STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155158	A. BUILDING 00 B. WING	01/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LIFE CARE CENTER OF THE WILLOWS	1000 ELIZABETH DR VALPARAISO, IN 46383

(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. This visit included the Investigation of Complaints IN00391790 and IN00391933. Complaint IN00391790 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00391933 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: December 27, 28, 29, 30, 2022 and January 3, 2023. Facility number: 000078 Provider number: 155158 AIM number: 100289310 Census Bed Type: SNF/NF: 57 Total: 57 Census Payor Type: Medicare: 4 Medicaid: 45 Other: 8 Total: 57 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/6/23.	F 0000	The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exits or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of Appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by	

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

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			the facility. This facility respectfully requests consideration of paper compliance for the cited deficiencies	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, record review and interview, the facility failed to accommodate the needs of a resident related to the call light being out of reach for 1 of 24 residents observed for call lights. (Resident 3) Finding includes: On 12/27/22 at 1:32 p.m., Resident 3 was observed seated in her recliner on the side of her bed eating lunch. The call light was on the floor on the opposite side of the bed. On 12/28/22 at 1:15 p.m., Resident 3 was observed lying in bed watching tv. The call light was on the floor next to the bed. On 12/30/22 at 9:02 a.m., Resident 3 was lying in bed with her eyes closed. The call light was hanging off the bed rail underneath the bed. The resident's record was reviewed on 12/30/22 at 2:29 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and schizophrenia.	F 0558	F 558 Reasonable Accommodations Needs Preferences **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 3 had no negative outcomes **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:** Other residents have the potential to be affected therefore an in house audit was completed on residents rooms to assure the call light was in reach by nursing management by date of compliance. **What measure will be put into**	01/26/2023

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	The Quarterly Minimum Data Set (MDS) assessment, dated 9/29/22, indicated the resident had moderate cognitive impairment and required extensive assistance of one with bed mobility. The resident had no impairments to her functional range of motion. Interview with the Director of Maintenance and the Director of Environmental Services during the environmental tour on 1/3/23 at 1:10 p.m., indicated they would let nursing know the call light had not been in reach. 3.1-3(v)(1)		**place or what systemic changes will be made to ensure that the deficient practices does not recur:** Nursing management will in service facility staff on proper placement of call light by date of compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Department heads will check rooms daily with angel rounds Monday through Friday to assure call lights in place. Weekend manager will check 5 rooms daily on Saturday and Sunday ongoing. Nursing management will audit 5 rooms weekly x 3 months then 3 rooms weekly x 3 months to ensure compliance. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	
F 0604 SS=D Bldg. 00	483.10(e)(1), 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from			

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	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. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. Based on observation, record review and interview, the facility failed to ensure Physician orders were received and a resident with a seatbelt and chest belt restraint was assessed and monitored for 1 of 1 residents reviewed for restraints. (Resident 2) Finding includes: On 12/27/22 at 2:27 p.m., and 12/28/22 at 11:53 a.m., Resident 2 was observed seated in her wheelchair. She was wearing a seatbelt and a chest belt. On 12/28/22 at 1:29 p.m., the resident was observed with the Infection Prevention (IP) Nurse and the Director of Nursing (DON) seated in her wheelchair with the seatbelt and chest belt in place. They indicated they were unaware the resident wore those items when up in her chair. The resident's record was reviewed on 12/28/22 at	F 0604	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 2 had no negative outcomes. Or der obtained for the seat, chest belt, restraint assessment completed and monitoring added to the TAR. It is determined this is not a restraint. **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:** Other residents have the potential to be affected	01/26/2023

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	11:36 a.m. The resident was admitted to the facility on 12/7/21. Diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy, epilepsy and profound intellectual disabilities. The Annual Minimum Data Set assessment, dated 12/13/22, indicated the resident had significant cognitive deficits and required extensive assistance of 2 staff for bed mobility and toileting, was dependent on 2 staff for transfers, and restraints were not used. A Special Instruction on the resident's profile page indicated the resident must have a seatbelt and chest belt in place when up in a chair. There were no Physician's Orders for the seatbelt or chest belt. There were no assessments for the seatbelt or chest belt. The December 2022 Treatment Administration Record lacked documentation the belts were being monitored. Interview with CNA 2 on 12/28/22 at 2:13 p.m., indicated she had worked with the resident for three or four months, and she always had seatbelts in place when up in her wheelchair. During the interview with the IP Nurse on 12/28/22 at 1:29 p.m., she indicated she would speak with the therapy department and contact the Physician for orders. 3.1-26(a) 3.1-26(b) 3.1-26(r) 3.1-26(s)		therefore and in house audit has b een completed on residents with l ap trays, any type of belt, and side rails. Side rail assessments, physical restraint assessments have been complete d on residents affected and care plans and Kardex update d by nursing management by date of compliance. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** . Nursing management will educate therapy and nursing staff on devices that can be considered a restraint, what assessments need completed and the care planning process for this by date of compliance. No licensed nursing or therapist will work after date of compliance without this education being completed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Nursing management will audit 5 charts weekly x 3 months then 3 charts weekly x 3 months to ensure compliance. Results will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	

