STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155689	A. BUILDING 00 B. WING	05/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF GOSHEN	2400 COLLEGE AVE GOSHEN, IN 46526

(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 the Investigation of Complaints IN00399036, IN00400643, IN00401470, IN00401728, IN00401801, IN00402873, IN00404537, IN00404638, IN00405995, and IN00407111. Complaint IN00399036 - No deficiencies related to the allegations are cited. Complaint IN00400643 - No deficiencies related to the allegations are cited. Complaint IN00401470 - Federal/state deficiencies related to the allegations are cited at F697. Complaint IN00401728 - Federal/state deficiencies related to the allegations are cited at F695. Complaint IN00401801 - Federal/state deficiencies related to the allegations are cited at F602, F697 Complaint IN00402873 - Federal/state deficiencies related to the allegations are cited at F697. Complaint IN00404537 - No deficiencies related to the allegations are cited. Complaint IN00404638 - Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00405995 - Federal/statedeficiencies related to the allegations are cited at F550 and F691. Complaint IN00407111 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited.	F 0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. Due to the low scope and severity of these findings we respectfully request a desk review in lieu of a traditional revisit.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Caley Nixon	Executive Director	06/02/2023

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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	Survey dates: April 26, 27, 28, and May 1, 2023 Facility number: 000091 Provider number: 155689 AIM number: 100290080 Census Bed Type: SNF/NF: 122 SNF: 15 Total: 137 Census Payor Type: Medicare: 22 Medicaid: 89 Other: 26 Total: 137 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 5/23/2023.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.			

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	§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on record review, observation, and interview the facility failed to provide incontinence care to promote dignity for 1 of 11 residents reviewed for dignity. (Resident G) Finding include: A record review was completed, on 4/26/2023 at 2:30 P.M. Resident G's diagnoses included, but were not limited to post-traumatic stress disorder, dysphasia, Parkinson's, and neuromuscular dysfunction of bladder. A Significant Change MDS (Minimum Data Set)	F 0550	**F550 – Resident Rights/Exercise of Rights** A. It is the practice of this facility to ensure all residents are provided care to promote dignity. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident G – resident has discharged from facility.	06/04/2023

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	Assessment, dated 2/28/2023, indicated Resident G was alert and oriented and able to make her own decisions regarding her care. She required extensive assist of 2 staff for bed mobility, transfers, dressing, toilet use, and required total assist for bathing. She required the use of a urostomy (an opening for urine drainage). During an observation and interview, on 4/27/2023 at 9:30 A.M., Resident G's room had a strong urine smell. The resident was in bed with her gown and linens were visibly saturated with urine extending down to the resident's right knee. The urostomy drainage bag was empty with a scant amount of white cloudy material in the tubing. The resident stated she had put her call light on at midnight and told the staff she believed she needed her brief changed, due to bowel incontinence. The resident indicated that staff said they would come back but they never did. At 4:00 A.M., Resident G phoned a friend and requested that they call the nursing station and ask for help for the resident. Resident G indicated an aide came to help and changed her brief. Resident G indicated at that time her urostomy bag was leaking and she was wet. The aide placed a bath towel along the resident's right side where the urostomy was located and told her care would be performed later. She indicated these instances are happening more often and have been going on for the last month. The way they treat me, it makes me feel like I am less than a human being and less important. A current care plan, dated 3/23/2023, indicated the resident needs assistance with activities of daily living due to diagnoses of neuromuscular disfunction of bladder and chronic pain. Interventions included but were not limited to: Continence-assist with incontinent care.		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All staff educated on resident rights and providing care to promote dignity. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-service on or before 6/4/23. This in-service will be conducted by the Executive Director or Designee and will include a review of resident rights related to providing care to promote resident dignity. The Executive Director/Designee will utilize a daily observational rounding tool to audit all residents are being provided care to promote dignity. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The	

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	A current care plan, dated 1/17/2023, indicated the resident has episodes of incontinence of bladder related to urostomy. Interventions included but not limited to: Empty urostomy every shift and as needed, and observe pattern of incontinence, and initiate toileting schedule if indicated. During an interview, on 4/27/2023 at 10:42 A.M., QMA 12 stated she was not aware of the resident laying in urine and the previous shift had not passed that information on to her. QMA 12 indicated the resident should not have been left wet with urine, the gown and linens should have been changed when the brief was changed, and the aide should have let a nurse know about the leaking urostomy bag. On 4/28/2023 at 2:30 P.M., the Administrator provided the "Alarm Average Response Time Report", for Resident G for the dates of 4/14/2023 through 4/28/2023. The report indicated the resident had waited for the aides response for the following response times: over 60 minutes times three on 4/16/2023, 55 minutes on 4/17/2023, 34 and 38 minutes on 4/18/2023, 33 and 37 minutes on 4/20/2023, over 60 minutes times 2 on 4/21/2023, over 59 minutes times 2 on 4/23/2023, 51 minutes on 4/24/2023, 47 minutes on 4/25/2023, 60 minutes on 4/26/2023. During an interview, on 5/1/2023 at 3:30 P.M., the Assistant Director of Nursing indicated that call lights should be answered in 5 minutes when possible and call times over 30 minutes are not acceptable. On 5/1/2023 at 12:10 P.M., the Administrator provided the policy titled "Call Lights: Accessibility and Timely Response", dated 12/22/2022, and indicated the policy was the one		Executive Director/Designee will be responsible for completing the QAPI Audit tools labeled "Resident Dignity" weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 06/04/2023** Compliance Date = 06/04/2023	

