STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 00 B. WING	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

(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 IN00429880 and IN00429901. Complaint IN00429880 - No deficiencies related to the allegations are cited. Complaint IN00429901 - State/Federal deficiency related to the allegation is cited at F677. Survey dates: March 20, 21, 22, 25, and 26, 2024 Facility number: 000178 Provider number: 155280 AIM number: 100273840 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type: Medicare: 2 Medicaid: 49 Other: 17 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 2, 2024.	F 0000	**DISCLAIMER STATEMENT:** **Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.** **We respectfully request a desk review to verify satisfaction of compliance with the alleged survey deficient practices.**	
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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Vanessa Roll	Administrator	04/15/2024

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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	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 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.			

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	§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 interview, observation, and record review, the facility failed to develop a care plan related to dentures for 1 of 20 residents care plans reviewed. (Resident 37) Findings include: During an interview on 03/21/24 at 10:01 A.M., a family member indicated Resident 37 had dentures, but he usually didn't have them in. He had kept playing with them and someone took them away and never offered them back. During an interview on 03/22/24 at 9:29 A.M., the resident was assisted out of bed by nursing staff member. The resident was assisted to his wheelchair and propelled to the hallway. He was not wearing his dentures. The resident indicated he was unsure of where his dentures were. During an observation on 03/22/24 at 9:32 A.M., the resident was offered a snack and accepted it. He did not have his dentures in and had not been offered them. He proceeded to eat his snack without difficulty. During an observation on 03/22/24 at 11:33 A.M., the resident was sitting at the dining table and served his lunch. The tray was a regular diet. He was eating and was not wearing his dentures. The staff had not offered them to him. The clinical record for Resident 37 was reviewed on 03/22/24 at 1:41 P.M. An Admission MDS (Minimum Data Set) assessment, dated 02/02/24,	F 0656	It is the policy of this facility to develop and implement a comprehensive person-centered dental care plan for each resident. Resident #37 received no negative outcome as a result of the alleged deficient practice. Resident #37 care plan has been updated. All residents have the potential to be affected by this alleged deficient practice. All residents were reviewed to ensure a dental care plan was in place by the Director of Nursing or designee by 3/27/24. Any concerns were addressed. No negative outcome has occurred due to the alleged deficient practice. MDS coordinator was in-serviced by the Administrator and/or designee on 3/27/24 on the facility expectation for care plan development for dental concerns. Any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. All residents should have a dental care plan to specify if they require the use of dentures. All resident's care plans have been reviewed by the DON or designee to include a dental care plan by 3/27/24. Any concerns have been addressed.	04/24/2024

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	indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, fractures, anemia, hypertension, diabetes, Alzheimer's disease, non-Alzheimer's dementia, malnutrition, anxiety, depression, and mood (affective disorder). The resident was edentulous. The care plan lacked a edentulous care plan. During an interview on 03/26/24 at 3:17 P.M., the Administrator indicated when a resident was admitted to the facility, the management team completed their assessments and developed their comprehensive care plan based on their assessments. The current, undated, facility policy titled, "Baseline Care Plan Assessment/Comprehensive Care Plans", was provided by the Administrator on 03/26/24 at 3:41 P.M. The policy indicated, "...The Comprehensive Care Plan will be finalized within 7 days of completion of the Full Comprehensive Care Plan..." 3.1-35(a)		Administrator and/or designee will utilize audit tool “dental log” to ensure dental care plans are in place. The audit tool will be used to monitor compliance and become part of the CQI agenda as part of the QAPI process. This audit will be completed five random residents per week for 4 weeks, then five random residents monthly for 3 months, then once a month quarterly thereafter until 95% compliance is achieved. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the QAPI committee. Any written action plan will be monitored by the Administrator monthly until resolved and substantial compliance is achieved.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on record review and interview the facility failed to provide routine bathing for 1 of 3 residents reviewed for ADL (Activities of Daily Living) care. (Resident B) Findings include:	F 0677	It is the practice of this facility to ensure residents that area unable to carry out activities of daily living such as, showers, will receive necessary services to maintain good hygiene according to their	04/24/2024