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F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other			

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	appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review and interview, the facility failed to develop and implement care plans related to the use of bed rails and restraints for 1 of 16 resident care plans reviewed. (Resident 2) Finding includes: On 12/27/22 at 2:27 p.m., and 12/28/22 at 11:53 a.m., Resident 2 was observed seated in her wheelchair. She was wearing a seatbelt and a chest belt. On 12/27/22 at 9:40 a.m., and 12/28/22 at 9:37 a.m., the resident was observed in bed. There were quarter rails on each top side and each bottom side of the bed, with a large pad that extended the full length of the bed on each side and approximately eight inches above the bed rails. The resident's record was reviewed on 12/28/22 at 11:36 a.m. The resident was admitted to the facility on 12/7/21. Diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy, epilepsy and profound intellectual disabilities. The Annual Minimum Data Set assessment, dated 12/13/22, indicated the resident had significant cognitive deficits and required extensive assistance of 2 staff for bed mobility and toileting, and was dependant on 2 staff for transfers.	F 0656	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 1. Resident # 2 had no negative outcomes, Care plan was completed for Side rails and positioning device use as well as Kardex updated to reflect updates. **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:** 2. Other residents have the potential to be affected therefore an IN house audit has been completed by MDS to assure residents with side rails and or restraints/positioning devices have care plans in place to address this by date of compliance. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** 3. MDS will be educated by the CRS on accuracy of care plans	01/26/2023

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	Restraints and bed rails were marked as not in use. A Bed Rail Assessment was completed on 12/7/21, the date of admission. There had been no additional quarterly assessments. There were no restraint assessments. There was no care plan related to the use of bed rails. There was no care plan related to the use of restraints. Interview with the Director of Nursing and Infection Prevention Nurse, on 12/28/22 at 1:29 p.m., indicated they were unaware the resident had a wheel chair seat belt and chest belt. They indicated the bed rails and pads were in place due to the resident's history of seizures, but indicated they were unaware there was not a care plan in place for the bed rails. 3.1-35(a)		R/t side rails, restraints/and or positioning devices and assuring care plans in place by date of compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** 4. DON/Designee will audit 5 residents Care plans weekly x 3 months then 3 residents weekly x 3 months to ensure compliance. Audit results will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to ensure a therapeutic brace was applied daily for a dependant resident	F 0684	**What corrective action(s) will be accomplished for those residents found to have been**	01/26/2023

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	as ordered for 1 of 1 residents reviewed for positioning and mobility. (Resident 2) Finding Includes: On 12/27/22 at 2:27 p.m., and 12/28/22 at 11:53 a.m., Resident 2 was observed seated in her wheelchair. She was not wearing AFOs (a type of brace to prevent contractures) to her lower extremities. On 12/28/22 at 1:11 p.m., the resident was observed with RN 1. The resident did not have her AFOs in place. The nurse instructed an aide to put them on the resident. On 12/30/22 at 3:10, the resident was in her wheelchair and did not have her AFOs in place. The resident's record was reviewed on 12/28/22 at 11:36 a.m. The resident was admitted to the facility on 12/7/21. Diagnoses included, but were not limited to, spastic quadriplegic cerebral palsy, epilepsy and profound intellectual disabilities. The Annual Minimum Data Set assessment, dated 12/13/22, indicated the resident had significant cognitive deficits and required extensive assistance of 2 staff for bed mobility and toileting, and was dependent on 2 staff for transfers. A Special Instruction on the resident's profile page indicated the resident was to wear AFOs. A Physician's Order, dated 12/7/21, indicated the resident was to wear AFOs to both legs when up in a wheel chair as tolerated. The December 2022 Treatment Administration Record indicated the AFOs were applied daily, there was no documentation of refusals.		**affected by the deficient practice?** Resident # 2 had no negative outcomes and AFO was placed on her immediately **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:** . Other residents have the potential to be affected therefore an in house audit has been completed by nursing management/therapy on residents that have splints, braces, palm protectors and AFOS to ensure compliance. Orders will be validated, assure on TAR, care plan, Kardex and in place on resident by date of compliance **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** Licensed Nursing and nursing assistants will be educated on adaptive devices, make sure they are care planned and on Kardex and in place on resident as ordered by nursing management by date of compliance. No nurse or aide will work after date of compliance without receiving this education. This education will also be presented on orientation.	

