STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155153	A. BUILDING 00 B. WING	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HEALTHWIN	20531 DARDEN RD SOUTH BEND, IN 46637

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January 9, 10, 11, 12, 13, 17, 18 and 19, 2023 Facility number: 000073 Provider number: 155153 AIM number: 100288820 Census Bed Type: SNF/NF: 98 SNF: 09 Total: 107 Census Payor Type: Medicare: 6 Medicaid: 68 Other: 33 Total: 107 These deficiencies reflect/reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 2/1/23.	F 0000	**Healthwin requests a desktop review (IDR) on tags F636, F692, and F757.** **Healthwin requests desk review for these citations.** **This plan of correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied.**	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-			

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

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	(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations			

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	that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on observation, interview and record review the facility failed to ensure the physician was notified of a large bruise and for refusal of daily weights for 2 out of 3 reviewed for notification of change. (Resident 72 & 78) Findings include: The clinical record review for Resident 72 was reviewed on 1/12/2023 at 1:18 P.M. Diagnoses included, but not limited to: atrial fibrillation, and heart failure. A Progress Note, dated 1/1/2023, indicated a bruise was noted to her left upper arm measuring 10 by 11, she is on Eliquis and recently wearing her left shoulder sling. On 1/10/2023 at 9:36 A.M., Resident 72 indicated therapy put her in a shoulder brace and it gave her a very large bruise. A Physician Order, dated 10/27/2022, indicated Eliquis 5 milligrams (ml) give 1 tablet by mouth 2 times a day. A Physician Order, dated 9/20/2022, indicated patient may wear sling to left arm for comfort as needed. During an interview, on 1/12/2023 at 8:58 A.M., the Director of Nursing (DON) indicated when a bruise is found the nurse fills out an occurrence report, altered skin integrity notification on paper, then in pointclickcare she fills out a physician notification #2 then tiger text the form to the	F 0580	**What corrective action(s) will be accomplished for those residents found to have been affected by the accepted POC must contain the following:** Medical provider was notified of changes with Resident 72 and Resident 78. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken:** All residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur ?** Medical provider will be notified of any new skin conditions, via PN2 with confirmation of route of notification to be documented on the PN2 and then scanned into the electronic medical record. Medication/treatment refusals that occur consecutively 3 times are to be communicated medical provider via PN2 Confirmation of route of notification to be documented on the PN2 and then scanned into	03/03/2023

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	physician. She did not have the documentation that the doctor was notified and indicated they did not follow their policy. On 1/12/2023 at 1:31 P.M., the DON provided a policy titled, "Physician Notification Services", dated 11/2017 and indicated the policy was the one currently used by the facility. The policy indicated "...To ensure significant changes in resident status are thoroughly assessed, communicated, and documented in the medical record. Notification of resident status changes to the attending practitioner via phone, fax and/or tiger text...." 2. The clinical record for Resident 78 was reviewed on 1/12/2023 at 4:29 P.M. The diagnoses included, but not limited to: chronic systolic and diastolic congestive heart failure, pleural effusion, and edema. A Physician Order, dated 10/11/2022, indicated "DAILY WEIGHTS- See PRN Edecrin for weight gain of 2# or greater in 24 h in the morning for CHF." A Medication Administration Record, dated January 2023, indicated Resident 78 refused daily weights on 1/3/2023, 1/5/2023, 1/6/2023, 1/7/2023, 1/8/2023, 1/14/2023 and 1/16/2023. During an interview, on 1/18/2023 at 9:07 A.M., the Director of Nursing (DON) indicated that she did not see any documentation that the physician was notified of resident refusing daily weights. She indicated that with review of the policy and resident gets tapped weekly for a thoracentesis she did not agree with notifying the physician of refusal.		the electronic medical record. Staff will be re-educated on the policy regarding physician notification. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.; what quality assurance program will be put into place** Our current tracking log was modified to include provider notification date. The provider notification date will be audited weekly for 4 weeks and monthly thereafter for 5 months. The audits will be shared at the monthly QAPI meetings.	

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	On 1/12/2023 at 1:31 P.M., the DON provided a policy titled, "Physician Notification", revised 11/3/22, and indicated the policy was the one currently used by the facility. The policy indicated "...Nurse Responsibilities d. Other ii. Refusals or non-compliance with care resulting in potential adverse effects...." 3.1-5(a)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law,			

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	including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure an allegation of abuse was reported immediately to the Administrator and to other officials, including the State Survey agency. Finding includes: During an interview with Resident 17, conducted on 1/11/2023 at 8:40 A.M., she indicated a night shift nursing staff member had woken her up in the middle of the night, insisted on checking her for incontinence and had been very rough and rude to her. Resident 17 indicated she had reported the incident and "someone from the office" had spoken with her about the incident. The clinical record for Resident 17 was conducted on 1/11/2023 at 3:00 P.M. Resident 17 was admitted to the facility with diagnosis including, but not limited to: displaced intertrochanteric fracture of the right femur (new 12/8/2022) chronic obstructive pulmonary disease, Atrial fibrillation, sick sinus syndrome, chronic ischemic heart disease, old myocardial infarction, Heart failure, chronic kidney disease stage 3, major depressive disorder, anxiety disorder, edema, hisotry of head injury, history of venous thrombosis and embolism, history of concussion, history of malignant neoplasm of the kidney, osteoarthritis, history of Tran-ischemic attack, pacemaker, hyperlipidemia, left artificial knee joint and hypertension. There were no nursing progress notes regarding the resident being upset at night by a nursing staff member or reports of staff mistreatment.	F 0609	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The reporting of alleged violations to be reported late to the IDOH gateway. The staff person involved has been re-educated on the steps when care concerns are brought up. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken:** All residents have the potential to be affected by the same deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** All staff will be re-educated on how to report abuse through an in-service. Administrator or designee will implement the abuse packet with all potential care concerns to determine if abuse has occurred. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	03/03/2023