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	currently used by the facility. The policy indicated " ...Call lights will directly relay to a staff member or centralized location to ensure appropriate response ...9 Ensure the call system alerts staff members directly or goes to a centralized staff work area. 10 All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires the appropriate personnel should be notified. 11 Process for responding to call lights: a. Turn off the signal light in the resident's room. b. Identify yourself and call the resident by name. c. Listen to the resident's requests and respond accordingly. Inform the resident if you cannot meet the need and assure him or her that you will notify the appropriate personnel. d. Inform the appropriate personnel of the residents need. e. Do not promise something you cannot deliver. On 5/1/2023 at 12:10 P.M., the Administrator provided a policy titled, "Promoting/Maintaining Resident Dignity", dated 12/22/2022, and indicated the policy was the one used by the facility. The policy indicated " ...The practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. 1. All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights ... 6. Respond to requests for assistance in a timely manner ... 9. Groom and dress residents according to resident preference ... 15. Random observations and/or verifications are conducted by the Directory of Nursing Services, or designee, to ensure compliance with this policy."			

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	This Federal tag relates to Complaint IN00405995. 3.1-32(a)			
F 0602 SS=E Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on interview and record review, the facility failed to prevent misappropriation of resident funds for 11 of 11 residents reviewed misappropriation of funds, (Residents E, S, T, U, V, W, X, Y, Z, BB, and CC). Findings include: On 4/27/23 at 3:18 P.M. during an interview, the Administrator indicated on 1/23/23 the facility was performing a routine audit, it was found that resident fund monies were missing from some resident accounts. The Administrator indicated an immediate investigation was initiated and the incident was immediately reported to the State Agency and to the local police department. The Administrator indicated the local police department was currently investigating the misappropriation of resident funds. The Administrator indicated the facility substantiated the misappropriation of resident funds and the Business Office Manager was immediately terminated based on the facility's investigation. The Administrator indicated 11 resident's had funds misappropriated from their accounts.	F 0602	**F602 – Free from Misappropriation/Exploitation** A. It is the practice of this facility to ensure all residents are free from misappropriation of resident property or funds. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident E – resident and/or responsible party notified, and funds replaced to resident account. Resident S - resident and/or responsible party notified, and funds replaced to resident account. Resident T - resident and/or responsible party notified, and funds replaced to resident	06/04/2023

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	On 4/28/23 at 10:48 A.M. during an interview with local police detective, the detective indicated he was notified of misappropriation of funds by the facility on 1/23/23 and the investigation was currently ongoing. The detective indicated he began contacting the families of the residents and found 11 residents that had money taken from their accounts. A police report was requested at that time, but was not provided as the case was not closed. The detective provided the case number. On 4/27/23 at 3:45 P.M., the Administrator provided the "Resident Statement Landscape," for Residents E, S, T, U, V, W, X, Y, Z, BB, and CC, and indicated the misappropriated funds were marked on each resident's statement with an "x." During an interview at that time, the Administrator indicated Resident E had been charged $9,000.00 that was collected in 3 separate, $3,000.00 checks from Resident E's family members. The Administrator indicated facility's Business Office Manager collected the $9,000.00 for Medicaid payment adjustments, but that the Business Office Manager never applied for Medicaid on behalf of the resident, so $9,000.00 should not have been collected from the resident nor the resident's family members. The Administrator indicated the Business Office Manager deposited the $9,000.00 into the resident's account then withdrew the $9,000.00 from the resident's account, where the $9,000.00 was not deposited in the facility account. The Administrator also provided a detailed email account from the facility's Sr. Business Office Manager related to misappropriated funds from Resident E's account. The Sr. Business Office Manager's email, dated 4/27/23 at 1:16 P.M.,		account. Resident U - resident and/or responsible party notified, and funds replaced to resident account. Resident V - resident and/or responsible party notified, and funds replaced to resident account. Resident W - resident and/or responsible party notified, and funds replaced to resident account. Resident X - resident and/or responsible party notified, and funds replaced to resident account. Resident Y - resident and/or responsible party notified, and funds replaced to resident account. Resident Z - resident and/or responsible party notified, and funds replaced to resident account. Resident BB - resident and/or responsible party notified, and funds replaced to resident account. Resident CC - resident and/or responsible party notified, and funds replaced to resident	