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	Interview with the Infection Prevention Nurse on 1/3/22 at 1:25 p.m., indicated staff should not be signing off AFOs as in place if they were off, refused or not tolerated. 3.1-37(a)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** . Nursing management/designee will audit 5 residents weekly x 3 months then 3 residents weekly x 3 months rotating shifts to ensure compliance. Results will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on interview and record review, the facility failed to ensure that residents received proper treatment and assistive devices to maintain hearing abilities related to not monitoring and assisting with a resident's hearing aid for 1 of 1 residents reviewed for hearing. (Resident 22) Finding includes: Interview with Resident 22 on 12/27/22 at 11:35 a.m., indicated the resident had hearing aids	F 0685	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 22 had audiology appointment set up for 01-23-23. Facility was never notified she had hearing aids and they were not on her inventory sheet. Once brought to SSD attention by surveyor she	01/26/2023

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	currently and had worn them for a while, however they were not working. She indicated that when they were working correctly, staff must help her put them in and take them out at night. She was not observed wearing hearing aids at the time of the interview and they were not in view in the room. Resident 22's record was reviewed on 12/29/22 at 10:54 a.m. The resident was admitted on 1/8/21. Diagnoses included, but were not limited to, stroke, hemiplegia affecting the left non-dominant side, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 10/20/22, indicated the resident was moderately cognitively impaired. She required extensive assistance with activities of daily living. The record lacked documentation related to the resident wearing hearing aids. Interview with CNA 1 on 12/29/22 at 2:57 p.m. indicated the resident had hearing aids and she would assist her with them. The resident always had complaints that her hearing aids were not working. Interview with the Director of Nursing on 12/30/22 at 9:51 a.m., indicated she had no further information to provide. 3.1-39(a)		immediately went and spoke with resident and resident stated they were in her top drawer but weren't working. SSD put new batteries in and they starting working immediately. Resident refused to wear until she is seen by audiologist. Family and MD aware **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:** Other residents have the potential to be affected therefore an in house audit will be completed for residents with vision and hearing devices to assure compliance. Residents requiring devices/repairs will be addressed by date of compliance. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** . SSD will be educated by ED to interview families as well as residents on admission for any hearing or vision devices that were being used on residents past, present etc. by date of compliance: **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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			recur: SSD will audit 3 residents' clinical records x 6 months to ensure compliance and any follow up required is in place. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure a treatment was in place for a resident with a pressure ulcer for 1 of 1 residents reviewed for pressure ulcers. (Resident 39) Finding includes: On 12/29/22 at 2:10 p.m., the Infection Preventionist/ Wound Nurse and LPN 1 were observed completing wound care for Resident 39. A wound to the left outer ankle was observed as a quarter sized area with a dark red pea sized center	F 0686	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 39 had no negative outcomes. Tx order obtained immediately. MD and family notified. **How other residents having the potential to be affected by the same deficient practice will be**	01/26/2023

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	and red surrounding skin. A wound to the right heel was observed as a small pea size maroon area. The skin was not open. The record for Resident 39 was reviewed on 12/28/22 at 2:41 p.m. Diagnoses included, but were not limited to, schizophrenia, anemia, and dementia. The resident was hospitalized on 11/22/22 and readmitted to the facility on 12/4/22. The Quarterly MDS (Minimum Data Set) assessment, dated 12/19/22, indicated the resident had one stage 2 pressure ulcer and two unstageable deep tissue injuries. The Admission/Readmission Collection Tool, dated 12/4/22, indicated the resident had a right buttocks stage 3 pressure ulcer, left ischium stage 1 ulcer, left lateral ankle stage 1 ulcer, and a right medial foot stage 1 ulcer. Wound Assessments, dated 12/6/22, indicated the Wound Nurse had assessed all the areas previously noted by the Floor Nurse and found a deep tissue injury (DTI) to the right heel, DTI to the left ankle, and stage 2 ulcer to the right buttocks. The Treatment Administration Record (TAR), dated 12/2022, indicated wound treatments had been implemented for the left lateral foot and right buttocks wounds on 12/5/22. There was a lack of documentation any treatment had been implemented for the right heel wound. Interview with the Infection Preventionist/ Wound Nurse on 12/29/22 at 10:58 a.m., indicated the area to the resident's right buttocks was currently healed. Only the wounds to the right heel and left ankle remained and the treatment		**identified and what corrective action(s) will be taken:** Other residents have the potential to be affected therefore an IN house audit on residents with ulcers of any type has been completed to ensure accurate and all have treatment orders by wound nurse by date of compliance. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** Wound nurse will complete the ABCS of wound care on village square by date of compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** DON/Designee will review 3 tx orders weekly for wounds to ensure compliance x 3 months, then 2 treatment orders x 3 months. Audits will presented to QAPI x 6 months and QAPI will determine the need for further audits.	