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	There was a note, dated 12/11/2022 about Resident 17 complaining of her room being "stifling hot" and a request for social services to talk to her was made. On 1/13/2023 any allegation of abuse and/or grievance from Resident 17 was requested for review. A grievance concern form was provided on 1/13/2023 at 12:00 P.M.. The grievance form, filled out for Resident 17 by an activities staff member, indicated the following: "My grievance is woken up (sic) at 2 AM to asked if I'm wet. On Sunday Dec 25, 2022 at 2 am, the CNA woke me up and asked if I was wet. I said no but she insisted on checking. The CNA was rough and moved my right leg which is broken in a way which hurt. The CNA raised my bed very high which scared me as I felt I might fall for out of bed." The form was signed by the resident and "Written by (staff member's name" was at the bottom of the grievance section. There were follow up notes, written in a different handwriting noted on the bottom and back of the form. During an interview with Activity staff member 24, conducted on 1/17/2023 at 11:56 A.M., she indicated she wrote the grievance for the resident on December 26. She indicated she did not date the grievance but the date 12/28/22 was written in another person's handwriting on the grievance form. Activity staff member 24 indicated she thought she gave it to her "boss" after she helped Resident 17 complete the form but she could not specifically remember to whom she had given the form. When queried as to whether she considered "rough" treatment of a staff member a possible allegation of abuse, Employee 24 indicated she did not make any "judgements" when helping residents complete grievance forms.		**recur, i.e.; what quality assurance program will be put into place** All alleged violations/abuse packets will be reviewed individually. Each individual case will be determined if abuse has occurred with appropriate reporting to the IDOH. All cases will be trended and reviewed at the monthly QAPI meeting.	

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	During an interview, conducted on 1/17/23 at 3:25 P.M., with the Life Enrichment Director, Employee 24's direct supervisor, he indicated he was not working on 12/26/2022 and Employee 24 had actually placed the completed grievance form for Resident 17 in the "Grievance" box, located in the great room. He indicated Employee 24 was nervous and could not remember what she had done with the completed grievance form when interviewed earlier in the day. The Life Enrichment Director indicated the policy was to actually give or notify the Administrator, who was also the facility Abuse Coordinator, of any allegation of abuse. He indicated Employee 24 could have actually handed the form to the Administrator but the Administrator got the form anyways as she was the employee that checked the Grievance boxes for "anonymous" concerns. During an interview with the Adminstrator, conducted 1/17/2023 at 3:20 A.M., indicated she found the grievance in the "Grievance" box and she did not consider the grievance an allegation of abuse but more of a pain issue with repositioning. She indicated she had delegated the follow up to the Director of Nursing and/or the Assistant Director's of Nursing. Review of the facility policy and procedure, titled, "Abuse, Neglect, Exploitation and Misappropriatation Reporting and Investigaiton" provided by the Director of Nursing on 1/11/2023 at 2:00 P.M. included the following: "...5. All incidents of abuse or suspected abuse must be reported immediately to the Adminsitrator, as well as the resident's responsible party...." 3.1-28(c)			

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F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is			

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	required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill			

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	Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview and record review, the facility failed to notify the Ombudsman of transfers/discharges for the month of October 2022 for 1 out of 4 reviewed for hospitalizations. (Resident 34) Finding includes: The clinical record review for Resident 34 was reviewed on 1/12/2023 at 4:34 P.M. Diagnoses included, but not limited to: fracture of left lower leg, left humerus, and right lower leg. Resident went to the hospital on 10/28/2022 after a fall and returned on 11/10/2022. During an interview, on 1/13/2023 at 11:14 A.M., Health Information Manager indicated she failed to e-mail the October transfer/discharges to the Ombudsman and should have.	F 0623	**What corrective action(s)will be accomplished for those residents found to have been affected by the deficient practice:** Submit the late monthly notification to the Long Term Care Ombudsman and Real Services. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken:** All residents that transfer/discharge out of the facility have the potential be impacted by the deficient practice.	03/03/2023

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	On 1/172023 at 1:04 P.M., the Administrator provided a policy titled, "Healthwin Transfer and Discharge Policy", revised 10/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...11. Non-Emergency Transfer/Discharges b. Provide transfer/discharge notice to the resident/representative and Ombudsman as indicated. 12. Emergency transfer/discharges h. The Social Service Director, or designee, will provide copies of notices for emergency transfers to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis, as long as the list meets all requirement for content of such notices...." 3.1-12(a)(6)(A)(iv)		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** A schedule is set of the first of every month to send the previous month's transfers/discharges out of the facility by Medical Records/designee. Staff will be re-educated on the process. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.; what quality assurance program will be put into place** Medical Records/designee will email the appropriate parties the transfer/discharge information and include the Administrator for the next 6 months. Transfers/Discharges will be reviewed at the monthly QAPI meetings.	
F 0656 SS=E 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			

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	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. §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, interview and record review, the facility failed to develop or follow a plan of care to meet the needs of 4 of 26 residents	F 0656	**What corrective action(s) will be accomplished for those residents found to have been**	03/03/2023

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	reviewed for care plans. (Resident 29, 78, 40 and 23) Findings include:1. The clinical record review for Resident 29 was reviewed on 1/13/2023 at 10:47 A.M. The diagnoses included, but not limited to: anoxic brain damage, autonomic dysreflexia, epilepsy and aphasia. A Quarterly Minimum Data Set (MDS), dated 11/21/2022 indicated she is total dependent for all activities of daily living. During an observation, on 1/10/2023 at 10:40 A.M., Resident 29 was reclined back in a wheelchair with a seat belt fastened across her lap. She had contractures to bilateral wrists; ankles and her neck was turned to the left side. During an observation, on 1/11/2023 at 10:20 A.M., she was reclined back in her wheelchair with a seat belt fastened across her lap. She made very little movement and was looking at the TV. During an observation, on 1/12/2023 at 11:08 A.M., she was reclined back in her wheelchair with a seat belt fastened across her lap. She slowly moved her right leg up a few inches and lowered it back down a few times. During an interview, on 1/13/2023 at 12:18 P.M., the Director of Nursing (DON) indicated that she does not see a care plan for the use of the seat belt and there should have been. 2. The clinical record for Resident 78 was reviewed on 1/12/2023 at 4:29 P.M. The diagnoses included, but not limited to: chronic systolic and diastolic congestive heart failure, pleural effusion and edema.		**affected by the deficient practice:** Resident 29's seatbelt order was added. The seat belt care plan and the C.N.A assignment was verified as a positional device due to her inability to rise/dependent from the wheelchair secondary to anoxic brain damage. Resident 78's thoracentesis was added to the care plan. Re-education of the floor staff regarding Resident 23's care plan interventions regarding assisted dining was reviewed. Resident 26's care plan reflects the use of the Dialysis Communication binder between the dialysis center and the facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken:** All residents have the potential be affected by the deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Order recaps to be pulled multiple times per week to verify the care plan is up to date as well as areas the corresponding care areas on the C.N.A. assignment sheet. Staff who assist with updating the care plan will be re-educated.	