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	During an observation in the dining room on 03/20/24 at 11:24 A.M., a staff member sat down next to the resident. Staff were assisting another resident at the table and cuing Resident B to keep her awake and focused as she was eating with her bare hands. The clinical record for Resident B was reviewed on 03/26/24 at 11:01 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 02/03/24, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, dementia and hypertension. The resident was totally dependent on staff members for bathing. The paper shower sheets for January, February, and March 2024, were provided by the DON (Director of Nursing) on 03/26/24 at 10:26 A.M. The records were dated and indicated the following: - On 01/01/24, the resident did not receive a shower, - On 01/07/24, the resident did not receive a shower, - On 01/21/24, the resident did not receive a shower, - On 02/05/24, the resident did not receive a shower, - On 02/12/24, the resident did not receive a shower, - On 02/15/24, the resident did not receive a shower, - On 02/23/24, the resident did not receive a shower, - On 02/26/24, the resident did not receive a shower, - On 02/29/24, the resident did not receive a		preferred schedule and method. Resident B has had no negative outcome to the alleged deficient practice. Resident was being showered in accordance with her preferred schedule and DON verified she was clean and dry on 3/28/24. All residents have the potential to be affected by this alleged deficient practice. 100% resident audit verifying cleanliness and good hygiene was completed on 3/28/24 by the DON and designee. Any concerns were addressed. Nursing education was held on 4/4/24 by the DON to review the "Activities of Daily Living" policy. Any staff who fail to comply with the points of the inservice will be further educated. DON/Designee will implement an audit tool, "Showers" to monitor compliance with completing showers in accordance with resident's preference. The audit tool will be used to monitor compliance and become part of the CQI agenda as part of the QAPI process. This audit will be completed on 5 random residents weekly x 4 weeks, then 5 random residents monthly for 3 months, then quarterly thereafter until 95% compliance is achieved. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the QAPI committee.	

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	shower, - On 03/04/24, the resident did not receive a shower, - On 03/07/24, the resident received a shower, - On 03/11/24, the resident did not receive a shower, - On 03/14/24, the resident received a shower, - On 03/17/24, the resident received a shower, and - On 03/21/24, the resident received a shower. The "Tasks" bathing report for January, February, and March 2024, from the EHR (Electronic Health Record) was provided by the DON on 03/25/24 at 11:30 A.M. The record indicated the following: - On 01/29/24, the resident received a shower, and her hair was washed, - On 02/02/24, the resident received a bed bath, and her hair was not washed, - On 02/09/24, the resident received a bed bath, and her hair was not washed, - On 02/20/24, the resident received a bed bath, and her hair was not washed, - On 02/26/24, the resident received a shower, and her hair was washed, - On 02/29/24, the resident received a shower, and her hair was washed, - On 03/07/24, the resident received a shower, and her hair was washed, - On 03/11/24, the resident received a shower, and her hair was washed, and - On 03/21/24, the resident received a shower, and her hair was washed. From January 1, 2024, to March 23, 2024, the resident should have received 24 showers or complete bed baths. The resident had only received 12 of the planned 24 baths. No resident bathing refusals were documented on either set of records.		Any written action plan will be monitored by the Administrator monthly until resolved and substantial compliance is achieved.	

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	The complete Care Plan was provided by the Administrator on 03/26/24 at 2:47 P.M. A Care Plan "Focus" indicated the resident had late loss ADLs and required staff assistance with ADLs. The interventions included, but were not limited to, "Bathe per resident preference 2x week and prn" (as needed). The Care Plan did not indicate the resident had a history of refusing care. During an interview on 03/22/24 at 9:52 A.M., CNA 2 indicated staff documented on shower sheets and on the computer. If a resident refused a shower it should be documented in both places. During an interview on 03/26/24 at 2:16 P.M., LPN 3 indicated the CNAs knew they were supposed to report to the nurse on duty if a resident refused care of any kind, especially showers. If a resident refused a shower, she would go to the resident and investigate why the resident was refusing. Residents generally got two showers a week. They usually got their hair washed with showers. Staff should mark it on the shower sheets if residents got their hair washed, nail care, and if the staff noticed anything like skin changes. They would mark the nurse was notified, then the nurse on the floor would sign the sheets. The current undated "Activities of Daily Living" policy was provided by the Administrator on 03/26/24 at 2:47 P.M. The policy indicated, "...Residents are given routine daily care...by a C.N.A. or a Nurse to promote hygiene, provide comfort and provide a homelike environment...ADL care of the resident includes...Assisting the resident in personal care such as bathing, showering...hair care...Do all required ADL documentation as required per policy and regulations..."			

