STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155143	A. BUILDING 00 B. WING	06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF TERRE HAUTE	3150 N SEVENTH ST TERRE HAUTE, IN 47804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 26, 27, 28, 29, and 30, 2023 Facility number: 000067 Provider number: 155143 AIM number: 100267880 Census Bed Type: SNF/NF: 73 Total: 73 Census Payor Type: Medicare: 7 Medicaid: 62 Other: 4 Total: 73 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 6, 2023.	F 0000		
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident			

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

Wendy McNamara Baker | HFA | 07/21/2023

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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	to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation, interview, and record review, the facility failed to ensure a resident was provided a comfortable and sanitary environment for 1 of 24 residents reviewed for a home-like environment (Resident 6). Finding includes:	F 0584	It is the policy of the facility to provide a safe, clean, comfortable and homelike environment. Facility reviewed policy and procedures regarding notification of administration of repair to drywall.	07/21/2023

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	On 6/26/23 at 8:05 a.m., Resident 6 was observed lying in bed with the bed against the wall. The wall was marked and scratched up significantly with a large area of the white drywall showing on the wall. On 6/27/23 at 10:18 a.m., Resident 6 was observed lying in bed with the bed against the wall. The wall was marked and scratched up significantly with a large area of the white drywall showing on the wall. On 6/29/23 at 9:25 a.m., Resident 6 was observed lying in bed with the bed against the wall. The wall was marked and scratched up significantly with a large area of the white drywall showing on the wall. On 6/29/23 at 12:29 p.m., the Maintenance Supervisor indicated the staff got the bed too close to the wall and the bed should be pulled out away from the wall. The wall needed to be repaired and painted. Staff should have sent him a work order to have the wall repaired, but he had not received a work order about the wall being marked up. On 6/29/23 at 2:30 p.m., the Maintenance Supervisor provided and identified an undated document as a current facility policy titled, "Resident Environmental Quality." The policy indicated, "...It is the policy of this facility to be designed, constructed, equipped, and maintained to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public...12. All facility personnel are responsible for reporting broken, defective or malfunctioning equipment or furnishings immediately upon identification of the issue...."		All employees were in serviced on reporting policy and procedures. Completed 7/21/23 Maintenace performed a walking visual inspection of the facility. Completed 7/14/23 Resident # 6 was not harmed. Resident #6 and/or POA did not voice concern with the scratches on the wall. The Wall of Resident #6 wall was repaired. Work completed on 7/21/23. The remaining identified areas are projected to be completed within the next 30 days. To ensure future compliance the head of housekeeping and/or maintenance director will complete a monthly visual inspection of all rooms and public spaces. A log has been created to track the condition of the areas. (Attachment A) The log will be submitted to the Executive Director and reviewed by the QAPI committee monthly for the next 3 months	

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	3.1-9(a) 3.1-19(f)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure the complete investigation of a resident-to-resident abuse allegation for 2 of 2 residents reviewed for abuse allegations (Residents 20 and 18). Findings include: On 6/28/23 at 2:04 p.m., a document titled, "Indiana Department of Health (IDOH) Survey Report System," dated 6/18/23 at 9:35 a.m., was provided by the Executive Director (ED). The document indicated Resident 20 had reported to a nurse that Resident 18 had touched her	F 0610	It is the policy of the facility to ensure that the facility policy and practices are consistent with the requirements stated in the regulations. The Incident between Resident #18 and Resident #20 was investigated. Resident #20 stated it was not witnessed by staff or any other residents. Residents were interviewed by facility staff with no other concerns identified. Resident #18 was instantly placed on 1:1.	07/21/2023

