 11:03 P.M. (three times in 24 hours) 11/13/22 None indicated			

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	11/14/22 1:40 A.M., 12:57 P.M., 9:06 P.M. (three times in 24 hours) 11/15/22 4:19 A.M., 1:59 P.M., 4:23 P.M., 10:27 P.M. (four times in 24 hours) 11/16/22 1:59 P.M., 7:56 P.M., 11:05 P.M. (three times in 24 hours) 11/17/22 1:59 P.M., 8:14 P.M. (two times in 24 hours) 11/18/22 1:10 A.M., 11:47 A.M., 9:59 P.M. (three times in 24 hours) 11/19/22 1:33 A.M., 1:03 P.M., 2:32 P.M. (three times in 24 hours) 11/20/22 5:13 A.M., 7:45 A.M., 2:58 P.M. (three times in 24 hours) 11/21/22 3:09 A.M. (one time in 24 hours) The clinical record lacked any other times that the resident was turned/repositioned. On 11/22/22 at 8:27 A.M., a current resident call system policy, revised October 2022, was provided and indicated the call light should be within reach of the resident whether in bed, sitting in a chair in their room, in the toilet and bathing areas. On 11/21/22 at 3:00 P.M., a current skin integrity and pressure injury policy, revised June 2021, was provided and indicated "It is the policy of this facility to provide care that is consistent with professional standards of practice to prevent pressure injuries and does not develop pressure injuries ... staff will assist and/or remind the resident to reposition and turn at least every 2 [two] hours or more frequent depending on the resident risk and skin health" 3.1-40(a)(1)			
F 0689 SS=D	483.25(d)(1)(2) Free of Accident			

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	155803	A. BUILDING 00 B. WING	11/22/2022

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Bldg. 00	Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure proper supervision was provided to prevent accident hazards for 1 of 5 residents reviewed for accidents. A resident was observed to carry a box cutter that staff was unaware he had in his possession. A medication cart was observed to be unlocked. (Resident 57, Hall 400) Findings include: 1. On 11/14/22 at 9:40 A.M., Resident 57 was observed in his room, sitting in his wheelchair, putting butter on some bread. At that time, the resident pulled a box cutter out of his front shirt pocket that he indicated he kept on his person to open snacks and boxes that he had in his room. On 11/17/22 at 11:14 A.M., Resident 57's clinical record was reviewed. Diagnoses included, but were not limited to, macular degeneration of right eye, monoplegia of upper limb affecting left nondominant side, anxiety disorder, history of traumatic brain injury, depressive disorder, and unspecified mood (affective) disorder. The most recent quarterly MDS (minimum data set) Assessment, dated 11/3/22, indicated that the resident was cognitively intact and an extensive assist of 1 (one) staff for toileting and physical help with bathing.	F 0689	The facility will ensure this requirement is met through the following corrective measures: 1. A. Resident 57 was reviewed by the IDT, including his physician and psych consultant and it was determined he is safe to maintain one box cutter in his possession for the purpose of independently opening his packages he receives almost daily. His plan of care was reviewed and revised. B. The medication cart was secured once administration was notified. 2. All residents have the potential to be harmed. See below for corrective measures. 3. A. The Risk Evaluation policy was reviewed and no changes were indicated. Nursing staff will be educated on this policy. The DON or his designee will review resident 57 weekly to include documentation, staff interviews and interview with resident 57 to ensure he remains appropriate to possess a box cutter. This will continue weekly indefinitely, as long as he is in possession of it. B. The policy on Medication	12/21/2022