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	indicated Resident E's family paid the facility 3 checks for $3,000.00 each that were deposited into Resident E's account on 9/27/22. On 5/01/23 at 9:00 A.M., the clinical records and Resident Statement Landscape accounts were reviewed for Residents E, S, T, U, V, W, X, Y, Z, BB, and CC. Resident E was admitted to the facility on 7/07/22. The resident's payer source was Medicare and a secondary supplemental policy. Review of Resident E's Resident Statement Landscape indicated on 9/27/23, 2 private sector checks were paid to the facility in the amount of $3,000.00 each, and 1 personal check was paid to the facility in the amount of $3,000.00, to total $9,000.00 that was deposited into Resident E's account. On 9/27/23, 3 separate "Care Cost Auto Withdrawals" were made, each in the amount of $3,000.00. On 11/10/23 a transaction of "RESIDNT [Resident] ADVANCE CASH" paid to Petty Cash in the amount of $388.00, was marked as misappropriated funds. Resident S was admitted to the facility on 6/30/22, payer source was Medicaid. Review of Resident S's Resident Statement Landscape indicated on 9/27/22 a transaction of "RESIDENT ADVANCE CASH" paid to Petty Cash in the amount of $150.00, was marked as misappropriated. Resident T was admitted to the facility on 5/01/17, payer source was Medicaid. Review of Resident T's Resident Statement Landscape indicated on 9/19/22 a transaction of "RESIDENT ADVANCE CASH" paid to Petty Cash in the amount of $90.00, was marked as misappropriated. Resident U was admitted to the facility on		account. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All resident accounts were immediately audited to ensure no further misappropriation of funds. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All staff will be in-service on or before 6/4/23. This in-service will be conducted by the Executive Director or Designee and will include a review of resident rights and resident abuse related to misappropriation of resident property or funds. The Executive Director/Designee will audit resident accounts monthly to ensure residents remain free from misappropriation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this	

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	11/14/18, payer source was Medicaid. Review of Resident U's Resident Statement Landscape indicated on 10/14/22 a transaction of "RESIDENT ADVANCE CASH" paid to Petty Cash in the amount of $100.00, was marked as misappropriated. Resident V was admitted to the facility on 3/17/22, payer source was Medicaid. Review of Resident V's Resident Statement Landscape indicated on 9/09/22 a transaction of "RESIDENT ADVANCE CASH" paid to Petty Cash in the amount of $500.00, was marked as misappropriated. Resident W was admitted to the facility on 3/15/21, payer source was Medicaid. Review of Resident W's Resident Statement Landscape indicated on 9/02/22 a transaction of "RESIDENT ADVANCE CASH" paid to Petty Cash in the amount of $500.00, was marked as misappropriated. On 9/09/22 a transaction of "RESIDENT ADVANCE CASH" paid to Petty Cash in the amount of $500.00, was marked as misappropriated. On 9/19/22 a transaction of "RESIDENT ADVANCE CASH" paid to Petty Cash in the amount of $300.00, was marked as misappropriated. On 10/14/22 a transaction of "RESIDENT ADVANCE CASH" paid to Petty Cash in the amount of $500.00, was marked as misappropriated. On 11/10/22 a transaction of "RESIDENT ADVANCE CASH" paid to Petty Cash in the amount of $300.00, was marked as misappropriated. Resident X was admitted to the facility on 7/09/13 and expired on 7/24/22, payer source was		corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/Designee will be responsible for completing the QAPI Audit tools labeled "Resident Funds" monthly for 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 06/04/2023** Compliance Date = 06/04/2023	

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	Medicaid . Review of Resident X's Resident Statement Landscape indicated on 8/09/22 a transaction of "RESIDENT ADVANCE CASH" paid to Petty Cash in the amount of $1000.00, was marked as misappropriated. On 8/09/22 a transaction of "TO CLOSE ACCOUNT" in the amount of $684.35, was marked as misappropriated. On 8/18/22 a transaction of "RESIDENT ADVANCE CASH" paid to Petty Cash in the amount of $684.35, was marked as misappropriated. Resident Y was admitted to the facility on 4/14/22 and expired on 9/16/22, payer source was Medicaid Pending. Review of Resident X's Resident Statement Landscape indicated on 8/09/22 a transaction of "RESIDENT ADVANCE CASH" paid to Petty Cash in the amount of $100.00, was marked as misappropriated. Resident Z was admitted to the facility on 5/13/22, payer source was Medicaid Pending. Review of Resident Z's Resident Statement Landscape indicated on 9/19/22 a transaction of "PUTTING INTO KEY BAND," paid to Petty Cash in the amount of $400.00, was marked as misappropriated. Resident BB was admitted to the facility on 2/24/20 and discharged to local hospice facility on 10/12/22, payer source was Hospice Private. Review of Resident bb's Resident Statement Landscape indicated on 11/22/22 a transaction of "RESIDENT ADVANCE CASH" paid to Petty Cash in the amount of $500.00, was marked as misappropriated. Resident CC was admitted to the facility on 6/28/19 and expired on 11/13/22, payer source was			