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	should have been the same for both of those areas. There was only a treatment order in place for the left ankle and she would correct it. A facility policy titled, Skin Integrity & Pressure Ulcer/Injury Prevention and Management, received as current, indicated "...Treatment orders. Treatment orders are written per Physician orders. If a resident has multiple wound sites, a complete and separate treatment order must be written for each site..." 3.1-40(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder			

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	receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility failed to ensure a resident received appropriate services related to an indwelling catheter for 1 of 1 residents reviewed for catheters. (Resident 22) Finding includes: Resident 22's record was reviewed on 12/29/22 at 10:54 a.m. Diagnoses included, but were not limited to, stroke, hemiplegia affecting the left non-dominant side, high blood pressure, and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 10/20/22, indicated the resident was moderately cognitively impaired. The resident had an indwelling catheter and required extensive assistance for activities of daily living. A Nurse's Note, dated 12/5/22 at 6:35 a.m., indicated the resident was transported to the hospital for a scheduled surgery. A Nurse's Note, dated 12/5/22 at 8:19 a.m., indicated the resident returned and did not have the procedure completed due to her arriving late. A Nurse's Note, dated 12/5/22 at 10:23 a.m., indicated the urologist's office was called to	F 0690	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 22 has had no negative outcomes. Urologist appointment is on 02-10-23 with Dr. Perlmutter. **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:** Other residents have the potential to be affected therefore an IN house audit will be completed on residents with catheters/and or follow up appointment with urologist. Any issues identified will be addressed by date of compliance. **What measure will be put into place or what systemic changes will be made to**	01/26/2023

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	reschedule the appointment. A Nurse's Note, dated 12/6/22 at 5:43 p.m., indicated the urologist's office called and indicated the resident would no longer be able to be seen in the office as the physician was leaving. A recommendation was made for another urologist. A Physician's Order, dated 12/6/22, indicated the office called and recommended [Physician's Name] for a urology consult. There was no further documentation related to a new appointment. Interview with the Director of Nursing on 12/30/22 at 3:05 p.m., indicated the resident was late to her original appointment because the appointment time had been written incorrectly for the transportation. She would follow up on the recommendation for the other urologist. 3.1-41(a)(2)		**ensure that the deficient practices does not recur:** Nurses notes will be reviewed daily in morning meeting/clinical to determine any follow up appointments that need scheduled for residents. If resident refuses they will be educated if able on risk and consequences of refusal and documented in the clinical record. POA and MD will be notified as well. Facility will attempt to reschedule if resident in agreement. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** . DON/Designee will validate all outside clinical appointments scheduled ongoing. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the			

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	resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to lack of implementation of dietary recommendations and monitoring intake for residents who were nutritionally at risk for 2 of 4 residents reviewed for nutrition. (Residents 39 and 47) Findings include: 1. On 12/29/22 at 2:10 p.m., the Infection Preventionist/Wound Nurse and LPN 1 were observed completing wound care for Resident 39. A wound to the left outer ankle was observed as a quarter sized area with a dark red pea sized center and red surrounding skin. A wound to the right heel was observed as a small pea size maroon area. The skin was not open. The record for Resident 39 was reviewed on 12/28/22 at 2:41 p.m. Diagnoses included, but were not limited to, schizophrenia, anemia, and dementia. The resident was hospitalized on 11/22/22 and readmitted to the facility on 12/4/22. The Quarterly MDS (Minimum Data Set) assessment, dated 12/19/22, indicated the resident had one stage 2 pressure ulcer and two unstageable deep tissue injuries.	F 0692	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 47 has had no negative outcomes. Her weights have been stable as of Dec 1, 2022. Resident 39 has had an overall decline ongoing even with current interventions, he is now on hospice and being kept comfortable with expected decline. **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:** Other residents have the potential to be affected therefore an in house audit will be completed on residents with supplements recommended by RD to ensure on tray card, MAR and % taken documented. **What measure will be put into place or what systemic changes will be made to**	01/26/2023