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	This citation relates to Complaint IN00429901. 3.1-38(a)(2)(A)			
F 0679 SS=E Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on interview, observation, and record review, the facility failed to provide activities for 1 of 4 stations reviewed. This had the potential to affect 13 of 68 resident residing in the facility. (Memory Springs-Dementia Unit) Findings include: During an interview on 03/21/24 at 9:53 A.M., a family member indicated the Memory Springs Station never had any activities. During a continuous observation on 03/26/24 from 10:06 A.M. through 11:45 A.M., the following was observed: - at 10:06 A.M. two residents were asleep in recliners, and four residents in the dining room, staff were present and talking with a couple of the residents,	F 0679	It is the practice of this facility to provide an ongoing program to support the residents on their choice of activities that supports the well-being of each resident. All residents, including those identified, have the potential to be affected by this alleged deficient practice. 100% audit was completed by the Activity Director of the residents' preferences for activities was completed on 4/4/2024. Any concerns were addressed. Activity staff education was held on 4/2/24 by the Administrator or Designee to review the "Activities Program" policy. Any staff who fail to comply with the points of the in-service will be further educated. Administrator/Designee will	04/24/2024

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	- at 10:33 A.M., there were four residents in the dining room. Two of the residents were sleeping, 1 resident was eating a snack, and another resident was looking at pictures. The activity calendar was observed hanging on a bulletin board and indicated the resident's were to fold laundry at 10:30 A.M. - at 10:43 A.M., 1 resident left the dining room and there was a CNA (Certified Nurse Aide) in the common area. There was no staff engaging residents in any activity, - at 11:05 A.M., there were four residents in the dining room, two of the residents were sleeping and there was no activity being completed. There were two residents asleep in recliners in the common area. - at 11:45 A.M., the residents were served their lunch. During a continuous observation on 03/26/24 from 1:55 P.M. through 2:25 P.M. the following was observed: - at 1:55 P.M., there were four residents in the dining room. One resident was asleep and another resident was trying to stand up and CNA 5 directed the Resident 43 to sit back down, - at 1:57 P.M., CNA 5 asked a Resident 34 to sit down in his wheelchair, - at 1:58 P.M., CNA 5 asked Resident 34 to sit down in his wheelchair, she took the resident to his room to put on a new shirt. She was the only staff member on the unit at the time, - at 2:05 P.M., no activity was being intiated. RN 6		implement an audit tool, “Activities Audit” to monitor compliance with activity participation in accordance with the residents’ preferences correctly. The audit tool will be used to monitor compliance and become part of the CQI agenda as part of the QAPI process. This audit will be completed five days a week for 4 weeks, then weekly for 4 weeks, then once a month for 6 months until the facility is within 95% compliance after the 6 months, the monitoring will be stopped. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the QAPI committee. Any written action plan will be monitored by the Administrator monthly until resolved and substantial compliance is achieved.	

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	entered the station, - at 2:06 P.M., Resident 43 propelled herself to Resident 65 who was asleep at the dining room table and woke him up, - at 2:09 P.M., Resident 34 asked to watch a football game. CNA 5 indicated she didn't believe football was on and went to the T.V. and turned on a western show and assisted Resident 34 in front of the T.V. Resident 43 was propelling herself around the dining room in her wheelchair, - at 2:11 P.M., Resident 65 was offered a snack and moved up to the table, Resident 43 had propelled herself to an empty table, and Resident 34 started propelling himself down the hallway, - at 2:13 P.M., CNA 5 asked Resident 34 to sit back down in his wheelchair. He sat back down and was offered to sit in a recliner. The resident refused. The resident again asked about watching a football game, CNA 5 indicated she had turned on a different show until the football game came on. She continued to converse with the resident who was down the hallway and facing away from the T.V., - at 2:16 P.M., Resident 43 approached Resident 65 and started to take his snack. CNA 5 told the resident it wasn't her snack and took the empty wrapper to the trash. The resident was not offered a snack, - at 2:17 P.M., CNA 5 left the station to answer a call light on a different station. RN 6 was present on Memory Springs, - at 2:17 P.M., Resident 43 was propelling herself around the dining room while RN 6 was sitting at a			