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	Medicaid. Review of Resident cc's Resident Statement Landscape indicated on 12/19/22 a transaction of "CLOTHING" paid to Petty Cash in the amount of $2000.00, was marked as misappropriated. A policy, titled "Abuse, Neglect, and Exploitation" dated 12/22/22 was provided by the Administrator on 5/01/23 at 4:17 P.M. The policy indicated,"It is the policy of this facility to provide protections for...each resident...that prohibit and prevent...misappropriation of resident property...'Misappropriation of Resident Property' means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent..." This Federal tag relates to complaint IN00401801. 3.1-28(a)			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on interview, observation, and record review, the facility failed to ensure showers had been completed per schedule and preference for 4 of 8 residents reviewed for Activities of Daily Living (ADL). (Residents G, E, H, O) Findings include: 1. During an interview, on 4/27/2023 at 9:30 A.M., Resident G stated she had only received 3 showers since admission, on 12/22/2022.	F 0677	**F677- ADL Care Provided for Dependent Residents** A. It is the practice of this facility to ensure that all residents receive showers per their preference. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	06/04/2023

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	155689	A. BUILDING 00 B. WING	05/01/2023

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	A record review was completed, on 4/27/2023 at 2:00 P.M. Resident G's diagnoses included, but were not limited to post-traumatic stress disorder, dysphasia, Parkinson's, and neuromuscular dysfunction of bladder. A Significant Change MDS (Minimum Data Set) Assessment, dated 2/28/2023, indicated Resident G was alert and oriented and able to make her own decisions regarding her care. She required extensive assist of 2 staff for transfers and required total assist for bathing. The resident's preference for choosing shower or bed bath was documented as very important. A current care plan, dated 3/23/2023, indicated the resident needed assistance with activities of daily living due to the diagnoses of neuromuscular disfunction of bladder and chronic pain. Interventions included but were not limited to personal hygiene and transfer assistance. The shower schedule indicated Resident G was to receive showers on Wednesday and Saturday evenings. The shower documentation, dated 3/29/2023 through 4/27/2023, indicated the resident had been showered once during that time on 4/10/2023. During an interview, on 5/01/2023 at 10:42 A.M., LPN 20 indicated the resident should have been receiving 2 showers per week. 2. On 5/01/23 at 9:00 A.M., the clinical record for Resident E was reviewed. Resident E was admitted on 7/07/22 with diagnoses that included but were not limited to, interstitial pulmonary disease, congestive heart failure, chronic obstructive pulmonary disease,		Resident G – resident discharged from facility Resident E - residents bathing preferences reviewed and updated Resident H - residents bathing preferences reviewed and updated Resident O - residents bathing preferences reviewed and updated **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient practice. All residents bathing preferences reviewed and updated. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 6/4/2023. This in-service will be conducted by the Director of Nursing or Designee and will include a review of resident ADLs related to shower preferences. The Director or Nursing/Designee will audit all resident shower schedules daily to ensure that all residents are receiving showers per preference. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	anxiety disorder, rheumatoid lung disease, and chronic respiratory failure with hypoxia. Resident E's most recent comprehensive Minimum Data Set (MDS), for significant change was dated 10/25/22 and indicated the resident had a Brief Interview for Mental Status (BIMS) that indicated the resident had moderate cognitive impairment. Resident E required extensive assistance of 2 persons for personal hygiene and was totally dependant on staff for bathing. Resident E's Care Plans included but were not limited to Activities of Daily Living, initiated 7/08/22 and indicated the resident should receive showers on Monday, Wednesday, and Fridays on day shift. Review of Resident E's Skin Check/Shower Sheets from 9/01/22 to 10/27/22, indicated the resident should have received showers on the following dates: 9/07/22, 9/09/22, 9/12/22, 9/14/22, 9/16/22, 9/19/22, 9/21/22, 9/23/22, 9/26/22, 9/28/22, 9/30/22, 10/3/22, 10/05/22, 10/07/22,10/10/22, 10/12/22, 10/14/22, 10/17/22, 10/19/22, 10/21/22, 10/24/22, and 10/26/22. The showers Resident E actually received were on, 9/7/22, 9/10/22, 9/21/23, 9/28/23, 10/07/22 10/28/2, and 10/29/22, for only 7 of 22 scheduled showers from 9/01/22 to 10/27/22. 3. A record review was completed on 4/26/23 at 11:17 A.M. Resident H's diagnoses included, but		**recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled “Shower QAPI” weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 06/04/2023** Compliance Date = 06/04/2023	

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	were not limited to diabetes, hypertension, obesity and hemiplegia. A Quarterly MDS(Minimum Data Set) Assessment, dated 3/15/2023, indicated the resident required extensive assist of 1 staff for bed mobility, transfers, dressing, toilet use and supervision for eating and was total assist for bathing. A shower schedule indicated Resident H was to receive showers on Wednesday and Saturday on the day shift. Resident H's shower documentation indicated she had not received a shower on 4/15/2023 and 4/22/2013. During an interview, on 4/27/2023 at 11:39 A.M., RN 17 indicated the resident had not received two showers weekly and should have.4. During a record review for Resident O conducted, on 4/28/2023 at 10:52 A.M., the Quarterly MDS (Minimum Data Set) Assessment, dated 3/29/2023, included, but was not limited to: a BIMS (Brief Interview for Mental Status) that indicated no cognitive impairment. No behavior issues were noted. Resident expressed that it was very important to choose the type of bath received. He required extensive assist of 2 staff for bed mobility, transfers, toileting, and extensive assist of 1 staff for dressing. Resident is on a scheduled pain medication and expressed occasional pain, rated at 6, that sometimes made it hard to sleep at night. He did not take any as needed pain medications. Physical therapy started 12/18/2022 and the resident received 79 minutes over 4 days. No record of a shower or bed bath could be found on 4/5, 4/8, or 4/22/2023. Documentation in the			