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	Wound Assessments, dated 12/6/22, indicated the resident had a left outer ankle deep tissue injury (DTI), a right heel DTI, and a right buttocks stage 2 pressure ulcer. The Nutrition Assessment, dated 12/7/22, indicated the resident had been recently hospitalized and had wounds. The recommendations were a multivitamin with minerals, a house shake at lunch and supper, and Remeron (mirtazapine, a medication used for appetite stimulation). A Progress Note, dated 12/8/22 at 1:51 p.m., indicated the resident was a readmission to the facility and had wounds to the left outer ankle and buttocks. The recommendation of the Dietician was multivitamin with minerals in addition to a house shake at lunch and dinner, and Remeron to stimulate appetite. A Progress Note, dated 12/16/22 at 7:41 a.m., indicated the resident had wounds. The recommendation of the Dietician was multivitamin with minerals in addition to super pudding at dinner, and Remeron to stimulate appetite. A Progress Note, dated 12/23/22 at 11:16 a.m., indicated the resident had wounds. The recommendation of the Dietician was multivitamin with minerals in addition to super pudding at dinner, and Remeron to stimulate appetite. There was a lack of documentation to indicate the dietary recommendations had been implemented or follow up completed. Interview with the Administrator on 12/29/22 at 11:34 a.m., indicated the dietary recommendations		**ensure that the deficient practices does not recur:** DON/DESIGNEE will address rd recommendations within 72 business hours to ensure completed, dietary notified, supplement recommended is put on Mar and % consumed documented ongoing. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Weekly resident at risk meeting will review weekly RD recommendations and assure above is completed ongoing. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	

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	had been missed, they had notified the Physician, and new orders were put in today. The recommendations had originally been made on 12/7/22. 2. Resident 47's record was reviewed on 12/28/22 at 11:38 a.m. Diagnoses included, but were not limited to, pneumonitis due to inhalation of food and vomit, high blood pressure, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 11/8/22, indicated the resident was severely cognitively impaired and required extensive assistance with eating. A Dietary Note, dated 11/29/22 at 2:42 p.m., indicated the resident had weighed 176 pounds in November and her weight had decreased by 4 pounds. The Registered Dietician recommended super cereal at breakfast due to the weight loss. The record lacked an order for super cereal at breakfast. The record lacked intake logs for the super cereal at breakfast. Interview with the Regional Nurse Consultant on 12/30/22 at 9:44 a.m., indicated they no longer put in orders for super cereal, but it should be tracked either on the Treatment Administration Record or the CNA Kardex. 3.1-46(a)(2)			
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			

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	jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the 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 observation, record review, and interview, the facility failed to ensure gastrostomy tube placement was checked prior to administering medications and the water flush was instilled via gravity for 1 of 1 gastrostomy tube medication administrations observed. (Resident 1) Finding includes: On 12/28/22 at 4:00 p.m., RN 1 was observed preparing medications for Resident 1. The resident was going to receive a pepcid tablet (a medication for gastroesophageal reflux), 20 milligrams tablet by way of her gastrostomy tube (G-Tube). The RN entered the resident's room. Prior to giving the medications, the RN attached a syringe with plunger to the G-Tube and pulled back to check for residual. There was no residual noted. She proceeded to administer a water flush prior to giving the medications, she used the plunger of	F 0693	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 1 had no negative outcomes. RN # 1 educated immediately on policy for g/t med administration by nursing management. **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:** Other residents have the potential to be affected therefor an in house audit has been	01/26/2023