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	table working on a laptop, another CNA entered the station, - at 2:21 P.M., RN 6 gave Resident 43 a drink, - at 2:24 P.M., Resident 43 approached Resident 65 and started talking to the resident, who was asleep, and - at 2:25 P.M., the CNA took Resident 43 to the restroom. During an interview on 03/26/24 at 10:13 A.M., CNA 5 indicated there was only one activity aide for the entire building so the CNA's on Memory Springs would help out with scheduled activities. During an interview on 03/26/24 at 2:28 P.M., CNA 5 indicated the activity aide was responsible for making sure the scheduled activities were being completed on Memory Springs. At 10:30 A.M., the lunch time drink cart came to the station and the CNA's would be busy serving the drinks. It was too busy at that time for them to complete activities. She wasn't sure why the activity aide had not been over there that day for the planned activities of at 10:30, laundry folding; or at 2:00 P.M., horseshoes. During an interview on 03/26/24 at 2:40 P.M., the Activity Director indicated she makes the resident's activity calendar for all the stations. Memory Springs had their own activity calendar. The activity department consisted of her and one other staff member. She drove the bus a lot and was not there during the days. The Activity Aide was responsible for completing the scheduled activities. If the activity aide was not able to get to an activity then the CNA's working the floor would be notified so they could complete the			

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	activity. The activity calendar for Memory Springs was placed in every resident room and on the bulletin board in the dining room. The activities should be completed when they are scheduled or should have asked the CNA's to complete them. The activity calendar was provided by the Activity Director on 03/26/24 at 2:51 P.M., the Memory Springs Activity Calendar included, but were not limited to, the following activities for 03/26/24: - 10:30 A.M., folding laundry and 2:00 P.M., horseshoes. The current, undated, facility policy titled, "Activities Program", was provided by the Administrator on 03/26/24 at 3:41 P.M. The policy indicated, "...It is the policy of the facility to provide an ongoing program of Activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of the residents...Facility will offer activities both individual and group to enhance the physical, mental and psychosocial well-being of residents, taking into consideration any limitations that the resident's might have individually or as a group...Facility will develop specialized activities for residents with Alzheimer's Disease and/or other Dementia related conditions. Nursing and SSD [Social Service Director] will assist with this endeavor..." 3.1-33(a) 3.1-33(c)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155280	A. BUILDING 00 B. WING	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF DILLSBORO-ROSS MANOR, THE	12803 LENOVER ST DILLSBORO, IN 47018

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	Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to follow physician's orders related to wound treatments and TED (anti-embolism) hose for 3 of 20 residents reviewed for quality of care. (Residents 44, 61, and 30) Findings include: 1. During an observation and interview on 03/20/24 at 1:33 P.M., Resident 44 was sitting on a couch in his room and indicated he had a sore on his toe. The clinical record for Resident 44 was reviewed on 03/21/24 at 2:38 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 02/21/24, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, diabetes, anemia, hypertension, non-Alzheimer's dementia, depression and pain in his left foot. A Wound assessment, dated 02/19/24, indicated the resident had an arterial wound to the left foot. A physician's order, dated 12/24/23 through 01/22/24, indicated the staff were to apply betadine moist gauze and alginate, foam, and sterile gauze between the left great toe and second toe, and wrap with gauze, every day shift.	F 0684	It is the practice of this facility to ensure residents have physician orders followed related to TED hose and wound treatments. Resident #44 arterial wound has been being monitored and treated in accordance with acceptable standards of practice. On 4/5/24, resident #44 had a wound evaluation completed by the DON or designee that has shown no negative outcome related to the alleged deficient practice. Resident #61 order for ted hose has been reviewed by the NP on 3/27/24. Based on resident's desire to not wear them has been considered and the order has been discontinued. Resident #61 has no negative outcome related to the alleged deficient practice. Resident #42 order for ted hose has been reviewed by hospice on 3/27/24. Based on resident's desire to not wear them for comfort has been considered and the order has been discontinued. Resident #42 has no negative outcome related to the alleged deficient practice. All residents with TED hose orders	04/24/2024