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	Resident 57's current care plans included, but were not limited to the following: "CARE PLAN / CRISIS PLAN: Because of my Hx [history] of thoughts/verbalizations of self harm due to my overall decline associated with my accident at age 13 and left side weakness resulting in increased depression, hopelessness, anxiety in my life in the past. My history of suicidal ideation's [sic] and attempt to end my life in the past my [PASRR] Level II [preadmission screening and resident review evaluation used to determine if a person had or was suspected to have had a mental illness, intellectual disability, or related condition and the specialized services they require] references the need for a crisis plan. The past 6 months of psychiatric and psychologist visits indicate no suicidal ideation's [sic] ", revised 11/15/22. "I have a [PASRR] Level II indicating MI (mental illness) with no specialized services required", revised 11/3/22. "I have a history of behavioral symptoms such as throwing objects at my roommate and being verbal aggressive to my roommates and staff. I have been observed making snide comments to staff and my roommates. I can be easily redirected when staff intervenes. I have a history of ordering items from [store name] that I'm not supposed to have in my room", revised 11/14/22. "I have a cognitive deficit related to traumatic head injury. My cognitive status appears to vary with some STM (short term memory) loss noted, revised 11/3/22. A social services note, dated 5/25/22 at 2:41 P.M., indicated Resident 57 threw a Styrofoam cup of		Storage was reviewed an no changes were indicated. Licensed staff and QMA's will be re-educated on this policy. The DON of his designee will make rounds 3 times weekly for 6 weeks and until 100% compliance is achieved, then weekly for 6 months and until 100% compliance is maintained to ensure carts are secured. 4. The findings of these audits/observations will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	water at his roommate because his roommate left the bathroom light on after leaving the restroom. A social services note, dated 6/6/22 at 3:07 P.M., indicated that a (physical) therapist had been notified by the ADON (Assistant Director of Nursing) that resident had a new electric wheelchair delivered to the facility and resident is sitting in electric wheelchair and refusing to get out of it. Therapist and DON (Director of Nursing) approached resident to try to educate him on needing to complete an electric wheelchair assessment to make sure he is safe and not at risk to cause harm to himself, staff, or other residents. Resident continued to refuse to get out of the electric wheelchair or for electric wheelchair to be stored in locked therapy gym until assessment can be completed. Social services notified of conversation and resident response. A behavior note, dated 7/6/22 at 4:32 P.M., indicated resident was upset that he was not approved to use electric wheelchair in the facility and that he "isn't going to do anything he's supposed to do" and not follow his diet. SW (social worker) asked him if he plans on hurting himself in any way by not following his diet. Resident indicated he wasn't sure. SW told him that if he plans on hurting himself this way that we would have to send him to a psych unit. Resident told SW he did not want to go to a psych unit and that he "will do what he's supposed to do, but not be happy about it". On 7/7/22 at 12:58 P.M., a medication administration note indicated resident still refused to take his medications, get his blood sugar measurement taken, and his insulin. The resident verbalized he is on strike.			

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	On 7/13/22 at 9:44 A.M., a social services note indicated SW spoke with resident regarding refusal of food provided by the facility and refusing medications. SW told resident that this could be considered a form of self harm. Resident says he is not trying to hurt himself and only trying to "rebel" d/t (due to) not passing test to use electric wheelchair. SW told him that it could still be viewed as self harm, and that self harm would warrant a trip to a psych unit. Resident voiced understanding. On 9/4/22 at 2:33 P.M., a nursing note indicated Resident 57 refused blood sugar checks and insulin stating that he is on a strike. On 11/11/22 at 11:51 A.M., a social service note indicated SW spoke with resident's family this date r/t (related to) items found in his room. SW made them aware that resident is not supposed to have these items in his room. Resident's sister did not confirm whether or not she knew he had them in his room, however said "you'll see the worst of him if he doesn't have those". On 11/22/22 at 9:00 A.M., Resident 57's roommate's (Resident 36) clinical record was reviewed. The most recent quarterly MDS Assessment, dated 9/23/22, indicated that he was severely cognitively impaired. On 11/17/22 at 1:47 P.M., Resident 57 was in his room on his computer. The box cutter was observed in the front pocket of his shirt while speaking to the resident. During an interview on 11/17/22 at 1:49 P.M., CNA 6 indicated she was not aware he had a box cutter, indicated he should not have one, and was visibly shocked upon hearing that he had a box cutter in			