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	Reviewing the medication administration record a new order is written weekly for each Thursday for a thoracentesis. During an interview on 1/12/2023 at 2:33 P.M., Resident 78 indicated she goes out to the hospital every week on Thursday for a thoracentesis. Today they pulled off 2,700 milliliters (ml). During an interview, on 1/18/2023 at 9:35 A.M., the Director of Nursing indicated that there was no care plan for the thoracentesis and there should have been. 3. Resident 23 was admitted to the facility with diagnosis included but not limited to: Alzheimer's disease, behavioral psychotic mood disturbance and anxiety, hyperlipidemia, severe protein calorie malnutrition, anxiety disorder, arteriosclerotic heart disease, hypothyroidism, major depressive disorder, hypertension, dysphagia, paroxysmal atrial fibrillation, cerebrospinal fluid drainage device, history of cardiac and vascular implant and graft, history of COVID. The most recent quarterly MDS assessments, completed on 12/14/2022 indicated the resident was rarely understood and required extensive staff assistance of one for eating needs. The most recent Nutritional Assessment for Resident 23, completed on 12/14/2022 by the dietician, indicated the resident BMI (Body Mass Index) was 16% and the resident had incurred an 8% weight loss in the past 180 days. The section to indicated the Caloric Needs required had "Comfort measures only" typed. The Diet order for Regular diet with think liquids. Cut up food. was indicated. Under the section to acknowledge pertinent diagnosis affecting nutrition, Dementia		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.; what quality assurance program will be put into place** The Director of Nursing/designee will audit the orders, care plan, and C.N.A. assignment to assure on a weekly x 4 consecutive weeks and monthly thereafter for 5 months. Audits will be reviewed at the monthly QAPI meeting.	

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	and Severe Pro (Protein) Cal (Caloric) Malnutrition was indicated. Under the Physical and mental functioning section - lipped plates, sippy cup and sauce/gravy as tolerated was indicated. Under the nutritional interventions the following was indicated: "Monthly wts (weights) Ensure Plus 1 bottle (van/strawberry) 1300 and 1800. Boost Breeze 1000. Double Desserts L/S ng offer pudding, yogurt, applesauce q shift per POA request." The current care plan regarding eating/nutritional needs included the following interventions: "Boost Breeze, Ensure Plus one bottle at 1 pm and 6 pm, (resident's name) loves ice cream..., monitor weights as ordered...regular diet with thin liquids...loves sweets. Double Desserts L/S. Likes applesauce. Likes coffee with creamer and hot tea. Serve at all meals. Likes oatmeal for bfast. Straws OK, inner lipped plate. Sippy cup with lid. Cut up all food..." On 01/11/23 at 9:26 A.M., Resident 23 was observed in the dining room on her nursing unit, seated in her wheelchair at a c-shaped table. An opened bottle of a nourishment shake with a straw in it was noted on the table close to the resident. At 9:29 A.M., the dietary staff cook placed a bowl of oatmeal to Resident 23 and a yellow divided plate of food. A nursing staff member opened up the resident's silverware and cut up her ham and walked away to pass other breakfast plates. At 9:32 A.M., Resident 23 was cued by a nursing staff member to eat. Resident 23 then reached with her fingers and picked up a piece of ham and ate it. She continued to reach for her breakfast food with her fingers. The resident continued to occasionally attempt to pick up some food with her fingers but received no cues and/or assistance to eat. At 9:44 A.M., Resident 23 was noted to			

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	manipulate the straw in the bottle of nourishment shake that was on the table near her. She did not drink the shake, just moved the straw around in the drink. On 1/12/23 at 9:17 A.M. ., Resident 23 was observed seated in her wheelchair in the dining room on her nursing unit asleep. The resident had a clothing protector over her clothes. There were no staff noted in the room and the resident did not have any food or beverages in front of her. The resident was observed at 9:33 A.M. and she had a plastic up of orange juice with no straw in front of her along with silverware, wrapped in a napkin and was still sleeping. The dietary cook was in the dining room with a portable steam table of food. At 9:35 A.M., the dietary cook placed a bowl of oatmeal in front of the resident but did not wake her up. A nursing staff member placed a packet of brown sugar near the resident but did not wake her up. At 9:36 A.M., a nursing staff member put brown sugar in Resident 23's oatmeal and did call the resident's name. At 9:37 A.M., a rimmed plate of food was placed in front of Resident 23. At 9:38 A.M., a nursing staff member cut up Resident 23's pancake, attempted to wake up Resident 23 again, and repositioned her wheelchair closer to the table. The staff member did not assist Resident 23 to eat. At 9:39 A.M., Resident 23 did wake up and used her fort to feed herself a few bites of food then placed the fork into the open glass of orange juice. After stirring the fork around in the orange juice, the resident then removed the fork and then continued to feed herself. She also was observed to pick up the cup and drink some of the juice. Resident 23 was observed on 1/13/23 at 9:27 A.M., seated in her wheelchair in the dining room on her nursing unit. The resident had been served a			

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	plastic up of orange juice. The resident was noted to be stirring her orange juice with a spoon. A nursing staff member placed a plastic straw into the resident's glass of orange juice and walked away. Resident 23 then was noted to dip the straw into the orange juice and lick the drips of juice from the bottom of the straw. Staff were not seated to cue or assist the resident with her meal. On 1/17/23 at 12:41 P.M., Resident 23 was observed in the dining room on her nursing unit, in her wheelchair positioned at a c-shaped table The resident had been served her meal tray and a plastic up of jello but her meat had not been cut up and she did not have any liquids to drink. Resident 23 was observed form 12:41 P.M. - 12:49 P.M. and she was not being assist and/or cued to eat. At 12:49 P.M., Resident 23 was attempting to eat her fruited jello with her butter knife. At 12:52 P.M., a nursing staff member was noted seated next to Resident 23 but the staff member was feeding another resident. The staff member was positioned with her back to Resident 23. The nursing staff member did turn once, reach over and place a spoon in Resident 23's jello for her. The resident then fed herself a few bits of cooked vegetables and noodles with her spoon. After spilling most of the noodles she attempted to feed herself with her spoon, Resident 23 became distracted and was noted to be folding her napkin and a clothing protector that was on the table in front of her. After a few minutes of folding these items Resident 23 then picked up her plate of food and moved it to the right of the clothing protector. She then attempted to reach over the folded clothing protector to obtain another bite of her food. At 12:52 P.M., Resident 23 was observed to attempt to feed herself jello with the plastic lid that had initially covered the bowl of jello. There were no nursing staff cueing and/or assisting Resident			