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	A physician's order, dated 01/23/24 through 02/13/24, indicated the staff were to apply betadine to the left big and second toe topically every shift. A physician's order, dated 02/14/24 through 03/01/24, indicated the staff were to apply betadine to the left big and second toe topically every day shift. A physician's order, dated 03/02/24 through 03/25/24, indicated the staff were to apply betadine to the second toe every day shift. The January, February, and March 2024, EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) lacked documentation that the treatments were completed for the following dates: - 01/01/24, - 01/04/24, - 01/11/24, - 02/11/24, - 02/13/24, - 02/16/24 day shift, - 02/18/24 day shift, - 03/05/24, and - 03/07/24. During an interview on 03/26/24 at 3:05 P.M., the DON (Director of Nursing) indicated a blank in the EMAR/ETAR could be an error of the nurse not signing out the medication or treatment or it wasn't completed. There should not be any blanks in the EMAR/ETAR. 2. During an interview and observation on 03/21/24 at 9:27 A.M., Resident 61 indicated they		and treatment orders have the potential to be affected by this alleged deficient practice. 100% audit was completed of these residents on 4/15/24 by the DON or designee. Any concerns were addressed. Nursing education was held on 4/4/24 by the DON to review the "Following Physician Orders" policy. Any staff who fail to comply with the points of the inservice will be further educated. DON/Designee will implement an audit tool, "Physician Orders" to monitor compliance with completing physician orders to ensure orders are charted correctly. The audit tool will be used to monitor compliance and become part of the CQI agenda as part of the QAPI process. This audit will be completed five days a week for 4 weeks, then weekly for 4 weeks, then once a month for 6 months, if the facility is within 95% compliance after 6 months, the monitoring will be stopped quarterly thereafter until 95% compliance is achieved. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the QAPI committee. Any written action plan will be monitored by the Administrator monthly until resolved and substantial compliance is achieved.	

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	had trouble with swelling in their feet and ankles. The staff did not put their TED hose on because they couldn't get them on easily. The resident was not wearing TED hose and their feet and ankles were swollen. The resident indicated they were left in bed a lot of the time because the staff had to use a lift to get them up. They had recently started taking the medication Lasix (a diuretic). During an observation and interview on 03/21/24 at 2:51 P.M., the resident was sitting in a recliner in their room. Their feet were swollen, and they were not wearing TED hose. They indicated staff had not offered to put their TED hose on them. There was a pair of clean white TED hose in the drawer of their nightstand. During an observation and interview on 03/22/24 at 11:23 A.M., the resident was sitting up in bed eating lunch. They indicated they had congestive heart failure and did not have their "tight socks" (TED hose) on today. Their feet were swollen. During an interview and observation on 03/25/24 at 10:43 A.M., the resident indicated the staff had not put their TED hose on them today and they had not offer to put them on. The resident's feet and ankles were swollen. The resident was lying in bed. They had asked to be put in their chair. The staff usually told them they only had one lift and it took two people to move them. During an interview and observation on 03/25/24 at 1:58 P.M., the resident indicated the staff had not gotten them up out of bed. They had told the staff they would like to get up. The resident was not wearing their TED hose. The clinical record was reviewed on 03/26/24 at 9:28 A.M. A Significant Change MDS assessment,			

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	dated 02/15/24, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, congestive heart failure and hypertension. The EMAR/ETAR for March 2023 was provided by the Administrator on 03/26/24 at 2:47 P.M. The record indicated the resident had a physician's order to apply knee high TED hose to both legs every day shift for edema prior to getting up in the morning, with a start date of 02/15/24. The record had been checked off each day indicating the hose had been applied as ordered. During an interview on 03/26/24 at 2:16 P.M., LPN (Licensed Practical Nurse) 3 indicated the CNAs (Certified Nurse Aides) usually applied TED hose to the residents who had orders for them. The nursing staff would pass the information on to the CNA staff if a resident required TED hose. The CNAs had not reported to her any residents refusing their TED hose. The CNAs knew they were supposed to report to nursing staff if a resident refused care of any kind. 3. Resident 30 was observed in his room on 03/21/24 at 10:02 A.M. The resident was sitting on the side of his bed with his feet on the floor. The resident was wearing slippers without socks. The tops of his bare feet and his lower legs were visible and appeared swollen and reddish pink in color. On 03/22/24 at 9:44 A.M., the resident was observed in his room sitting on the side of his bed with his feet on the floor. The resident was wearing slippers without socks. The tops of his bare feet and his lower legs were visible and appeared swollen and reddish pink in color. On 03/22/24 at 11:20 A.M., the resident was sitting			