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	EMR (electronic medical record) indicated Resident O received a shower on 4/15/2023. No other documentation for showers was noted. Shower sheets provided by the Administrator, on 4/28/2023 at 1:15 P.M., indicated Resident O only received showers on 4/12, 4/19, and 4/26/2023. No documentation of refusals of showers could be found. During an interview, on 4/28/2023 at 1:58 P.M., CNA 11 indicated residents receive showers 2 times a week and if they refuse, staff documents it on a shower sheet and reports it to the nurse. During an interview, on 4/28/2023 at 2:02 P.M., QMA 12 indicated she tries to encourage the resident and if they still refuse, she reports it to the nurse. During an interview, on 4/28/2023 at 2:04 P.M., the Unit Manager indicated they try to offer another day and if they still refuse then the family is notified and it is documented in the Progress Notes in the EMR. On 5/1/2023, shower refusals for Resident O could not be found in the EMR. During an interview, on 5/1/2023 at 1:37 P.M., the Unit Manager indicated that the documentation of refusals by Resident O were not present but should have been. During an interview, on 5/1/2023 at 1:39 P.M., LPN 19 indicated that she documented refusals of showers, for other residents, in the hydration assessment. On 5/1/2023 at 1:46 P.M., shower refusals could			

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	not be found in hydration assessments. On 5/1/2023 at 12:10 P.M., the Administrator provided the policy titled, "Activities of Daily Living", dated 12/22/2022, and indicated the policy was the one currently used by the facility. The policy indicated"...The facility will, based on the resident's comprehensive assessment and consistent with the resident's need and choices, ensure a resident's abilities in ADL's do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care...." This Federal tag relates to complaint IN00404638. 3.1-38(a)(3)			
F 0691 SS=D Bldg. 00	483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, record review, and interview, the facility failed to ensure the facility had physician orders for the care of a urostomy, and the facility failed to ensure a urostomy drainage bag was emptied and not positioned on the floor for 1 of 3 residents reviewed for urinary drainage devices. (Resident G) Finding includes: A record review, on 4/26/2023 at 11:40 A.M.	F 0691	**F691 – Colostomy, Urostomy, or Ileostomy Care** A. It is the practice of this facility to ensure urostomy drainage bags are emptied as needed and not placed on the floor. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	06/04/2023

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	Resident G's diagnoses included but not limited to post-traumatic stress disorder, dysphagia, Parkinson's, and neuromuscular dysfunction of bladder. A Significant Change MDS (Minimum Data Set) Assessment, dated 2/28/2023, indicated Resident G required extensive assist of 2 staff for bed mobility, transfers, dressing, toileting, and total assist for bathing. Resident G required the usage of a urostomy for bladder drainage. A current care plan, dated 1/17/2023, indicated the resident has episodes of incontinence of bladder related to urostomy. Interventions included but not limited to: Empty urostomy every shift and as needed, and observe pattern of incontinence, and initiate toileting schedule if indicated. Resident G's record lacked physician orders for the care of and maintaining of the urostomy and the urinary drainage bag. During an observation, on 4/28/2023 at 9:10 A.M. the resident's urostomy drainage bag was on the floor with 3500 mL (milliliters) of urine. The drainage bag was expanded with urine backing up the tubing. The tubing was observed with a buildup of white sediment. During an interview, on 4/28/2023 at 9:50 A.M., RN 6 indicated the urostomy drainage bag should be emptied at the start of every shift, and the bag should not have been on the floor. During an interview, on 4/28/2023 at 2:20 P.M., RN 6 indicated she was unaware that the resident did not have any orders to care or maintain the urostomy and stated there should have been orders.		**practice:** Resident G – resident discharged from facility **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents who utilize a urostomy drainage bag have the potential to be affected by this deficient practice. All residents who utilize a urostomy drainage bag were reviewed and care plans updated as needed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 6/4/2023. This in-service will be conducted by the Director of Nursing or Designee and will include a review of colostomy, urostomy, and ileostomy care. The Director or Nursing/Designee will complete catheter QAPI review weekly to ensure all residents utilizing drainage bags are being cared for appropriately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	On 5/1/2023 at 4:03 P.M., the Administrator provided the policy titled "Ostomy Care-Colostomy, Urostomy, and Ileostomy", dated 11/22/2022, indicated the policy was the one currently being used by the facility. The policy indicated " ...It is the policy of this facility to ensure that residents who require colostomy, urostomy, or ileostomy services receive care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences ...3 Ostomy care will be provided by licensed nurses under the orders of the attending physician...." On 5/1/2023 at 4:03 P.M., the Administrator provide the policy titled, "Catheter Care", dated 12/22/2022, and indicated the policy was the one currently used by the facility. The policy indicated " ...It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use ...8 Empty drainage bags when bag is half-full or every 3 to 6 hours. 9 Ensure drainage bag is located below the level of the bladder to discourage backflow of urine ...." This Federal tag relates to Complaint IN00405995. 3.1-47(a)(3)		**into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled "Catheter" weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 06/04/2023** Compliance Date = 06/04/2023	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (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			