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	inappropriately. No physical injury had been noted. The immediate action taken was to place Resident 18 on one on one (1:1) observation while out of bed and every 15-minute checks while in bed. The ED, Director of Nursing (DON), family, and physician had all been made aware. On 6/19/23, Resident 18 was sent out to a behavioral health facility. The document lacked any further follow-up information. 1. Resident 20's record was reviewed on 6/28/23 at 1:33 p.m. The profile indicated the resident's diagnoses included, but were not limited to, cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it) and metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood). A quarterly Minimum Data Set (MDS-a standardized assessment tool that measures health status in nursing home residents) assessment, dated 5/23/23, indicated the resident had moderate cognitive deficit. A progress note, dated 6/18/23 at 10:20 a.m., indicated the resident had come to the nurse's station in her wheelchair and was crying. The nurse took the resident to her room where she told the nurse the Resident 18 had pulled up her shirt and touched her breast, then pulled on her pants out and stuck his hand down the front of her pants. The resident demonstrated how the incident had happened. The nurse provided reassurance and notified the ED and DON. 2. Resident 18's closed record was reviewed on 6/28/23 at 2:06 p.m. The profile indicated the resident's diagnoses included, but were not limited to, cellulitis of left lower limb (a common		Resident# 20 was not harmed by the alleged violation All staff were educated regarding the proper investigation protocol. Competed 7/21/23 Facility will utilize Abuse Investigation Checklist. (Attachment B) The Executive Director will review and sign off on the Investigation Checklist. All Investigations will be reviewed by the QAPI committee at least quarterly for the next 2 quarters. If no further concerns are identified the QAPI committee will end the review of the abuse checklist.	

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	bacterial skin infection that causes redness, swelling, and pain in the infected area of the skin), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should) and alcohol dependence uncomplicated (a chronic disease in which a person craves drinks that contain alcohol and is unable to control his or her drinking). A quarterly Minimum Data Set (MDS-a standardized assessment tool that measures health status in nursing home residents) assessment, dated 5/21/23, indicated the resident had severe cognitive deficit and had no documented behaviors. A Social Services Director (SSD) progress note, dated 6/19/23 at 9:49 a.m., indicated the resident had presented with sexually inappropriate behavior towards another resident. He was immediately placed on one on one. Family and doctor notified. Patient being admitted to behavioral health for evaluation and treatment. During an interview, on 6/29/23 at 8:34 a.m., Certified Nurse Aide (CNA) 5 indicated she had just heard about the incident from Resident 20. No one had ever interviewed her about the incident. During an interview, on 6/29/23 at 8:38 am, Licensed Practical Nurse (LPN) 7 indicated she only heard about the incident from other staff. No one had ever interviewed her about the incident. During an interview, on 6/29/23 at 8:39 am, CNA 8 indicated she had been at the nurse's station when the resident reported it to the nurse. No one had ever interviewed her about the incident. During an interview, on 6/29/23 at 9:00 a.m., the			

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	SSD indicated she and the ED made the decision to send the resident out. The physician had no questions or concerns and gave the order to send the resident to the behavioral health facility. There had been no other behaviors with the resident towards other residents reported. There had been a report of an inappropriate request for sexual favors from a female staff on 2/10/23, when he had attempted to reach up a staff's shirt and requested the staff perform oral sex on him. The resident had a care plan addressing this behavior. She further indicated she had not been a part of the investigation process. During a telephone interview, on 6/29/23 at 9:32 a.m., LPN 11 indicated she was working the unit where the incident happened but did not witness the incident. She was a new nurse at the facility, and the resident went to another nurse to report it. She may have been on a break or at lunch when it happened. She was told about it from the other nurse who the resident reported it to. The other nurse had already contacted the ED and DON. No one had ever interviewed her about what she knew about the incident prior to this call today. During a telephone interview, on 6/29/23 at 9:40 a.m., CNA 10 indicated she was walking down the hall and Resident 20 told her what had happened. She immediately reported it to her nurse on the unit and to another nurse who had been a nurse at the facility longer than the nurse on her hall. The male resident was immediately placed on 1:1 and he was in constant sight of the staff the entire shift. As far as she was aware of, the male resident had never done anything like that to another resident in the facility before. She had been told he had made suggestive comments to other staff during his shower times but had not done so to her personally. No one had ever interviewed her			

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	regarding the incident. During an interview, on 6/29/23 at 10:14 a.m., the Business Office Manager (BOM) indicated she had come into the facility, on the date of the incident, because she lived close to the facility, and interviewed all female residents in the facility. At the same time, she provided a document with names of the residents on it. The document had handwritten notes next to the female names on the document. The document was not presented as part of the investigation packet by the ED on 6/28/23 at 2:04 p.m., when the investigation report information had been initially presented. During an interview, on 6/28/23 at 11:10 a.m., the ED indicated the male resident had not ever acted out towards any of the other residents before this incident. The incident happened in a common area of the facility. No one witnessed the incident. The female resident approached staff and was upset and told them what had happened. They immediately placed the male resident on 1:1. A full skin assessment was completed on the female resident, with no findings, and support was provided for her. After contacting the physician, the physician gave the order for a psych evaluation on the resident. The resident was placed in a behavioral health facility for evaluation and treatment. On 6/28/23 at 2:04 p.m., the ED provided a document, with a revision date of March 2021, titled, "Abuse Prevention Program," and indicated it was the policy currently being used by the facility. The policy indicated, "...Protection of the Resident...Should an incident or suspected incident of resident abuse...be reported, the Administrator, or his/her designee, will appoint a member of management to investigate the alleged			