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	on the side of his bed with his feet on the floor eating lunch. The resident was wearing slippers without socks. The tops of his bare feet and his lower legs were visible and appeared swollen and reddish pink in color. On 03/25/24 at 2:59 P.M., the resident was observed sitting in his wheelchair in the dining room during bingo. The resident was wearing slippers without socks. The tops of his bare feet and his lower legs were visible and appeared swollen and reddish pink in color. On 03/26/24 at 10:04 A.M., the resident was observed in his room sitting on the side of his bed with his feet on the floor. The resident was wearing slippers without socks. The tops of his bare feet and his lower legs were visible and appeared swollen and reddish pink in color. The resident's clinical record was reviewed on 03/25/24 at 2:16 P.M. A Significant change MDS assessment, dated 01/29/24, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, coronary artery disease, diabetes, hypertension, and Parkinson's disease. The resident exhibited no behaviors and did not reject care during the assessment review period. The resident's current physician's orders included, but were not limited to, an open ended order, with a start date of 11/21/23, that indicated the resident was to wear knee high TED hose every day. The stockings were to be applied in the morning and removed before bed. The March 2024 EMAR was reviewed on 03/25/24 at 2:16 P.M. The EMAR was initialed by nursing staff were to indicate the resident's TED hose			

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	were applied every day except on 03/14/24. On 03/14/24, it was documented, that was the only day of the reviewed time, the resident refused the TED hose. During an interview on 03/26/24 at 10:25 A.M., CNA 4 indicated she always worked on Station 3 and was familiar with the resident. If a resident was supposed to wear TED hose staff would try and put them on the resident. If they refused, they would try again. If the resident continued to refuse, they would let the nurse know. She was not sure if the resident was supposed to wear TED hose. There were other residents on Station 3 that wore them. One resident usually already had them on when she got to work in the mornings. Another resident's TED hose were usually laying out on the back of their wheelchair or some other place in their room; she would see the hose when she went in to provide care. CNA 4 was not sure how she would check the resident's record to determine if they were supposed to wear TED hose. They didn't use CNA sheets. During an interview on 03/26/24 at 10:27 A.M., LPN 3 indicated she didn't think the resident wore TED hose. The current, undated, facility policy, titled "PHYSICIAN ORDERS--(FOLLOWING PHYSICIAN ORDERS)", was provided by the DON on 03/26/24 at 2:12 P.M. The policy indicated, "...It is the policy of the facility to follow the orders of the physician..." 3.1-37(a)			
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			

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	Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to label and store medications appropriately for 2 of 3 medication storage refrigerators observed. (Station 1 medication refrigerator and Station 3 medication refrigerator) Findings include: Medication storage was observed on 03/26/24 at 1:41 P.M., with the ADON (Assistant Director of Nursing). 1. The medication refrigerator on Station 1	F 0761	It is the policy of this facility to store tuberculin medication appropriately. 3/28/24 all medication refrigerators have been audited to ensure tuberculin medication are dated appropriately. Any concerns were addressed. Nursing education was held on 4/4/24 by the DON to review the "Tuberculin Recommended Storage" guidelines. Any staff who fail to comply with the points of the in-service will be further	04/24/2024