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	facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on interview, observation and record review, the facility failed to obtain a physicians order prior to reinserting a gastrostomy tube after tube was dislodged for 1 of 3 residents reviewed for enternal feedings. (Resident R) Findings include: During an interview, on 4/28/23 at 1:40 P.M., Resident R's spouse indicated the facility had called her last night to notify her that Resident R's gastrostomy tube had come out. Spouse indicated she requested Resident R be sent out to the hospital due to the fact the tube has come out 3 times. Spouse indicated she learned that a nurse had reinserted the gastrostomy tube and had not taken him to the hospital. Resident R indicated a nurse had put the feeding tube back in at the facility. During an observation, on 4/28/23 at 1:47 P.M., Resident R's gastrostomy tube was inserted, area around insertion site was bright red, no gauze	F 0693	**F693 – Tube Feeding Mgmt/Restore Eating Skills** A. It is the practice of this facility to obtain physician orders prior to reinserting gastrostomy tube. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident R – nurse practitioner notified and reviewed resident, new order received, all orders and care plans reviewed and updated. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this deficient	06/04/2023

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	noted to area and gastrostomy tube was not anchored. A record review was completed on 4/28/23 at 2:40 P.M., Resident R's diagnoses included, but were not limited to: Alzheimer's disease, hemiplegia and hemiparesis, cerebral infarction affecting left dominant side, muscle weakness, hypertension, chronic obstruction pulmonary disease, dysphagia oropharyngeal phase, squamos cell carcinoma of nose, cerebellar stroke and peripheral vascular disease. During an interview, on 5/1/23 at 11:51 A.M., the Assistant Director of Nursing (ADON) indicated nursing staff did not obtain a physicians order to reinsert the gastrostomy tube, and one should have been in place. On 5/1/23 at 1:35 P.M., the Executive Director provided the policy titled, "Care and Treatment of Feeding Tubes", with a review date of 12/22/22, and indicated the policy was the one currently used by the facility. The policy indicated"...8. Order a. When to replace and/or change a feeding tube (generally as ordered/scheduled by the physician, when a long term feeding tube comes out unexpectedly, or when the tube is worn and clogged...." 3.1-47(a)(2)		practice. All nurses educated on physician orders and putting verbal orders in EMAR system when received and all residents with gastrostomy tubes have received standing order for replacement as needed from MD. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 6/4/2023. This in-service will be conducted by the Director of Nursing or Designee and will include a review of physician orders. The Director or Nursing/Designee will physician order review daily to ensure all physician orders are transmitted into EMAR system when received. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled “Enteral Orders”” weekly for 4 weeks and	

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			monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 06/04/2023** Compliance Date = 06/04/2023	
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to ensure oxygen was provided as ordered, failed to change oxygen equipment and failed to ensure oxygen equipment was dated for 4 of 5 residents reviewed for oxygen use. (Residents N, M. C, F). Findings include: 1. During an observation, on 4/26/2023 at 2:57 P.M., Resident N's oxygen was running at 2 liters per minute. The oxygen tubing and humidification bottle were undated.	F 0695	**F695 – Respiratory/Tracheostomy Care and Suctioning** It is the practice of this facility to ensure oxygen is provided as ordered and equipment dated. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident N – tubing, bottle and equipment dated and stored	06/04/2023

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	A record review was completed, on 4/26/23 at 4:00 P.M. Diagnoses for Resident N included but were not limited to, pulmonary embolism, cardiomyopathy, multiple sclerosis, paroxysmal atrial fibrillation. A Physician Order, dated 4/24/2023, indicated oxygen at 1 liter per nasal cannula every 2 hours for one day weaning off oxygen. The current care plan, dated 4/22/2023, indicated Resident N was to receive special services/procedures. Interventions included but were not limited to, Respiratory Care (Specify i.e. Oxygen, nebs, BiPap, Cpap, trache) The MAR (Medication Administration Record), dated April 2023, indicated Resident N had been weaned off of the oxygen use on 4/25/2023. During an observation, on 4/27/2023 at 11:45 A.M., Resident N was in bed with nasal cannula laying on bedside table. Resident N stated that she had taken the nasal cannula off and forgot to put it back on. The oxygen flow was running at 2 liters. During an observation, on 4/28/2023 at 11:45 A.M., Resident N's oxygen was running at 2 liters per nasal cannula. During an observation, on 5/1/2023 at 9:52 A.M., the concentrator was running at 2 liters with the oxygen tubing laying across the bedside table. The oxygen tubing and humidification bottle were undated, but the equipment bag was dated 4/24/2023. During an interview, on 5/1/2023 at 10:11 A.M., RN 17 indicated there was no existing order for the		appropriately and orders updated to reflect current usage. Resident M – tubing, bottle, and equipment dated and stored appropriately and orders updated to reflect current usage. Resident C – tubing, bottle, and equipment dated and stored appropriately and orders updated to reflect current usage. Resident F – tubing, bottle, and equipment dated and stored appropriately. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents receiving oxygen therapy have the potential to be affected by this deficient practice. Audit was completed for all residents utilizing respiratory therapy, orders and care plans reviewed and updated as appropriate. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nursing staff will be in-serviced on or before 6/4/2023. This in-service will be conducted by the Director of Nursing or Designee and will include a review of physician orders and respiratory care. The Director or	