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	23 with her meal, she had still not been served any beverages and she was only served one bowl of fruited jello. At 12:55 P.M., Resident 23 was noted to obtain a few noodles on a spoon but dropped them onto the folded clothing protector. She then spent a few minutes picking up noodles off of the clothing protect and eating them with her fingers. At 1:00 PM., Resident 23 was observed attempting to eat a "bite" from her clothing protector. At 1:04 P.M., Resident 23 was observed struggling to obtain noodles from the food she had dropped onto the clothing protector which was folded on the table. At 1:10 P.M., CNA 19 was queried regarding specific nutritional interventions for Resident 23. CNA 19 indicated the resident was supposed to have a lipped plate and her food cut up for her. When specifically asked about beverages, CNA 19 indicated the resident was supposed to have a lidded up. CNA 19 then realized Resident 23 had not been served any beverages with her meal and obtained a glass of orange juice in a lidded cup for her. When asked if there were any other interventions, CNA 19 indicated she was not sure. The paper dietary card was retrieved from the table beside Resident 23. The card indicated, in addition to the interventions verbalized by CNA 19, the resident was to have double desserts, liked coffee and hot tea and applesauce. CNA 19 confirmed the resident did like "sweets" and would often eat those food items first when served her meals. 4. Based on observation, record review and interviews, the facility failed to ensure 1 of 1 residents reviewed for dialysis services had communication between the facility and the dialysis center and had documentation the dialysis access site was visually observed for			

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	complications after treatments. (Resident 26) Findings include: The clinical record for Resident 26 was reviewed on 1/10/2023 at 2:50 P.M. Resident 26 was admitted to the facility with diagnosis, included but were not limited to: encephalopathy- acute 1/4/2023, Urinary tract infection 1/5/2023,, e coli, end stage renal, dm. chronic obstructive pulmonary disease, congestive heart failure-diastolic chronic, dementia, sleep apnea, hypothyroidism, history of COVID 19, Major Depressive Disorder, hypertension, hyperlipidemia, history of malignant neoplasm of the breast, gastroesophageal reflux disease and Anemia. The most recent Minimum Data Set (MDS) assessment, conducted as a quarterly assessment on 11/02/2022 indicated Resident 26 received dialysis treatments. The physician's orders for Resident 26 included orders for the resident to go to a dialysis center three days a week for treatments and for the facility to check the "thrill and Britt in the mornings. There were no specific physician orders to check the resident's dressing and dialysis access site when she returned from her dialysis treatments. Review of the Medication and Treatment records for Resident 26 indicated there was documentation of the resident's dialysis treatments, medications and documentation of the daily check for the thrill and bruit of the resident's fistula, but there was no documentation regarding assessing the resident's dialysis access site and dressing after she returned from her treatments.			

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	Resident 26 was not observed in her room on 1/9/2023 during the morning and early afternoon. During an interview with LPN 25, conducted on 1/9/2023 he indicated the resident was at her dialysis treatment. Resident 26 was observed on 1/10/23 at 11:38 A.M. seated on the side of the bed in her room. The resident was noted to have a dressing on her upper left arm. During an interview, conducted on 1/17/23 at 11:46 A.M. . with LPN 25 and 26, they indicated they were currently not utilizing a dialysis"binder" for Resident 26. They indicated the dialysis center "kept" the binder. They indicated it had not been in use for "a few months.' During an interview with the Medical Records Manager, Employee 26, conducted on 1/18/2023 at 3:14 P.M. she indicated she sets up dialysis binders for any resident receiving dialysis. She indicated the staff were to fill out the report prior to sending the resident to the dialysis center and the dialysis center was to document specific information about the resident's condition and/or treatment when they sent the resident back. She indicated she did not know why the nurses were no utilizing the dialysis binder for Resident 26. Employee 26 indicated the facility requested the actual treatment records from the dialysis center be faxed to the facility. These records, requested approximately every other week, were then scanned into the resident's electronic record. Employee 26 indicated these records were not coming back in the binders so the facility just had the dialysis center fax the requested documentation.			

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	The current care plan for Resident 26, current through 4/6/2023, related to her diagnoses of End Stage Renal Disease (ESRD) and need for dialysis included but were not limited to the following interventions: "Assess and record every shift; type of access device, location of access, condition of dressing, date of last dialysis treatment, any post dialysis s/sx resident is exhibiting and any treatment given to alleviate symptoms....send communication book to dialysis with (resident's name) for each visit...." Review of the facility policy and procedure, titled "(facility name) Care Planning Special Needs - Dialysis policy), provided by the Director of Nursing on 1/18/2023 at 9:45 A.M., included the following: "...2. The care plan will reflect the coordination between the facility and the dialysis provider and will identify nursing home and dialysis responsibilities. 3. Interventions will include, but not limited to: ...b. Pre and post weights c. Assessing, observing, and documenting care of access sites, as applicable...g. Provision of medications on dialysis treatment days, such as which medications are: i. Administered during dialysis ii. Held prior to dialysis iii. Given prior to dialysis iv. Administered by dialysis staff...4. Nursing staff will provide a report to the dialysis provider regarding the resident's condition and treatment provisions each dialysis treatment day, and as needed. 5. The Dialysis Communication book for communication between nursing and center includes: face sheet, order summary, labs, transfer/discharge paperwork, blank telephone orders if needed, and progress notes forms for written communication on the dialysis session. 6. If no written report is received upon return from dialysis, nursing staff will call the dialysis provider to receive a report...."			