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	contained an open vial of TB (Tuberculin) serum with no label indicating when it was opened. The vial was about half full. The ADON could not recall when the last resident was admitted to the unit. 2. The medication refrigerator on Station 3 contained an open vial of TB serum with no label indicating when it was opened. The vial was one quarter full. The ADON could not recall when the last resident was admitted to the unit. LPN (Licensed Practical Nurse) 3, who was present at the time, indicated she had administered the serum to Resident 8 last week. During an interview on 03/26/24 at 2:10 P.M., the DON (Director of Nursing) indicated the TB serum vials should be dated when they were opened. The TB serum package insert was provided by the DON on 03/26/24 at 2:18 P.M. The directions for storage indicated, "...A vial...which has been entered and in use for 30 days should be discarded...Do not use after expiration date..." The current undated "MEDICATION STORAGE IN THE FACILITY" policy was provided by the DON on 03/26/24 at 2:18 P.M. The policy indicated, "...Medications and biological [sic] are stored safety [sic], and properly following the manufacturer or supplier recommendations..." 3.1-25(j)		educated. DON/Designee will implement an audit tool, “Medication Storage” to monitor compliance with tuberculin storage to ensure solution is stored and dated properly. The audit tool will be used to monitor compliance and become part of the CQI agenda as part of the QAPI process. This audit will be completed five days a week for 4 weeks, then weekly for 4 weeks, then once a month for 3 months, quarterly thereafter until 95% compliance is achieved then audits will be stopped. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the QAPI committee. Any written action plan will be monitored by the Administrator monthly until resolved and substantial compliance is achieved.	
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.			

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	Based on observation and interview, the facility failed to provide a homelike environment related to odors for 1 of 4 stations reviewed. This had the potential to affect 13 of 68 resident residing in the facility. (Memory Springs-Dementia Unit) Findings include: During an observation on 03/20/24 at 9:51 A.M., there was a strong urine odor when entering Memory Springs. During an observation on 03/21/24 at 10:50 A.M., there was a strong urine odor in the common area of Memory Springs. The common area had seven recliners with cloth pads covering the seats. There were two recliners with residents sitting in them, asleep. During an observation on 03/22/24 at 1:41 P.M., there was a urine odor when entering Memory Springs, there were a few residents in the dining room. The common area had several recliners with cloth pads on the seats. The common area was open to the dining room. During and observation on 03/26/24 at 10:06 A.M., the common area in Memory Springs had a urine odor, there were several recliners with cloth pads on them. During an interview on 03/26/24 at 2:31 P.M., the Housekeeping Supervisor indicated all the stations would get cleaned everyday. The housekeeping staff were to clean everything in the resident room, that included sweeping and mopping the floors, and cleaning the toilets. The common area recliners in Memory Springs were cleaned by the nursing staff. If a recliner got moved to a resident room the the housekeeping	F 0921	It is the practice of this facility to provide a safe, functional, sanitary, and comfortable environment for each resident. All residents, including those identified, have the potential to be affected by this alleged deficient practice. 100% environmental audit will be completed by the Housekeeping supervisor or designee of the unit identified as “memory springs” with identified areas corrected by 4/24/24. Environmental staff education was held on 4/3/24 by the Administrator and Housekeeping supervisor to review the “Home-Like Environment” policy. Any staff who fail to comply with the points of the in-service will be further educated. Administrator/Designee will implement an audit tool, “Environmental Audit” to monitor compliance with cleanliness and sanitation. The audit tool will be used to monitor compliance and become part of the CQI agenda as part of the QAPI process. This audit will be completed five days a week for 4 weeks, then weekly for 4 weeks, then once a month for 3 months, then quarterly thereafter until 95% compliance is achieved for 6 months. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting, an action plan will be written by the QAPI committee.	04/24/2024

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	staff would deep clean it. During an observation and interview on 03/26/24 at 2:34 P.M., the Housekeeping Supervisor entered Memory Springs and as she walked through the dining room, she indicated she could smell the urine odor and the odor was a little stronger in the common area with the recliners. The nursing staff were to keep the cloth pads on the recliners. At 2:38 P.M., she exited Memory Springs and indicated it smelled a lot better off the unit. During an interview on 03/21/24 at 9:58 A.M., a family member indicated the Memory Springs always smelled like urine. The current, undated, facility policy titled, "HOMELIKE ENVIRONMENT" was provided by the Administrator on 03/26/24 at 3:41 P.M. The policy indicated, "...It is the policy of the facility to ensure that the environment provided by the facility is safe, sanitary, functional and comfortable. The surroundings for the residents must also be "homelike" de-emphasizing the institutional character of the setting to the greatest extent possible..." 3.1-19(f)(5)		Any written action plan will be monitored by the Administrator monthly until resolved and substantial compliance is achieved.	