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	the syringe and pushed the water through the tube instead of letting the water instill via gravity. The RN administered the medication and then gave a water flush by gravity. The record for Resident 1 was reviewed on 12/30/22 at 11:48 a.m. Diagnoses included, but were not limited to, stroke, dysphagia (difficulty swallowing), and gastrostomy. The 11/25/22 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively impaired and required a feeding tube. A Care Plan, dated 9/9/22, indicated the resident required tube feeding related to stroke and dysphagia. Interventions included, but were not limited to, check for tube placement and gastric contents/residual volume per facility protocol and record. Interview with the Director of Nursing on 12/30/22 at 9:53 a.m., indicated the water flush should have been instilled by gravity and tube placement checked by air bolus. 3.1-44(a)(2)		completed of residents receiving meds, feedings and or flushes through g/tubes by date of compliance. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** Nursing management will educate licensed nurses on policy/procedure of g/t feedings, med administration and flushing and will have competencies completed by date of compliance. No nurses will work after date of compliance without this education band competency being completed. This education will be presented on orientation as well. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Nursing Management will observe 3 nurses weekly rotating shifts x 3 months then 2 nurses weekly x 3 months to ensure compliance. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed			

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	rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. Based on observation, record review and interview, the facility failed to attempt alternative measures and assess the necessity for bed rails quarterly as required for 1 of 1 residents reviewed for bed rails. (Resident 2) Finding includes: On 12/27/22 at 9:40 a.m., and 12/28/22 at 9:37 a.m., the resident was observed in bed. There were quarter rails on each top side and each bottom side of the bed, with large seizure pads that extended the full length of the bed on each side and approximately eight inches above the bed rails. The pads obstructed the resident's view of the room and window. The resident's record was reviewed on 12/28/22 at 11:36 a.m. The resident was admitted to the facility on 12/7/21. Diagnoses included, but were	F 0700	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 2 has had bed rail assessment completed. No negative outcomes occurred. **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:** Other residents have the potential to be affected therefore an in house audit has been completed on resident's that are using bed rails for enablers/and or restraints. Residents using bed	01/26/2023

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	not limited to, spastic quadriplegic cerebral palsy, epilepsy and profound intellectual disabilities. The Annual Minimum Data Set assessment, dated 12/13/22, indicated the resident had significant cognitive deficits and required extensive assistance of 2 staff for bed mobility and toileting, and was dependant on 2 staff for transfers. Bed rails were marked as not in use. A Bed Rail Assessment was completed on 12/7/21, the date of admission. There had been no additional quarterly assessments. There had been no previous interventions prior to implementing the bed rails and seizure pads. Interview with the Director of Nursing and Infection Prevention (IP) Nurse, on 12/28/22 at 1:29 p.m., indicated the bed rails and pads were in place due to the resident's history of seizures. The resident's family had used them in that manner when the resident was admitted. They agreed the bed rails and pads obstructed her view. The IP Nurse indicated she would check in to what else was available and contact the resident's family. During a follow up interview with the IP Nurse on 12/28/22 at 2:44 p.m., she indicated there were no additional bed rail assessments completed. 3.1-35(a)		rails have had side rail assessments completed. This has been completed by nursing management by date of compliance. Currently and at time of survey the facility had no side rails being used as restraints. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** Education will be provided to licensed staff on where to locate, how to complete accurately and determine if enabler/restraint and if restraint must complete restraint assessment as well, and care plan in place for use of side rails by nursing management by date of compliance. No licensed nurses will work after date of compliance unless education completed **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Nursing management will review 5 residents' side rail assessments weekly x 3 months and then 3 residents weekly x 3 months. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, related to labs not completed as ordered and lack of documentation the Physician was notified of lab results for 1 of 5 residents reviewed for unnecessary medications. (Resident 5) Finding Includes: The record for Resident 5 was reviewed on 12/29/20 at 1:48 p.m. The resident was admitted on	F 0757	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 5 had no negative outcomes. MD notified and lab order discontinued r/t IV antibiotics. Other labs ordered rescheduled to be drawn. **How other residents having the potential to be affected by the same deficient practice will**	01/26/2023