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	oxygen use and the order had been completed on 4/25/2023. During an observation, on 5/1/2023 at 10:13 A.M., with RN 17, Resident N's oxygen tubing and humidification bottle were undated. RN 17 indicated both should have been dated and that the bag currently dated for 4/24/2023 should have been changed and dated weekly. Resident N's was not wearing the nasal cannula. The oxygen concentrator was currently running at 2 liters. RN 17 indicated Resident N's oxygen order was for one liter and was to have been weaned off of the oxygen. 2. During an observation, on 4/2620/23 at 3:05 P.M., Resident M was sitting up in wheelchair with a portable oxygen tank on the back the wheelchair. All of the oxygen tubing and oxygen/concentrator tubing and humidification were undated. The oxygen equipment bag had a date of 4/20/2023. Resident M indicated that "sometimes her oxygen has run out and has had to wait for it to be filled". During an interview, on 4/26/2023 at 3:17 P.M., LPN 4 entered the resident's room and checked the portable oxygen tank. She checked Resident M's portable oxygen tank and stated, "the oxygen tank is checked daily" and prior to "going anywhere". LPN 4 indicated that resident M's current oxygen order was for 2 liters continuously per nasal cannula. During an observation, on 4/27/2023 at 11:50 A.M., Resident M's portable oxygen was on at 2 liters per minute. The humidification water bottle and tubing on the concentrator remained undated. During an observation, on 4/28/2023 at 10:02 A		Nursing/Designee will audit all residents utilizing respiratory care weekly to ensure orders and being followed and all equipment is properly labeled and stored. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for completing the QAPI Audit tools labeled "Respiratory QAPI" weekly for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow-up. **By what date the systemic changes will be completed: 06/04/2023** Compliance Date = 06/04/2023	

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	M., Resident M's oxygen was on at 2 liters. The humidification water bottle and tubing on the concentrator remained undated. A record review was completed on 4/27/2023 at 2:30 P.M. Resident M's diagnoses included, but were not limited to, hypertension, seizures, and atrial fibrillation. A Physician's Order, dated 2/1/2023, indicated oxygen at 2 liters per minute via nasal cannula every shift had been discontinued on 2/1/2023. The TAR (Treatment Administration Record), dated for April 2023, indicated that Resident M was not receiving oxygen currently. During an observation, on 4/28/2023 at 11:46 A.M., Resident M's oxygen was on at 3 liters per minute. The nasal cannula tubing was dated 4/28/2023 and the humidification bottle remained undated. During an observation, on 5/1/2023 at 9:57 A.M., Resident M's oxygen was on at 4 liters per minute per nasal cannula. The humidification bottle remained undated. A current care plan, dated 12/22/2022, indicated Resident M was at risk for respiratory distress. Interventions included, but were not limited to: oxygen as ordered. During an interview, on 5/1/2023 at 10:05 A.M., RN 17 indicated the oxygen tubing, humidification bottle and equipment bag should have been changed once per week, and that humidification bottle should have been dated. RN 17 indicated that Resident M's current oxygen order was for oxygen at 2-3 liters per nasal cannula. RN 17			

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	reviewed Resident M's current physician orders, and indicated the order for oxygen use had been discontinued "a long time ago on 2/1/2023". RN 17 stated that nursing management is responsible for updating orders. 3. During an observation, on 4/26/2023 at 3:02 P.M., Resident C was observed using oxygen at 3 liters per minute via a nasal cannula. The humidification water bottle was empty and dated 4/20/2023. The filter on the back of the concentrator was filled dust. A BiPAP (assisted breathing machine) was located on the nightstand with a small amount of water in it and a gray colored film along the bottom edge of the water reservoir. A record review was completed on 4/26/2023 at 3:37 P.M. Resident C's diagnoses included, but were not limited to chronic obstructive pulmonary disease, congestive heart failure, sleep apnea, diabetes and narcolepsy. Current physician orders included: BiPAP full face mask on at hs (hour of sleep) and off in am. Clean BiPAP humidifier weekly with warm soapy water and rinse thoroughly, fill with water solution of 1 vinegar/3 water mix. Soak for 30 minutes and rinse thoroughly then replace back on BiPAP machine. Oxygen- clean oxygen filter every week on Sunday night shift with an order date of 4/30/2023. During an interview, on 4/26/2023 at 4:05 P.M., LPN 5 indicated the resident didn't use the BiPAP machine. She opened water reservoir on the machine. Water spilled out on the table. LPN 5 indicated "well maybe she does use it". LPN 5 indicated the machine was not clean and the water humidification bottle to the concentrator should have been replaced if empty.			