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F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, record review and interviews, the facility failed to ensure care plans were revised and updated regarding nutritional needs and weight loss for Resident 37 and splint usage for Resident 29.	F 0657	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Per the hospital history and	03/03/2023

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	Findings include: 1. Resident 37 was admitted to the facility with diagnoses included, but not limited to: toxic encephalopathy, acute and chronic respiratory failure with hypoxia, pneumonia, chronic gout, chronic obstructive pulmonary disease, epilepsy, generalized anxiety disorder, history of malignant neoplasm of the prostate, hypertension, urine retention, chronic peripheral venous insufficiency, history traumatic brain injury and major depressive disorder recurrent. The initial Minimum Data Set (MDS) assessment, completed on 11/8/2022 indicated the resident required supervision for eating needs and had a weight of 181 pounds. . The most recent MDS assessment, competed on 11/30/2022 , indicated the resident required supervision for eating needs and had a weight of 173 pounds. Review of the weight records for Resident 37 indicated he had weighed 181 pounds upon admission November 4, 2022. The resident's weight, December 4, 2022 was noted to be 167.6 pounds. The resident's 30 day weight loss was 9.25 %. The current health care plan related to Resident 37's nutritional needs indicated the following: "(Resident's name) does not have any nutrition/meal intake concerns." The plan also indicated it was unclear what the resident's base weight range was "160's, 170's or 180's" The goal was for the resident to experience "weight maintenance" The interventions included: "Monitor weights as ordered. ,Regular diet. Monitor intakes. Record consumption.* dislikes		physical, Resident 37 had a comment in his chart related to fluid overload on 11/3/22. Lasix was ordered and continued at the facility. It is believed the weight fluctuations are due to the fluid overload. There was no need for the care plan revision since he had an edema care plan in place and current. An order was added to the medical record for Resident 29 for a seatbelt to be used when up in wheelchair. The care plan and C.N.A. assignment sheet was verified. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken?** All residents could be impacted by the deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Order recaps to be pulled multiple times per week to verify the care plan is up to date as well as areas the corresponding care areas on the C.N.A. assignment sheet. Staff who assist with updating the care plan will be re-educated. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.; what quality**	

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	pork, soup, spaghetti, peas." The most recent nutritional assessment, completed for Resident 37 on 11/30/2022 indicated the resident's weight was 170 pounds. The weight at 30 days was documented as "Unknown." The Usual Body Weight (UBW) was marked as "Large weight discrepancies 160's to 180's." The resident's BMI was marked as 25.0 and Weight status was marked "No significant weight change." The estimated caloric needs, protein needs and fluids needs were assessed. The resident's diet was indicated to be Regular. The only nutritional intervention indicated on the assessment was "Weekly weights." The assessment did not mention the resident's recent hospitalization. During an interview, with the Director of Nursing, conducted on 1/19/2023 at 9:50 A.M., she indicated the dietician only made quarterly notes for residents. When asked if there were any notes regarding the significant weight loss for Resident 37, she provided a nursing progress notes, titled " Weight Warming" which indicated the resident had a 7.4% weight change in the past 30 days. At the bottom of the form, the dietician had written the following: "Reweights being done but correct base weight is still unknown. Per NP, no edema gains or losses have occurred. Meal intakes are mostly 75%. Will use 172.6 pounds on the MDS since the 170's was (Resident's name) discharge weight in hospital." The care plan regarding nutritional needs was not updated or revised in regards to the significant weight loss incurred by Resident 37. Review of the facility policy and procedure, titled, "Weight Monitoring" provided by the Director of		**assurance program will be put into place** The Director of Nursing/designee will audit the orders, care plan, and C.N.A. assignment to assure on a weekly x 4 consecutive weeks and monthly thereafter for 5 months. Audits will be reviewed at the monthly QAPI meeting.	

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	155153	A. BUILDING 00 B. WING	01/19/2023

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	Nursing on 1/19/2023 at 10:50 A.M. indicluded the following: "...Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) made indicate a nutritional problem...1. The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: c. Developing and consistently implementing pertinent approaches. d. Monitoring the effectiveness of interventions and revising them as necessary...3. Interventions will be identified, implemented, monitored and modified (as appropriate) consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status....." 3.1-35(c)(2)(B) 2. The clinical record review for Resident 29 was reviewed on 1/13/2023 at 10:47 A.M. The diagnoses included, but not limited to: anoxic brain damage, autonomic dysreflexia, epilepsy and aphasia. A Quarterly Minimum Data Set (MDS), dated 11/21/2022 indicated she is total dependent for all activities of daily living. During an observation, on 1/10/2023 at 10:40 A.M., Resident 29 was reclined back in a wheelchair with a seat belt fastened across her lap. She had contractures to bilateral wrists; ankles and her neck was turned to the left side. She did not have on any hand/arm splints or leg braces. During an observation, on 1/11/2023 at 10:20 A.M., she was reclined back in her wheelchair			

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	with a seat belt fastened across her lap. She made very little movement and was looking at the TV. She did not have on any hand/arm splints or leg braces. A Care Plan, dated 9/27/2022, and indicated [Resident name] has contractures to all four extremities, autonomic dysreflexia. Bilateral wrist splints for contractures as scheduled. During an interview, on 1/13/2023 at 12:28 P.M., the Director of Nursing indicated she no longer has an order for hand splints and the care plan should have been discontinued. On 1/17/2023 at 1:04 P.M., the Administrator provided a policy titled, "Healthwin-Comprehensive Care Plans, revise 10/22, and indicated the policy was the one currently used by the facility. The policy indicated "...9. Care plan revisions occur on a routine basis. Examples of adjustments to the care plan include but not limited to order changes, incidents, and behaviors...." 3.1-35(d)(2)(B)			
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, interview and record	F 0684	**What corrective action(s) will**	03/03/2023

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	review, the facility failed to ensure orders were in place for an arm sling, use of a seat belt, and PRN (as needed) diuretic for 3 out of 23 charts reviewed physician orders. (Resident 29, 72, & 78) Findings include: 1. The clinical record review for Resident 29 was reviewed on 1/13/2023 at 10:47 A.M. The diagnoses included, but not limited to: anoxic brain damage, autonomic dysreflexia, epilepsy and aphasia. A Quarterly Minimum Data Set (MDS), dated 11/21/2022 indicated she is total dependent for all activities of daily living. During an observation, on 1/10/2023 at 10:40 A.M., Resident 29 was reclined back in a wheelchair with a seat belt fastened across her lap. She had contractures to bilateral wrists; ankles and her neck was turned to the left side. During an observation, on 1/11/2023 at 10:20 A.M., she was reclined back in her wheelchair with a seat belt fastened across her lap. She made very little movement and was looking at the TV. During an interview, on 1/13/2023 at 12:06 P.M., the Director of Nursing (DON) indicated this a restraint free facility. That resident 29 cannot release the seat belt and does not see an order for the seat belt and there should have been one. During an interview, on 1/17/2023 at 10:06 A.M., Therapy Director indicated there was no documentation addressing a recommendation for the use of the seat belt. 2. The clinical record review for Resident 72 was		**be accomplished for those residents found to have been affected by the deficient practice:** Resident 29 order for the seatbelt was immediately corrected. Occupational therapy determined there was a skilled need to address further seating and positioning needs. Physical therapy determined there was a skilled need to address tone reduction. Resident 72 the order was also updated for the nursing staff to be able to sign off in the TAR. Resident 78's orders were immediately corrected. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken:** All residents have the potential to be impacted by the deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** The facility will implement an interdisciplinary meeting to review the orders, care plan, C.N.A. assignment sheet as well as the MDS information to determine if any additional changes need to be made for all long-term care residents on a quarterly basis.	