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	12/31/20. Diagnoses included, but were not limited to, metabolic encephalopathy, cerebral infarction, vascular dementia and Diabetes Mellitus. The Admission Minimum Data Set assessment, dated 10/10/22, indicated the resident had significant cognitive impairment, and was dependent on 2 staff for transfers, and extensive assistance of 2 staff for bed mobility and toileting. He had taken antidepressants, anticoagulants, antibiotics and insulin during the assessment period. A Physician's Order, dated 10/10/22, indicated to obtain a CBC (complete blood count) CMP (comprehensive metabolic panel) and CRP (c-reactive protein) lab test every week and notify the Physician. A Physician's Order, dated 10/7/22, indicated to obtain a A1C (blood test to measure average blood sugar) every three months. The CBC, CMP and CRP results were available for 10/10, 10/31, 11/7, 11/21 and 11/28/2022. There were no additional labs and no order to discontinue the labs. There were no results for an A1C. There was no documentation in the progress notes the labs had been completed or results sent to the Physician. Interview with the Director of Nursing (DON) on 12/29/22 at 2:20 p.m., indicated lab results should be in the residents's hard chart. If they weren't, then they could call the lab and have them sent over. The lab did not send results to the Physicians. During a follow up interview on 12/30/22 at 10:10		**be identified and what corrective action(s) will be taken:** Other residents have the potential to be affected therefore an in house audit has been completed going back 90 days to ensure no other labs missed. Any issued will be addressed by date of compliance **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** . Licensed nursing will be educated on policy and process of labs. When order received a requisition will be made then and faxed to lab and order placed on TX sheet and on day of draw nurse to call lab and validate it was drawn. Results must be called or faxed to MD. MD must acknowledge he has reviewed by signing lab results and signed lab is to be put into clinical record or scanned into clinical record. If done via phone then nurse must document in clinical record that MD aware of labs and if new orders or not. Nursing management will review routine labs monthly with change over and make requisition, send to lab, put on TX sheet and validate lab drawn. This education will be completed by date of compliance by nursing management and any	

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	a.m., the DON indicated the lab had received orders to discontinue the weekly labs at the end of November, but the facility had not. She did not know how that had happened. On 12/30/22 at 12:20 p.m., Infection Prevention Nurse called the lab and obtained a copy of the A1C drawn on 11/7/22. There was no documentation the Physician had been notified of the results. 3.1-48(a)(3)		nurse not completing education prior will not be allowed to work until done. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** Nursing management will review 5 charts weekly x 3 months then 3 charts weekly x 3 months to ensure compliance. Audits will be presented to QAPI x 6 months and QAPI will determine the need for further audits.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment			

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	conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.			

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	Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation and interview, the facility failed to ensure infection control guidelines were in place and implemented related to handling of medications and personal protective equipment (PPE) worn incorrectly during resident care for random observations for infection control. (Resident 1) Findings include: 1. On 12/28/22 at 4:00 p.m., RN 1 was observed during medication administration for Resident 1. RN 1 washed her hands and then removed a pepcid tablet from the medication card. The medication fell onto the medication cart. The RN picked up the tablet with her bare hands and placed it into a medication bag to crush the medication prior to administration of the medication via a gastrostomy tube. 2. On 12/28/22 at 4:15 p.m., RN 1 was observed entering Resident 1's room. The door was marked Enhanced Barrier Precautions, which indicated to wear a gown and gloves while performing resident care, including accessing a gastrostomy tube. The RN entered the room and prepared to give the resident medications via her gastrostomy tube wearing only gloves. Interview with RN 1 indicated she was not aware she had to wear a gown to give medications via a gastrostomy tube and she should not have	F 0880	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident # 1 has had no negative outcomes. Nurse # 1 was educated immediately on proper Infection Control practices r/t handling of meds and PPE. **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:** Other residents have the potential to be affected therefore an in house audit will be completed on residents with tube feedings and on EBP by IP by date of Compliance. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** The IP will in service licensed nurses and QMAS on appropriate	01/26/2023

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	handled the medication with her bare hands. Interview with the Director of Nursing on 12/30/22 at 9:53 a.m., indicated the nurse should not have handled the medication with her bare hands and should have had on a gown and gloves per the Enhanced Barrier Precautions signage posted on the door. 3.1-18(b)		handling of medications with infection control procedure and wearing appropriate PPE r/t different types of precautions by date of compliance. Any nurse or aide that does not complete this education will not work until completed after date of compliance. Nurses will have t/f competencies completed by IP by date of Compliance and nurses, QMAS, and aides will have competencies completed on appropriate and required use of PPE for different types of isolation by IP by date of compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** IP will observe 5 staff members weekly x 3 months then 3 staff members weekly x 3 months rotating shifts to ensure compliance. Audits will be presented to QAPI monthly x 6 months and QAPI will determine the need for further audits.	
F 0888 SS=D Bldg. 00	483.80(i)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more			

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	since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in			

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	paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests			

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	for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements			