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	4. During an observation, on 4/27/2023 at 9:36 A.M., Resident F was observed using oxygen at 2 liters via nasal cannula. The humidification bottle was dated 4/1/2023 and the air intake vent on the back of the concentrator was full of dust. A clinical record review was completed on 4/27/2023 at 10:27 A.M. Resident F's diagnoses included, but were not limited to congestive heart failure, hypertension, diabetes, depression, and chronic obstructive pulmonary disease. A Significant Change MDS (Minimum Data Set) Assessment, dated 3/13/2023, indicated Resident F was alert and oriented and able to make own decisions and used oxygen. During an interview, on 4/27/2023 at 11:49 A.M. RN 17 indicated the water bottle should have been replaced and the filter should have been cleaned. On 5/1/2023 at 12:10 P.M., the Administrator provided the policy titled,"Oxygen Administration", dated 12/22/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...1. Oxygen is administered under orders of a physician, except in the case of an emergency... 5.c. Change humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer... 7. Cleaning and care of equipment shall be in accordance with facility policies for such equipment..." This Federal tag relates to Complaint IN00401728. 3.1-47(A)(6)			
F 0697 SS=D	483.25(k) Pain Management			

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Bldg. 00	§483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to ensure pain management instructions were followed per physician's order for 1 of 2 residents reviewed for pain. (Residents E) Finding includes: On 5/01/23 at 9:00 A.M., the clinical record for Resident E was reviewed. Resident E was admitted to the facility on 7/07/22 with diagnoses that included, but were not limited to, interstitial pulmonary disease, congestive heart failure, chronic obstructive pulmonary disease, anxiety disorder, rheumatoid lung disease, chronic respiratory failure with hypoxia, dependence on supplemental oxygen, and shortness of breath. Resident E's most recent comprehensive Minimum Data Set (MDS), for significant change was dated 10/25/22. The Brief Interview for Mental Status (BIMS) indicated Resident E had moderate cognitive impairment, received routine pain medication and additional pain medication as needed for frequent and limiting pain. Review of the resident's Physician's Orders indicated the resident's prescribed medications included but were not limited to; Admission to local Hospice Services dated 10/19/22, (due to end-stage pulmonary fibrosis), Morphine Sulfate (Concentrate) 100 MG/5 ML, to give 0.5 ML by mouth every 2 hours as needed for pain and air hunger, to begin 10/23/22 at 7:30 P.M.	F 0697	**F697 – Pain Management** It is the practice of this facility to ensure pain management instructions are followed per physicians orders. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident E – has discharged from facility **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents receiving pain management have the potential to be affected by this deficient practice. All residents receiving pain management have been reviewed to ensure that all medications are being delivered and documented per physicians orders. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	06/04/2023

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	Morphine Sulfate (Concentrate) 20 MG/ML, to give 0.5 ML by mouth every 4 hours for pain and air hunger, to begin 10/29/22 at 4:00 A.M., Review of Resident E's Medication Administration Record indicated the resident did not receive the following medications as ordered, Morphine Sulfate (Concentrate) 20 MG/ML, to give 0.5 ML by mouth every 4 hours was not administered on 10/29/22 at 4:00 A.M., and 12:00 P.M., Review of Resident E's Care Plans included but were not limited to; "[Resident] is at risk for pain due to: chronic respiratory failure with hypoxia, interstitial pulmonary disease...Administer medication as ordered..." Dated 7/13/22. The policy, titled "Medication Administration," dated 12/22/22 was provided by the Administrator on 5/01/23 at 12:00 P.M., and indicated it was the current facility policy. The policy indicated, "Medications are administered by licensed nurses...as ordered by the physician...Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician..." On 5/1/2023 at 12:15 P.M., the Administrator provided the policy titled,"Pain Management', dated 12/22/2022, and indicated the policy was the one currently used by the facility. The policy indicated"...The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person centered care plan and the resident's goals and preferences. 1. The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in		**practice does not recur:** All nursing staff will be in-serviced on or before 6/4/2023. This in-service will be conducted by the Director of Nursing or Designee and will include a review of pain management and EMAR documentation. The Director or Nursing/Designee will review all residents receiving pain medication daily to ensure that medications are administered and documented in EMAR appropriately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Director of Nursing/Designee will be responsible for facility EMAR daily for 4 weeks and monthly for at least 6 months. If 100% is not achieved an action plan will be developed. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed: 4/6/2023** Compliance Date = 4/6/2023	

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	consistent assessment of a resident's pain... c. Asking the patient to rate the intensity of his/her pain using a numerical scale, a verbal or visual descriptor that is appropriate and preferred by the resident. Evaluate to resident's medical condition. current medication regimen, cause and severity of the pain and course of illness to determine the most appropriate analgesic therapy for pain...." This Federal tag relates to Complaints IN00401470, IN00401801 and IN00402873. 3.1-37(a)			