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	his possession. She further indicated he has temper tantrums and if he doesn't get his way, he will throw things on floor and go on strike. On 11/17/22 at 1:54 P.M., the unit manager indicated she was not aware Resident 57 had a box cutter. She further indicated he got [store name] items that came in brown boxes delivered frequently on Sundays so it came straight to him with no questions. On 11/17/22 at 2:42 P.M., the unit manager, indicated she and a social worker went to talk to the resident about the box knife. She indicated the resident states he is not giving it up because he needs it to open packages. She further indicated when she asked if he sleeps with it, he said he leaves it on the bedside table. The unit manager indicated that she educated the resident on this being a safety hazard because someone may pick it up and not know what it is and hurt themselves or others. On 11/18/22 at 10:20 A.M., Resident 57 was observed in his room. The unit manager had the resident open the locked drawer in his dresser. Maintenance gave the resident a key on a lanyard for him to keep around his neck. The resident opened the drawer with the key and revealed that he had a pocket knife, the box knife previously observed, a box of more box knives, and his wallet in the locked drawer. During an interview on 11/21/22 at 10:15 A.M., CNA 6 indicates that Resident 57 does need help at times with toileting, with his showers and shaving twice a week, and she sees the resident everyday. 2. On 11/17/22 at 6:23 A.M., the medication cart on the 400 Hall was observed to be unlocked sitting			

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	at the end of the hall closest to the nurses station. At 6:25 A.M. QMA 15 and CNA 17 walked by the medication cart. LPN 21 and CNA 19 walked by the medication cart. At 6:30 A.M. CNA 17 walked by the medication cart. At 6:30 A.M. CNA 17 walked by the medication cart. At 6:35 A.M. QMA 15 walked up to the cart and locked it. During an interview on 11/21/22 at 9:10 A.M., LPN 7 indicated the medication cart should be locked when it's out of site. On 11/21/22 at 2:00 P.M., a current Guidelines for Medication Storage and Labeling policy, revised 10/22, was provided and indicated medications and biological's in medication rooms, carts, and refrigerators are maintained within: a. Secured (locked) locations, accessible only to designated staff. On 11/21/22 at 3:00 P.M., A current risk evaluation policy, revised June 2022, was provided and indicated "It is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assisted devices to prevent avoidable accidents ... hazards refer to elements of the resident environment that have the potential to cause injury ... " 3.1-45(a)			
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.			

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	The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview the facility failed to ensure the safety of residents during the administration of oxygen therapy by not changing oxygen tubing weekly for 2 of 2 residents. (Resident 28, Resident 77) Findings include: 1. On 11/14/22 at 8:47 A.M., Resident 77 was observed to be lying in bed with oxygen on. The oxygen tubing and humidification bottle were not dated. On 11/15/22 at 8:30 A.M., Resident 77 was observed wearing oxygen with the tubing and water humidification bottle not dated. On 11/17/22 at 7:33 A.M., Resident 77 was observed wearing oxygen with the tubing and water humidification bottle not dated. On 11/16/22 at 8:40 A.M., Resident 77's clinical record was reviewed. Diagnosis included but not limited to, nondisplaced interotrancheric fracture of the left femur, history of falls, and essential hypertension. The most recent MDS (minimum data set) Assessment dated 10/17/22 included a cognition status considered moderately impaired. Physician's orders included, but were not limited to: Oxygen at 2 liters per minute, ordered 11/11/22 and	F 0695	The facility will ensure this requirement is met through the following corrective measures: 1. Residents 28 and 77 were not harmed and oxygen tubings and humidifiers were changed accordingly. 2. All residents receiving oxygen therapy have the potential to be affected and all oxygen tubings and humidification bottles were checked and changed accordingly. 3. The Cleaning and Changing Respiratory Equipment policy was reviewed and no changes were indicated. Licensed staff were re-educated on this policy. The DON or his designee will audit oxygen tubing and humidification bottles weekly for 6 weeks and until 100% compliance is achieved, then twice monthly for 6 months and until 100% compliance is maintained. 4. The findings of these audits/observations will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	12/21/2022