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	incident. The individual conducting the investigation will, at a minimum...Interview the person(s) reporting the incident; Interview witnesses to the incident; Interview the resident (as medically appropriate); Interview the resident's attending physician as needed to determine the resident's current level of cognitive function and medical condition; Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident...A completed copy of the incident report and written statements...must be provided...The Administrator will provide a written report of the results of all abuse investigations...." 3.1-28(a) 3.1-28(d)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure proper storage of respiratory equipment and failed to obtain and follow physician orders for 2 of 2 residents reviewed for respiratory care (Residents 25 and 10). Findings include:	F 0695	t is the policy of the facility to ensure that the facility policy and practices are consistent with the requirements stated in the regulations. The facility changes Oxygen tubing, bags, water every week and as need for soilage. Nurses were in serviced regarding facility Respiratory Care Policy.	07/21/2023

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	1. On 6/26/23 at 10:28 a.m., Resident 25's unbagged nebulizer mouthpiece and tubing were observed on the resident's nightstand table next to the nebulizer machine. The resident was resting in her recliner. On 6/28/23 at 9:10 a.m., Resident 25 was observed to be sitting in her recliner talking with her spouse. An unbagged nebulizer mouthpiece and tubing were observed on the resident's nightstand table next to the nebulizer machine. On 6/29/23 at 9:40 a.m., Resident 25 was observed to be resting in her recliner. An unbagged nebulizer mouthpiece and tubing were observed on the resident's nightstand table next to the nebulizer machine. Resident 25's record was reviewed on 6/27/23 at 3:08 p.m. The profile indicated the resident diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD-a group of diseases that cause airflow blockage and breathing-related problems) and chronic and acute respiratory failure (acute or chronic impairment of gas exchange between the lungs and the blood causing hypoxia [inadequate supply of oxygen] with or without hypercapnia [too much carbon dioxide in your blood]). A significant change in status Minimum Data Set (MDS) assessment, dated 6/4/23, indicated the resident was cognitively intact and received oxygen therapy. A care plan, dated 6/16/23, indicated the resident was at risk of respiratory distress related to chronic respiratory failure and COPD. Interventions included but were not limited to, administer medications as ordered and oxygen as		Completed 7/21/23 Residents # 25 and #10 suffered no harm for the allegations. DNS and/or will perform weekly checks to ensure that the tubing/oxygen bag is dated, and Nebulizer tubing and mask are in the bag when not in use. The DNS and/or designee will review at minimum of 10 respiratory patients per week for the next 4 weeks. A minimum of 5 per week for 4 weeks 1 per week for 2 weeks. Any identified concerns will be corrected and education will be provided immediately to the nursing staff. The weekly checks will be reviewed by the QAPI committee monthly for the 3 months. The QAPI committee will monitor the logs and determine if any further monitoring is required.	

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	ordered. A physician's order, dated 6/1/23, indicated albuterol sulfate nebulization solution (a medication that can help people with lung problems, like asthma or obstructive pulmonary disease, breathe easier); 2.5 milligrams (mg)/3 milliliters (ml) 0.83%. 1 vial orally via nebulizer 4 times a day. During an interview, on 6/29/23 at 2:25 p.m., Licensed Practical Nurse (LPN) 12 indicated after the resident had completed their nebulizer treatment, the nurse was to rinse out the nebulizer equipment and then place in a plastic bag for storage while not in use. During an interview, on 6/30/23 at 8:23 a.m., the Regional Nurse Consultant indicated nebulizer tubing and mouthpiece should be placed in a bag after use. On 6/30/23 at 9:32 a.m., the Regional Nurse Consultant provided an undated document, titled, "Oxygen Administration," and indicated it was the policy currently being used by the facility. The policy indicated, " ...e. Keep delivery devices covered in plastic bag when not in use ...." 2. On 6/27/23 at 10:06 a.m., Resident 10 was observed to be resting in bed, the resident was receiving oxygen through a nasal cannula at 3.5 liters (L). No date was noted to be on the oxygen tubing. On 6/28/23 at 10:14 a.m., Resident 10 was observed to be resting in bed, the resident was receiving oxygen through a nasal cannula at 3.5L. No date was noted to be on the oxygen tubing.			