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	reviewed on 1/12/2023 at 1:18 P.M. Diagnoses included, but not limited to: atrial fibrillation, and heart failure. A Physician Order Sheet, dated 9/30/2021, indicated "Pt. may wear sling to left arm for comfort as needed. No directions specified for order. " Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) there was no documentation or order appearing that the resident wore the brace that gave her a bruise to the left arm. During an interview on 1/1220/23 at 10:26 A.M., the Director of Nursing (DON) indicated the order does not appear for the nurses to sign off because a schedule was not selected when the order was entered, and it should have been. 3. The clinical record for Resident 78 was reviewed on 1/12/2023 at 4:29 P.M. The diagnoses included, but not limited to: chronic systolic and diastolic congestive heart failure, pleural effusion, and edema. A Physician Order, dated 10/11/2022, indicated "...DAILY WEIGHTS- See PRN Edecrin for weight gain of 2# [pound] or greater in 24 h [hour] in the morning for CHF[congestive heart failure]...." A Physician Order, dated 12/5/2022, indicated "...Furosemide Tablet 20 milligrams (MG), give 1 tablet by mouth every 24 hours as needed for weight gain...." A Care Plan, dated 10/11/2022, indicated interventions of: Daily weights in the morning. Notify Physician of a 2# weight gain in 24 hours.		The interdisciplinary team will be educated on the process. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.; what quality assurance program will be put into place** Meeting minutes will be turned into the Director of Nursing/designee weekly x 4 consecutive weeks and monthly thereafter for 5 months. The results will be shared at the monthly QAPI meetings.	

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	And give cardiac medication as ordered. During an interview, on 1/17/2023 at 4:24 P.M., the Director of Nursing (DON) indicated the order was incorrect the PRN edecrin was discontinued on 11/11/2022 and the daily weight order was not changed to Lasix and it should have been. On 1/12/2023 at 1:31 P.M., the Administrator provided a policy titled, "Healthwin-Physician Ordered Services", dated 11/2017, and indicated the policy was the one currently used by the facility. The policy indicated "...Policy: The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality. "Professional Standards of Quality" means that care and services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting...."			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interveiw and record reveiws the facility failed to provide adequate supervision, and monitoring of hot liquids to	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	03/03/2023

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	prevent an at risk resident from sustaining a 2nd degree burn. (Resident 40) Finding includes: During an observation with wound care on 1/10/23 at 9:56 A.M., they were addressing the coffee burn to Resident 40's hip and thigh area. During an interview conducted at that time with LPN 22 and NP (Nurse Practitioner) 23 the wound team indicated the burn area measured 28.6 cm (centimenter) x 12.7 cm x 0.1cm During an interview, with Resident 40 on 1/12/2023 at 9:55 A.M., she indicated she was in her room in her bed with the head elevated she indicated she had eaten breakfast already but did not want any coffee or hot chocolate just juice and water. A clinical record review for Resident 40 was conducted on 1/17/2023 at 8:34 A.M. Diagnoses included, but not limited to: paraplegia, unspecified injury at T2-T6 level of thoracis spinal cord, sequela unspecified, ataxia unspecified, not intractable without status epilepticus, type 2 diabetes mellitus without complications. On 12/29/2022 at 11:41 A.M., a note indicated the following: Right thigh was identified as an Intact serum filled blister. Area measured 23.0 cm, length= 9.7 cm, width=5.6 cm notes= Fluid filled blister to right trochanter/hip. Peri wound blanchable, normal color. Resident 40 reported it did not hurt as much as it did initially. Education was encouraged to eat a well balanced protein rich diet to optimize would healing. Educated staff about ensuring lids are on cups and residents have the correct adaptive equipment.		**practice:** Resident 40 was reassessed to ensure the appropriate adaptive equipment is in place for hot liquids. The coffee machine on the unit where Resident 40 resides is temped on a daily basis. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken:** All resident who drinks coffee in the facility are at risk for accidents. Coffee machines are not to exceed 140 degrees based on the guidelines set forth in the policy. All coffee machines are temped on a daily basis. Per the hot liquid policy, all residents are assessed on admission, quarterly, and change of condition to determine highest functional level. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** Staff re-education of the hot liquid policy. Re-education of the binders are placed in the solariums with the master list of adaptive equipment and temperature logs for the coffee machines will be in the dietary binders. **How the corrective action(s)**	

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	On 12/29/2022 at 11:41A.M. a note indicated Resident 40 had spilled a hot drink in her bed. Cold water was documented as having been applied to the area. Resident 40 denied any pain or discomfort at that time. On 12/29/2022 4:22 P.M., a progress note concerning a hot drink indicated treatment was to cleanse the left posterior thigh with soap and water. Pat it dry and apply A&D ointment every shift and as needed. On 12/29/2022 at 8:55 P.M., a progress note indicated the Resident 40 was alert and oriented x 3 and had a fluid filled blister to her Right side and hip. She denied any pain or discomfort upon care. On 12/30/2022 at 6:34 A.M., a progress note indicated fluid filled blister's were present to Resident 40's right side and hip. Resident 40 denied pain and discomfort during the shift. On 12/30/2022 at 11:50 A.M., Resident 40 was evaluated by NP 24. A SOAP NOTE indicated, "...Subjective: pt is seen for burn lesion Objective: Pt is seen for possible burn lesions. Resident has spilled a hot drink in her bed. it appears right hip bulla 2nd degree burn which covers 2 hands approximately 2 % surface area burns. no s/sx of pain or infection vs:130/70, 98.8, 99, 18, 99% Assessment: pt is a paraplegic, DM, seizures, migraines . denies any pain or discomfort. States her mood is ok, denies depression, any fever, chills, lower abdominal pain, discomfort. Mother updated. pt has 2nd degree burns.Plan: start wound care apply silvadene daily and clean with normal saline cover with telfa drgs start keflex 500mg tid x 7 days...." On 12/30/2022 at 1:34 P.M., a Note Text indicated		**will be monitored to ensure the deficient practice will not recur, i.e.; what quality assurance program will be put into place** Audits of the appropriate adaptive equipment will be conducted by the Director of Nursing or designee weekly x 4 weeks then monthly x5 to ensure physician orders, care plan, C.N.A. assignment sheet, are up to date. Visual observations will be completed by Director of Nursing or designee weekly x 4 weeks then x 5 months to ensure staff is following the proper procedures. Audit results will be shared at the monthly QAPI meeting to determine effectiveness.	