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	discontinued 11/17/22 Oxygen humidifier at 2 liters per minute, ordered 11/17/22, and discontinued at time of death on 11/18/22. Resident 77's clinical record lacked a current order on the frequency of changing oxygen tubing. During an interview on 11/17/22 at 9:41 A.M. LPN 11 indicated oxygen tubing was to be changed every week. 2. On 11/15/22 at 9:55 A.M., Resident 28 was observed sitting in her wheelchair in her room. The oxygen tubing and humidifier bottle in her room were dated 11/28/21 and the tube going from the humidifier to the machine was dated 11/28 (year was not indicated). On 11/17/22 at 10:14 A.M., Resident 28's clinical record was reviewed. Diagnoses included, but were not limited to, COPD (chronic pulmonary obstructive disease). The most recent significant change MDS (minimum data set) Assessment, dated 10/12/22, indicated Resident 28 was cognitively intact and was receiving oxygen therapy. Current physician's orders included, but were not limited to, change oxygen tubing and filter weekly every night shift every Sunday, dated 3/13/22 and PRN (as needed) oxygen at 2 lpm (liters per minute) via nasal cannula, dated 3/9/22. A current care plan, revised 12/11/20, indicated "I have chronic obstructive pulmonary disease (COPD) related to chronic bronchitis. Resident states sometimes she uses Oxygen at night when she feels short of breath." On 11/17/22 at 12:50 A.M., the oxygen tubing and			

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	humidifier bottle were again observed but were dated 11/14/22. The tube from the humidifier to the machine was dated 11/28 (year was not indicated). During an interview on 11/15/22 at 9:55 A.M., Resident 28 indicated she uses her oxygen when she is short of breath, mostly at night. She further indicated that she did not know how often they checked her oxygen tubing and machine, but she didn't believe it was weekly. During an interview on 11/21/22 at 9:39 A.M., LPN (Licensed Practical Nurse) 9 indicated the oxygen tubing and waters (humidifiers) should be changed every Sunday on night shift. On 11/21/22 8:44 A.M., the DON (Director of Nursing), provided a current Cleaning and Changing Respiratory Equipment policy, dated February 2018. The policy indicated that " It is the policy of this facility to ensure the safety of residents by cleaning and changing respiratory equipment...nasal cannulas are to be changed weekly and as needed, a clean plastic bag will kept at bedside to place the nasal cannula when not in use..." 3.1-47(a)(6)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview, and record review, the facility failed to ensure the necessary care and services	F 0698	The facility will ensure this requirement is met through the	12/21/2022

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	were provided for 1 of 1 residents reviewed for dialysis. A resident's weights were not taken as ordered. (Resident 15). Finding includes: On 11/16/22 at 1:03 p.m., Resident 15's clinical record was reviewed. Resident 15 had diagnoses that included, not limited to, unspecified diabetes mellitus, end stage renal disease, dependence on dialysis. An annual MDS (Minimum Data Set) assessment, dated 8/12/22, indicated Resident 15's cognition was intact. Care plans were reviewed and included, not limited to: I have end stage kidney disease requiring dialysis and experience Hypotension, itching and nausea at times. Interventions included, not limited to, I will participate in my dialysis as scheduled three times weekly. Mon. Wed. Fri..., My weights and vital signs will be obtained as ordered and monitored. Date Initiated: 10/30/2017. November physicians order were reviewed and included, but not limited to, daily weight on M/W/F, order date 6/24/22. The November EMAR (Electronic Medication Administration Record) was reviewed and did not contain the order to obtain weights. Resident 15's weights were reviewed from 6/24/22 until 11/4/22. The following weights were recorded: 7/1/22- 211.2 lbs 8/8/22- 211 lbs 9/14/22-212.5 lbs 9/30/22- 212.7 lbs		following corrective measures: 1. Resident 15 was not harmed. The physician was notified and the order updated per his direction. 2. All residents receiving dialysis have the potential to be affected and were audited to ensure weight orders were entered accurately and remain appropriate. 3. The Dialysis policy was reviewed and no changes were indicated. Licensed staff will be re-educated on this policy. The DON or his designee will audit the dialysis weights twice weekly for 6 weeks and until 100% compliance is achieved, then weekly for 6 months and until 100% compliance is maintained to ensure they are obtained as ordered. 4. The findings of these audits/observations will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	10/11/22- 213 lbs 11/422- 213.8 lbs On 11/17/22 at 1:24 p.m., RN 1 indicated CNA's obtain resident's weights, and the nurse was responsible to enter the weights in the MAR (Medication Administration Record). RN 1 indicated Resident 15 should have had an order for weights on the EMAR (Electronic Medication Administration Record), and should also be listed with the vital signs. RN 1 further indicated a weight order was not showing up because a time was not listed when to obtain the weights. On 11/17/22 at 1:30 p.m., the DON indicated the weight order should have been on the MAR, the nurses are responsible to ensure an order gets put on the MAR. A current Dialysis policy, revised 4/21, was provided 11/22/22 at 8:27 A.M., and indicated "...Weights will be monitored weekly at the SNF [skilled nursing facility] and three times weekly pre and post dialysis via the dialysis team. This information will be provided to the facility and placed in the EMAR [electronic medication administration record] by the EMAR Coordinator" 3.1-37(a)			
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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	155803	A. BUILDING 00 B. WING	11/22/2022