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	On 6/29/23 at 12:11 p.m., Resident 10 was observed to be resting in bed, the resident was receiving oxygen through a nasal cannula at 3.5L. No date was noted to be on the oxygen tubing. On 6/29/23 at 2:40 p.m., Resident 10 was observed to be resting in bed, the resident was receiving oxygen through a nasal cannula at 3.5L. No date was noted to be on the oxygen tubing. On 6/30/23 at 08:23 a.m., Resident 10 was not noted to be in her room. The Oxygen concentrator in her room was on and the oxygen level was set at 3.5L. Resident 10's record was reviewed on 6/28/23 at 11:23 a.m. The profile indicated the resident diagnoses included, but were not limited to, COPD and chronic and acute respiratory failure with or without hypercapnia. An admission Minimum Data Set (MDS) assessment, dated 4/28/23, indicated the resident was cognitively intact and received oxygen therapy. A care plan, dated 5/1/23, indicated the resident was at risk for respiratory distress related to chronic respiratory failure and COPD. Interventions included but were not limited to, administer medications as ordered and oxygen as ordered. A physician's order, dated 5/1/23, indicated Oxygen at 5L per nasal cannula at all times due to COPD. The record lacked a physician order for tubing to be dated and changed out weekly. During an interview, on 6/27/23 at 10:06 a.m., Resident 10 indicated she had an order for 5L of			

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	oxygen to be administered per nasal cannula. During an interview, on 6/29/23 at 2:20 p.m., LPN 14 indicated oxygen tubing was changed and dated weekly unless soiled and needed to be changed out before then. LPN 14 indicated resident 10 had an order for 5L of oxygen per nasal cannula. During an interview, on 6/30/23 at 8:23 a.m., the Regional Nurse Consultant indicated Resident 10's oxygen concentrator did show a level of 3.5L of oxygen, she was unsure why the resident was not being administered the 5L as ordered by the physician. On 6/30/23 at 9:32 a.m., the Regional Nurse Consultant provided an undated document, titled, "Oxygen Administration," and indicated it was the policy currently being used by the facility. The policy indicated, " ...1. Oxygen is administered under orders of a physician ...b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated ...." 3.1-47(a)(6)			
F 0732 SS=A Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.			

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	(B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure accurate staffing sheets were posted daily for 1 of 5 days during the recertification survey. Finding includes: During an observation, on 6/26/23 at 12:27 p.m., the staffing sheet posted on the bulletin board in the lobby area was dated for 6/23/23. During an interview, on 6/30/23 at 2:23 p.m., the Administrator indicated the staff posting was	F 0732	t is the policy of the facility to ensure that the facility policy and practices are consistent with the requirements stated in the regulations. The facility reviewed policy and procedures for posting of nursing staff. The Nursing scheduler is responsible for the posting of the nursing hours Monday - Friday	07/21/2023

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	placed on the bulletin board on Fridays for the whole week. She further indicated a staff member had not pulled off the previous day's posting. On 6/30/23 at 2:27 p.m., the Administrator provided a document, with a revised date of July 2016, titled, "Posting Direct Care Daily Staffing Numbers," and indicated it was the policy currently being used by the facility. The policy indicated, " ...1. Within 2 hours of the beginning of each shift, the number of Licensed Nurses and the number of unlicensed nursing personnel directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format ...."		and the weekend supervisor is responsible for the posting on the weekends. The receptionist will check daily to ensure the posting is up to date. The receptionist will log that posting is completed. Any discrepancies will be reported the house supervisor, DNS or Executive Director immediately. The executive Director will review the log 1x per week for the next 4 weeks to ensure compliance and 1x every two weeks for 30 days and randomly thereafter.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs			