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	new orders from NP to cleanse burn wound with NS (normal saline) BID (twice a day) and pat dry then apply Silvadine cream and cover with dry clean dressing. On 12/30/2022 at 5:06 P.M., a nurses note indicated Resident 40 had been up in her chair most of the shift. She denied any discomfort to her right hip area. 1/10/2023 11:01 A.M., a note text indicated NP 23 saw Resident 40 to re-assess wound to right hip and left thigh rear. A care plan, with a revision date of 12/20/2021, indicated Resident 40 was at risk for injury (burns) due to inability to safely handle hot liquids. The goal, with a revision date of 6/14/22, was that she would be able to handle hot liquids without risk of injury through the review date. A second goal with a revision date of 6/14/2022 indicated she would have minimal injuries from exposure to hot liquids/overheated tap water through the review date. Interventions were insulated mug with lid-supervision with all hot liquids. Assess ability to handle cups of hot liquids. On 1/17/2023 at 10:30 A.M., Dietary Supervisor 8 was interviewed. She indicated the staff take the tempertures of hot liquids for every meal prior to staff serving the drinks to residents,from the coffee machines. She indicated the temperatures should not be above 130 degrees she indicated she would make copies of the temperatures starting with October/2022 thru January/2023 and give them to the DON. During an environmental round conducted on 1/18/2023 at 1:58 P.M. with Maintenance Supervisor 21 and CFO 20 they both indicated the			

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	facility does not maintain the coffee machines or monitor the temperature of the coffee machines. The machines are provided by [a local distributing company] and that the dietary department is responsible for those machines. On 1/18/2023 at 2:45 P.M., the DON provided copies of the coffee temperture logs. The records omitted dinner shifts, there were omissions and incomplete documation identifying which unit was temped for breakfast, lunch or dinner. The month of December began with 12/17/2022. Several types of forms were used for dietary staff to log their information. On 1/19/2023 at 10:15 A.M. the DON provided a copy of a contract from (local company) HPS System Advantage Contract 51 (local company)/HPS System Advantage to provide the following: The agreement/tabletop contract indicated they would maintain temperture maintenence (coffee machines). It was dated February 19th, 2019. The Dietary Supervisor unable to provide documention of last visit. On 1/19/2023 at 11:03 A.M., the DON provided the policy titled " [Facility]-Hot Liquid Safety" with unknown effective or revision date, and indicated the policy is the one currently used by the facility. The policy indicated "...Policy Explanation and compliance Guidelines...2 The tempertures of hot liquids willl be checked in the dietary department prior to distribution to the nursing units. If the temperature is greater than 140 degrees fahrenheit, hold the liquid in the dietary department until it reaches an appropriate temperature....3. All resident are assess for their ability to handle containers and consume hot liquids. Residents will be assessed on admission, quarterly,			

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	annually, and change of condition. Residents with diffculities wiil receive appropriate supervision and use assistive devices in order to consume hot liquids. Interventions will be individualized and noted on the resident's plan of care.			
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 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 2 of 3 residents reviewed for nutritional needs had interventions initiated and implemented to prevent weight loss. (Resident 23 and 37) Findings include: 1. Resident 23 was admitted to the facility with	F 0692	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The Director of Nursing/designee and Registered Dietitian reassessed the nutritional status of Resident 23 and Resident 37.	03/03/2023

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	diagnoses included, but not limited to: Alzheimer's disease, behavioral psychotic mood disturbance and anxiety, hyperlipidemia, severe protein calorie malnutrition, anxiety disorder, arteriosclerotic heart disease, hypothyroidism, major depressive disorder, hypertension, dysphagia, paroxysmal atrial fibrillation, cerebrospinal fluid drainage device, history of cardiac and vascular implant and graft, history of COVID. The most recent quarterly MDS assessments, completed on 12/14/2022, indicated the resident was rarely understood and required extensive staff assistance of one for eating needs. The resident's weight record indicated she weighed 104 pounds on 8/1/2022 and weighed 96 pounds on 1/3/2023 which was a 9.3% body weight loss. The most recent Nutritional Assessment for Resident 23, completed on 12/14/2022 by the dietician, indicated the resident BMI (Body Mass Index) was 16% and the resident had incurred an 8% weight loss in the past 180 days. The section to indicated the Caloric Needs required had "Comfort measures only" typed. The Diet order for Regular diet with think liquids. Cut up food. was indicated. Under the section to acknowledge pertinent diagnosis affecting nutrition, Dementia and Severe Pro (Protein) Cal (Caloric) Malnutrition was indicated. Under the Physical and mental functioning section - lipped plates, sippy cup and sauce/gravy as tolerated was indicated. Under the nutritional interventions the following was indicated: "Monthly wts (weights) Ensure Plus 1 bottle (van/strawberry) 1300 and 1800. Boost Breeze 1000. Double Desserts L/S ng offer pudding, yogurt, applesauce q shift per POA		Revisions were made to the care plans and revised interventions were reviewed with staff involved in the care of each resident. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken?** The facility has determined that all residents have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** An in-service education program was conducted by the Director of Nursing/designee regarding monitoring assisted dining for proper intake of fluids and food. The Registered Dietitian was educated on consulting the physician as to the root cause of weight fluctuations. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.; what quality assurance program will be put into place?** The Director of Nursing/designee will monitor the weight report to ensure appropriate measurements are recorded and complete as well as monitor weight fluctuations. The Director of Nursing/designee will complete weekly chart audits for 4 consecutive weeks and	

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HEALTHWIN	20531 DARDEN RD SOUTH BEND, IN 46637