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	Based on interview and record review, the facility failed to provide contraindications for gradual dose reduction trials for residents on psychotropic medications for 2 of 5 residents reviewed for unnecessary medications. (Resident 54, Resident 67) Findings include: 1. On 11/16/22 at 1:00 P.M., Resident 54's clinical record was reviewed. Diagnosis included, but were not limited to, unspecified dementia, psychotic disturbance, mood disturbance, anxiety, major depressive disorder, and anxiety disorder. The most recent quarterly MDS (minimum data set) Assessment, dated 8/20/22, indicated Resident 54 was cognitively impaired. A Pharmacist note, dated 7/27/22, recommended a gradual dose reduction of risperidone 0.25 mg bid (twice a day), ordered 3/28/22. The physician failed to provide a contraindication why a gradual dose reduction should not be attempted. 2. Resident 67's clinical record was reviewed on 11/16/22 at 12:20 P.M. The most recent annual Minimum Data Set (MDS) Assessment, dated 8/31/22, indicated the resident was mildly cognitively impaired. Diagnoses included, but were not limited to, dementia unspecified severity, with other behavioral disturbance, bipolar disorder, unspecified, and schizoaffective disorder, unspecified. Physician order indicated that there was an order for Aripiprazole 5 mg daily for schizoaffective disorder. A pharmacist recommended a gradual dose reduction of Arpiprazole from 5 mg to 4 mg on 9/13/22. The physician's response, dated 9/13/22,	F 0758	The facility will ensure this requirement is met through the following corrective measures: 1. Residents 54 and 67 were not harmed. The ordering practitioner was notified and documentation to explain rationale for declination has been obtained. 2. All residents receiving psychotropic medications have the potential to be affected. All related pharmacy recommendations received for the past 30 days were reviewed to ensure compliance. 3. The Psychoactive Medications/ Gradual Dose Reduction (GDR)/Unnecessary Medications Policy was reviewed and no changes were indicated. Nursing administration and physicians/physician extenders were educated on this policy. The DON or his designee will review all completed pharmacy recommendations monthly to ensure rationale is provided when declining recommended reductions and that 100% compliance is achieved. 4. The findings of these audits/observations will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	12/21/2022

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	was "disagree". The physician failed to provide a contraindication for why a gradual dose reduction should not be attempted. A current care plan for risk for side effects related to the use of antipsychotics included, but was not limited to, the following interventions: "My use of psychotropic medications will be reviewed quarterly by a pharmacist and the interdisciplinary team to ensure the need for continued use and the appropriateness for a gradual dose reduction". A copy of the care plan was received 11/21/22 at 3:12 P.M., and the care plans and interventions were not dated. During an interview on 11/18/22 at 3:30 P.M., the DON (Director of Nursing) indicated that physicians did not always provide contraindications on the GDR (Gradual Dose Reduction). On 11/21/22 at 8:44 A.M., the DON provided a policy dated with a revision of 10/22 titled Psychoactive Medications/ Gradual Dose Reduction (GDR)/Unnecessary Medications Policy. The policy indicated "... To ensure gradual dose reduction attempts are made unless contraindicated. Procedure...the Director of Clinical Services will ensure that the physician in notified of recommendations...if there is a dose reeducation and it is contraindicated....there is a reason he/she disagrees with the recommendation. " 3.1-48(b)(2)			
F 0776 SS=D Bldg. 00	483.50(b)(1)(i)(ii) Radiology/Other Diagnostic Services §483.50(b) Radiology and other diagnostic services.			