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	listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure proper labeling on a medication card for 1 of 7 residents reviewed for medication administration (Resident 33). Finding includes: During a medication administration observation, on 6/29/23 at 9:00 a.m., Resident 33's medication card indicated the resident was to receive one half of a tablet of 20 miligrams (mg) of Lexapro (a medication used to treat depression and/or anxiety) daily. A current physician's order, dated 6/21/23, indicated Lexapro 20 mg, give one tablet by mouth daily for depression. A discontinued physician's order, dated 2/7/23, indicated Lexapro 20 mg, give one half tablet by mouth daily for depression. During an interview, on 6/29/23 at 9:05 a.m., Licensed Practical Nurse (LPN) 12 indicated Resident 33's order had changed recently for her Lexapro medication and her dose had increased. She indicated the medication label on the card was not correct and that staff was supposed to go by what their computer said for medication dosage and directions. During an interview, on 6/29/23 at 10:20 a.m., LPN 13 indicated when there was a change in a	F 0761	It is the policy of the facility to ensure that the facility policy and practices are consistent with the requirements stated in the regulations. The facility has reviewed current policy and procedures and have licensed nursing staff regarding the policy for proper labeling of medications. Resident #33 received the proper dose of medication. The licensed nurse administered medication based on EMAR order from the prescribing physician. Audit was completed on 7/13/2023 to ensure all medications were properly labeled. DNS/Designee will audit medication cards a minimum of 1x per week for the next 4 weeks and 1 every other week for 4 weeks and 1x for the 3 and final month to ensure that medication cards properly reflect any changes made by the primary care physician. Any inaccuracies will be corrected immediately, and education will be	07/21/2023

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	medication order, the facility had stickers that should be placed on the medication card to indicate a direction change. Staff also used a black marker on the medication label to mark out the old directions, so staff were aware of a change to the order. She indicated the pharmacy would also send a new medication card with a new label to indicate the change. On 6/29/23 at 11:22 a.m., the Regional Nurse Consultant provided a document, with a revised date of April 2019, titled, "Administering Medications", and indicated it was the policy currently being used by the facility. The policy indicated, " ...10. The individual administering the medication checks the label Three (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication ...." 3.1-25(k)(5)		provided to the licensed nursing staff. The DNS and/or Designee will record all medication cards reviewed and any concerns identified. The QAPI committee will review the logs monthly for the next 3 months to ensure compliance. The committee will determine if further monitoring required.	
F 0802 SS=E Bldg. 00	483.60(a)(3)(b) Sufficient Dietary Support Personnel §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.			

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	§483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). Based on observation, interview, and record review, the facility failed to provide sufficient dietary support personnel in the kitchen for 72 of 73 residents who received food from the kitchen for 1 of 1 week of the survey. Findings include: During an observation of lunch service in the main dining room, on 6/26/23 at 11:30 a.m., the residents received their lunch meals on paper plates. On 6/26/23 at 11:44 a.m., the Dietary Manager (DM) indicated they were using paper plates for the residents' lunches because there was only two dietary staff for the kitchen. On 6/28/23 at 2:31 p.m., the Registered Dietician Consultant (RD) indicated the facility had challenges for staffing in the kitchen. There used to be three to four dietary staff for each shift, not two staff for a shift, which made it hard for the staff to complete all the kitchen duties. The paper plates were used in the dining room because the facility did not have enough dietary staff to wash the dishes. On 6/28/23 at 3:23 p.m., the RD provided and identified a document as a current facility policy titled, "Dietary Services-Staffing," dated February 2023. The policy indicated, "...Policy: The facility employs sufficient staff with the appropriate competencies and skill sets to carry out the functions of the Food and Nutrition Services...6.	F 0802	it is the policy of the facility to ensure that the facility policy and practices are consistent with the requirements stated in the regulations. No Residents were harmed by only having 2 dietary employees, The facility continues to have sufficient dietary support. Leadership and additional staff had and continue to be assisting the dietary department. The facility continues to advertise and recruit additional dietary staff. Since July 1 six additional dietary employees have been hired. Certified Dietary Manager, Human resources and Executive will continue to review staffing and scheduling needs Executive Director, Human Resources CDM meet weekly to discuss hiring strategies. Human Resources will continue to advertise and recruit.	07/21/2023

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	The facility will provide sufficient support personnel to safely and effectively carry out the supportive functions of the Food and Nutrition Services...." 3.1-20(h) 3.1-35(c)(2)(C)			