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	of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; Based on observation, record review and interview, the facility failed to properly implement policies and procedures to prevent the transmission of COVID-19 related to ensuring contracted staff were vaccinated or had an exemption in place for 1 of 4 contracted staff reviewed for COVID-19 vaccinations. (Contracted Staff 1) Finding includes: On 12/28/22, Contracted Staff 1 (CS 1), who worked for a pest control company, was observed in the building spraying for pests. On 1/3/23, the facility was asked to provide documentation of four random contracted staffs' vaccination status or exemption status. The current policy, "COVID-19 Vaccination Program Policy for Associates," indicated, "The facility will ensure that associates have received the appropriate number of doses of the primary vaccine series unless exempted as required by law..." Interview with Infection Prevention Nurse on 1/3/23 at 12:10 p.m., indicated CS 1 was not vaccinated and did not have an exemption on file. Interview with the Maintenance Director on 1/3/23 at 1:10 p.m., indicated that the pest control company sent various employees out each month and CS 1 had been to the facility before.	F 0888	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Vendor notified he cannot enter facility until vaccinated or an exemption has been completed. **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:** Other residents/staff have the potential to be affected therefore an audit of all vendors has been completed by the IP to assure vaccine completed or exemption completed by date of Compliance. No other issues noted. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** The Ip will ensure all vendors have their vaccines/or exemptions completed ongoing. IP will enter any new vendors into the HCP vaccine log immediately once contracted to ensure compliance.	01/26/2023

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur: Ip will audit HCP vaccine log weekly and assure updated and accurate ongoing.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to marred and gouged walls and missing floor tile for 2 of 2 units. (East Unit and West Unit) Findings include: During the Environmental tour with the Director of Maintenance and the Director of Environmental Services on 1/3/23 at 1:10 p.m., the following was observed: 1. East Unit: a. In Room 30, there was a hole in the wall above the call light box. The walls behind the recliner near bed 1 were gouged. The privacy curtain for bed 1 was dirty and had a white substance on it. The walls near the room door frame were marred. Two residents resided in the room. b. In room 33, the floor tile in front of bed 1 was missing. The bottom inside corner of the bathroom door was gouged and the heat cover was loose and falling off. One resident resided in the room.	F 0921	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the deficient practice. East Unit Room 30 hole in the wall by call light box fixed gouged wall behind recliner, Privacy curtain removed and washed, Walls near room door frame marred. Repairs completed 01/04/2023 Room 33- Tile missing in front of bed, Bottom inside corner of the bathroom door gouged, and heat cover was loose. Replaced 2 tiles cover reconnected gouges repaired 01/04/2023 Room 45-Bathroom walls and floor were dirty cleaned 01/03/2023, Gouges on wall behind bed 2 01/04/2023 fixed Room 49- Wall under sink was gouged, chipped paint, baseboard	01/26/2023

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	c. In room 45, the bathroom walls and floors were dirty. There were gouges in the wall behind bed 2. Two residents resided in the room. d. In room 49, the wall underneath the sink was gouged, had chipped paint, and the baseboard was peeling away from the wall. The side rail on bed 2 was dented. The edge of the footboard on bed 2 was peeling off. 2. West Unit: a. In room 10, the floors were sticky. b. In room 13, the side rails were taped with gray duct tape. Interview with the Director of Maintenance and Director of Environmental Services at the time, indicated all of the above were in need of cleaning and/or repair. 3.1-19(f)		peeling away from the wall corrected 01/04/2023, inside rail on bed 2 was dented replaced rail 01/04/2023, the edge of the foot board on bed 2 was peeling off. Replaced 01/04/2023 West Unit Room 10 Floors were sticky cleaned 01/03/2023 Room 13-siderails taped with Grey duct tape. Removed duct tape 01/03/2023 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** The Director of Maintenance and the Director of Housekeeping Where in serviced by the Executive Director on maintaining Safe/functional/sanitary/comfortable environment on 01/04/2023. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practices does not recur:** A full facility audit will be conducted on vent covers, Broken Tiles, marring and gouging of walls, duct tape on side rails to ensure all areas maintain a functional and safe environment. All areas identified are being put on the schedule to be repaired or replaced 5 rooms a week starting **01/30/2023 to** ensure a Safe/functional/sanitary/comfortable environment, this will be	

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			recorded in our weekly T.E.L.S preventive maintenance system. Staff will be reeducated to document in the maintenance daily work binder to ensure maintenance is aware and can fix any area timely to be completed by 01/26/2023 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** The Maintenance Director or designee will submit the weekly audits monthly to the Executive Director or Designee to review at the safety committee meeting and QA for a period of 6 months to ensure 100% compliance. The QA committee will determine at that time if the audits need to continue. Results will be presented to PI x 6 months. PI will determine the need for further audits.	