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	§483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. Based on observation, interview and record review, the facility failed to obtain radiology services as ordered by the physician for 1 of 1 resident needing STAT(immediate) X-Ray procedures. A resident with a recent left hip replacement due to left hip fracture from a fall, fell and did not receive STAT radiologic images timely. (Resident G) Findings include: On 11/21/22 at 1:42 P.M., Resident G's clinical record was reviewed. Diagnoses included, but were not limited to, dementia, history of falling, and presence of left artificial hip joint. An MDS (minimum data set) Assessment was not available due to the resident being admitted to the facility on 7/6/22 and discharging 7/10/22. A physician narrative progress note, dated 7/7/22, indicated Resident G was pleasantly confused and the provider was unable to assess the resident's cognition. Nursing notes were reviewed and indicated the	F 0776	The facility will ensure this requirement is met through the following corrective measures: 1. Resident G was sent to the hospital to obtain x-ray. Radiology services agreement was terminated and a new provider obtained. 2. All residents have the potential to be affected. The radiology services agreement was terminated and a new provider contracted. 3. The current radiology services contract indicates STAT turnaround time to be 5 hours. Licensed staff will be re-educated on this. The DON or his designee will audit 3 times weekly to ensure all ordered x-ray services are obtained timely for 6 weeks and until 100% compliance is achieved, then weekly for 6 months to ensure 100% compliance is maintained.	12/21/2022

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	following: On 7/8/22, the resident was found at 11:20 A.M. on the floor of her bedroom by her wheelchair. Resident G showed no signs of pain and was unable to answer when asked about pain. On 7/8/22, the resident was found at 5:25 P.M. laying on her left side on the floor near the nurse's station. Upon assessment, blood was found on the resident's hands, eyebrows, nose and carpet. Bleeding was actively occurring from her left nostril and the bridge of her nose had minimal swelling at this time. Resident G could not state if pain existed. On 7/8/22 at 6:35 P.M., the facility received an order from Resident G's primary physician for a STAT X-Ray of the left hip and left shoulder due to an unwitnessed fall. On 7/8/22 at 6:36 P.M., the contracted mobile radiology service provider was notified of STAT X-Ray orders. On 7/9/22 at 7:30 P.M., Resident G's family called the facility for the X-Ray results. At that time, the facility contacted the contracted mobile radiology service provider back and was told STAT X-Rays would be done in the morning on 7/10/22. On 7/10/22 at 1:02 P.M., Resident G's family came into the facility concerned the STAT X-Rays were not yet completed and requested resident be sent to the ER (emergency room) for evaluation. On 7/10/22, ER records indicated imaging completed during the ER visit identified an acute appearing subtrochanteric proximal left femur fracture. The resident was subsequently admitted		4. The findings of these audits/observations will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	

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	to the hospital and had an ORIF (open reduction and internal fixation) surgical repair of the left periprosthetic femur fracture, and a revision of the femoral component of recent left hip arthroplasty (joint replacement surgery) and was discharged on 7/14/22. A service agreement between the mobile radiology service provider and the facility, dated 12/23/21, was provided by the DON (Director of Nursing) on 11/22/22 at 9:53 A.M., and indicated the mobile radiology service provider shall "provide radiology services for facility patients in accordance with: accepted standards of medical care ... ". It lacked a definition of the timeframe a STAT order should be completed. During an interview on 11/22/22 at 9:00 A.M., the contracted mobile X-Ray service provider was contacted and staff indicated a STAT order should be completed within 2-4 hours. The contracted company is located 182 miles, approximately 2 (two) hours and 54 (fifty-four) minutes away from the facility. During an interview on 11/21/222 at 8:50 A.M., the DON indicated there was not a current policy for a timeframe in which STAT orders need to be completed. He further indicated they go by whatever the company providing the mobile service defines as STAT. This Federal tag relates to Complaint IN00387822. 3.1-49(g)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an			

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	infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or			

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	organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview and record review, the facility failed to properly prevent and/or contain COVID-19 for 3 of 33 residents reviewed for infection control, and 1 of 6 residents observed for care. (Resident 23, Resident 39, Resident 31, Resident 4) Findings include: On 11/21/22 at 10:00 A.M., The Centers for Disease Control and Prevention (CDC) COVID Data Tracker for Warrick County was accessed.	F 0880	The facility will ensure this requirement is met through the following corrective measures: 1. Residents 23, 39, 31 and 4 were not harmed. See below for corrective measures. 2. All residents have the potential to be affected. See below for corrective measures. 3. The COVID-19 and TBP policy and the Perineal Care Check-Off was reviewed and no changes	12/21/2022

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	The county transmission level was moderate. 1. On 11/21/22 at 10:32 a.m., CNA 1 was observed to don a gown and face shield and enter room 312 where Resident 23, and Resident 39, were in transmission based precautions due to COVID-19. CNA 1 had on a surgical mask. A sign that indicated "droplet precautions" was observed on the door. On 11/21/22 at 10:40 a.m., CNA 1 indicated they were supposed to put on a blue gown, face shield, go in the room and put on gloves. CNA 1 pointed to the N95 masks that were on the door and indicated they were supposed to put on a COVID mask. 2. On 11/14/22 at 8:45 A.M., Resident 31 was observed to be in TBP (Transmission Based Precautions) for being COVID positive. On 11/14/22 at 11:00 A.M., CNA (Certified Nurse Aide) 11 was observed prior to entering Resident 11's room donning an an-95 mask over surgical mask. At that time CNA 11, indicated that resident was on transmission based precautions due to being COVID POSITIVE. On 11/15/22 at 10:30 A.M., Resident 31's record was reviewed. Diagnosis included, but were not limited to, COVID positive. Resident 31 tested positive for COVID on 11/6/22. The resident's daughter and MD were notified. The MDS (minimum data set) Assessment dated on 9/14/22 indicated that the resident was mildly cognitively impaired. A care plan dated on 5/12/21 with revision on 11/7/22, indicated that the resident will follow facility protocol for COVID-19 screening and precautions.		were indicated. The DON/IP or his/her designee will randomly observe donning of PPE 10 times weekly, on random days, to include weekends, and shifts for 6 weeks and until 100% compliance is achieved, then 10 per month for 5 months and until 100% compliance is maintained. The DON/IP or his/her designee will observe pericare 5 times weekly, on random days, to include weekends, and shifts weekly for 6 weeks and until 100% compliance is achieved, then 5 per month for 6 months and until 100% compliance is maintained. 4. The findings of these audits/observations will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly. Directed POC- Hamilton Pointe Health and Rehabilitation 3800 Eli Place Newburgh, IN 47630 CCN/Provider Number: 155803 AIM Number: 201110390 Facility ID: 012966 Survey Cycle Start Date **November 22, 2022** Survey Event ID **IFOH11** Deficiency F 880 Based on observation, interview and record review, the facility failed to properly prevent and/or contain COVID-19 for 3 of 33	

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	On 11/21/22 at 9:53 A.M., during an interview with the IP (Infection Preventionist Nurse), she indicated that "All residents on TBP have PPE outside their door, staff wear N95, not on top of surgical mask, ..." 3. On 11/16/22 at 9:17 A.M., CNA (Certified Nurse Aide) 6 and QMA (Qualified Medication Aide) 15 were observed providing incontinence care to Resident 4. CNA 6 cleaned the resident's anal area from front to back with a wet, soapy washcloth. CNA 6 continued to apply the new incontinence brief with the same gloves and then rolled the resident onto the right side and held them there while QMA 15 went to get the nurse to inspect a new open wound on the left buttocks. On 11/16/22 at 10:49 A.M., Resident 4's clinical record was reviewed. Diagnoses included, but were not limited to, quadriplegia, cerebral palsy, and unspecified urinary incontinence. The most recent quarterly MDS (minimum data set) Assessment indicated Resident 4 was cognitively intact and was an extensive assist of 2 (two) staff for bed mobility, totally dependent with assist of 2 (two) staff for transfers and toileting, and totally dependent with the assist of 1 (one) staff for eating and bathing. During an interview on 11/21/22 at 10:12 A.M., CNA 6 indicated after cleaning the resident's peri (perineal) area, gloves and water should be changed. She further indicated after washing resident's backside (anal area) gloves should be changed and hands washed. On 11/21/22 at 3:00 P.M., a current bed bath/perineal care check off list, revised December 2018, was provided by the DON (Director of Nursing) who indicated it was the current policy, indicated that after cleansing the anal area, bath		residents reviewed for infection control, and 1 of 6 residents observed for care. (Resident 23, Resident 39, Resident 31, Resident 4) **Root cause analysis** **Finding 1)** What: Staff did not don a N95 before entering a red room. Why: Staff said she just forgot Immediate corrective action: Staff member was re-educated on necessary PPE in red room. **Finding 2)** What: A surgical mask was left on and an N95 placed on over the surgical mask before entering a red room. Why: CNA stated she just got confused as to what she was supposed to wear. Immediate corrective action: The CNA was re-educated on what to wear when entering a red room and where to find that information. **Finding 3)** What: CNA did not change water, gloves and wash hands when completing dirty portion of perineal care before going to clean. Why: CNA states she was nervous being watched. Immediate corrective action: The CNA was re-educated on the proper procedure with pericare. **Corrective measures** Reeducation and inservices with staff including:	

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	water and gloves should be changed. On 11/21/22 at 8:44 A.M., the DON (Director of Nursing), provided a policy dated 9/30/22 of COVID-19 and TBP policy. The policy indicated that " It is the policy of this facility to minimize exposures to respiratory pathogens and promptly with Clinical Features... for the COVID-19 and to adhere.... recommendations... The must have a process to identify and manage individuals with with SATS-CoV-2...the facility should ensure that everyone is aware of recommended Infection and Prevention and Control (IPC) practices in the facility." 3.1-18(b)(2) 3.1-18(l)		·Maintaining proper isolation procedures by donning and doffing the appropriate PPE and utilizing proper pericare technique. Summary: Root cause analysis determined the need for daily observations and continual re-education by the IP and facility administration. Continued non-compliance will result in disciplinary action and possible termination to protect residents and staff. Competencies will be completed and daily rounding by the IP or designee using the Infection Control Patient and Staff Surveillance tool to continue for a period of six weeks and until 100% compliance is achieved then two times weekly for a period of at least 6 months and compliance is maintained to be determined by the QAPI Committee. The Facility LTC infection control self-assessment was reviewed with the corporate IP it was agreed that it is an accurate assessment of the facility (see attached). Survey findings, root cause analysis reviewed with corporate IP, Medical Director, Administrator, facility IP, and Director of Clinical Services. The plan of action was agreed upon.	

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaints IN00391521, IN00387822, and IN00383534. Complaint IN00391521 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00387822 - Substantiated. Federal/State deficiencies related to the allegations are cited at F580 and F776. Complaint IN00383534 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: November 14, 15, 16, 17, 18, 21, 22, 2022 Facility number: 012966 Residential Census: 48 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on December 2, 2022.	R 0000	**The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.**	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on interview and record review, the facility failed to ensure infection control practices were maintained during medication administration. A	R 0414	The facility will ensure this requirement is met through the following corrective measures:	12/21/2022

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HAMILTON POINTE HEALTH AND REHAB	3800 ELI PLACE NEWBURGH, IN 47630

(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
	staff member handled medications with bare hands for 1 of 5 residents observed for medication administration. (Resident 400) Finding includes: On 11/18/22 at 8:00 a.m., LPN 1 was observed to prepare and administer Medications to Resident 400, touching each pill with her bare hands. On 11/18/22 at 8:15 a.m., LPN 1 indicated she probably should not have touched the medications with her hands, and was supposed to put the medications in the cup with the bottle.		1. Resident 400 was not harmed. The staff member responsible was re-educated on medication handling. 2. All residents have the potential to be affected. Staff responsible for medication administration will be re-educated on medication handling (see below). 3. The General Guidelines for Medication Administration policy was reviewed and no changes were indicated. Staff responsible for medication administration will be re-educated on this policy. The Charge Nurse or her designee will complete 4 medication pass observations weekly for 6 weeks and until 100% compliance is achieved, then 5 per month for 5 months and until 100% compliance is maintained. 4. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly.	