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	request." The current care plan regarding eating/nutritional needs included the following interventions: "Boost Breeze, Ensure Plus one bottle at 1 pm and 6 pm, (resident's name) loves ice cream..., monitor weights as ordered...regular diet with thin liquids...loves sweets. Double Desserts L/S. Likes applesauce. Likes coffee with creamer and hot tea. Serve at all meals. Likes oatmeal for bfast. Straws OK, inner lipped plate. Sippy cup with lid. Cut up all food..." On 1/11/23 at 9:26 A.M., Resident 23 was observed in the dining room on her nursing unit, seated in her wheelchair at a c-shaped table. An opened bottle of a nourishment shake with a straw in it was noted on the table close to the resident. At 9:29 A.M., the dietary staff cook placed a bowl of oatmeal to Resident 23 and a yellow divided plate of food. A nursing staff member opened up the resident's silverware and cut up her ham and walked away to pass other breakfast plates. At 9:32 A.M., Resident 23 was cued by a nursing staff member to eat. Resident 23 then reached with her fingers and picked up a piece of ham and ate it. She continued to reach for her breakfast food with her fingers. The resident continued to occasionally attempt to pick up some food with her fingers but received no cues and/or assistance to eat. At 9:44 A.M., Resident 23 was noted to manipulate the straw in the bottle of nourishment shake that was on the table near her. She did not drink the shake, just moved the straw around in the drink. On 1/12/23 at 9:17 A.M. ., Resident 23 was observed seated in her wheelchair in the dining room on her nursing unit asleep. The resident had a clothing protector over her clothes. There were		monthly thereafter for the next 5 months. The audit results will be shared at the monthly QAPI meeting to determine effectiveness. IDR: Resident 23 was provided assistance with meals from the staff. Requires cueing and physical assistance during meals. Resident 23 is comfort measures only with a recent discharge from hospice within the last 6 months. Resident 23 is provided supplements regularly related to the diagnosis of severe protein calorie malnutrition. Resident 37 was readmitted to the hospital 11/17/22 and was found to be in fluid overload and required increased diuretics per the discharge summary from the hospital. Weight loss was not due to nutrition, but edema. A baseline weight was trying to be established post admission due to recent edema and diuresis.	

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	no staff noted in the room and the resident did not have any food or beverages in front of her. The resident was observed at 9:33 A.M. and she had a plastic up of orange juice with no straw in front of her along with silverware, wrapped in a napkin and was still sleeping. The dietary cook was in the dining room with a portable steam table of food. At 9:35 A.M., the dietary cook placed a bowl of oatmeal in front of the resident but did not wake her up. A nursing staff member placed a packet of brown sugar near the resident but did not wake her up. At 9:36 A.M., a nursing staff member put brown sugar in Resident 23's oatmeal and did call the resident's name. At 9:37 A.M., a rimmed plate of food was placed in front of Resident 23. At 9:38 A.M., a nursing staff member cut up Resident 23's pancake, attempted to wake up Resident 23 again, and repositioned her wheelchair closer to the table. The staff member did not assist Resident 23 to eat. At 9:39 A.M., Resident 23 did wake up and used her fort to feed herself a few bites of food then placed the fork into the open glass of orange juice. After stirring the fork around in the orange juice, the resident then removed the fork and then continued to feed herself. She also was observed to pick up the cup and drink some of the juice. Resident 23 was observed on 1/13/23 at 9:27 A.M., seated in her wheelchair in the dining room on her nursing unit. The resident had been served a plastic up of orange juice. The resident was noted to be stirring her orange juice with a spoon. A nursing staff member placed a plastic straw into the resident's glass of orange juice and walked away. Resident 23 then was noted to dip the straw into the orange juice and lick the drips of juice from the bottom of the straw. Staff were not seated to cue or assist the resident with her meal.			

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	On 1/17/23 at 12:41 P.M., Resident 23 was observed in the dining room on her nursing unit, in her wheelchair positioned at a c-shaped table The resident had been served her meal tray and a plastic up of jello but her meat had not been cut up and she did not have any liquids to drink. Resident 23 was observed form 12:41 P.M. - 12:49 P.M. and she was not being assist and/or cued to eat. At 12:49 P.M., Resident 23 was attempting to eat her fruited jello with her butter knife. At 12:52 P.M., a nursing staff member was noted seated next to Resident 23 but the staff member was feeding another resident. The staff member was positioned with her back to Resident 23. The nursing staff member did turn once, reach over and place a spoon in Resident 23's jello for her. The resident then fed herself a few bits of cooked vegetables and noodles with her spoon. After spilling most of the noodles she attempted to feed herself with her spoon, Resident 23 became distracted and was noted to be folding her napkin and a clothing protector that was on the table in front of her. After a few minutes of folding these items Resident 23 then picked up her plate of food and moved it to the right of the clothing protector. She then attempted to reach over the folded clothing protector to obtain another bite of her food. At 12:52 P.M., Resident 23 was observed to attempt to feed herself jello with the plastic lid that had initially covered the bowl of jello. There were no nursing staff cueing and/or assisting Resident 23 with her meal, she had still not been served any beverages and she was only served one bowl of fruited jello. At 12:55 P.M., Resident 23 was noted to obtain a few noodles on a spoon but dropped them onto the folded clothing protector. She then spent a few minutes picking up noodles off of the clothing protect and eating them with her fingers. At 1:00 PM., Resident 23 was observed attempting to eat a "bite" from her clothing protector. At 1:04			

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	P.M., Resident 23 was observed struggling to obtain noodles from the food she had dropped onto the clothing protector which was folded on the table. At 1:10 P.M., CNA 19 was queried regarding specific nutritional interventions for Resident 23. CNA 19 indicated the resident was supposed to have a lipped plate and her food cut up for her. When specifically asked about beverages, CNA 19 indicated the resident was supposed to have a lidded up. CNA 19 then realized Resident 23 had not been served any beverages with her meal and obtained a glass of orange juice in a lidded cup for her. When asked if there were any other interventions, CNA 19 indicated she was not sure. The paper dietary card was retrieved from the table beside Resident 23. The card indicated, in addition to the interventions verbalized by CNA 19, the resident was to have double desserts, liked coffee and hot tea and applesauce. CNA 19 confirmed the resident did like "sweets" and would often eat those food items first when served her meals. 2. Resident 37 was admitted to the facility with diagnosis included, but not limited to: toxic encephalopathy, acute and chronic respiratory failure with hypoxia, pneumonia, chronic gout, chronic obstructive pulmonary disease, epilepsy, generalized anxiety disorder, history of malignant neoplasm of the prostate, hypertension, urine retention, chronic peripheral venous insufficiency, history traumatic brain injury and major depressive disorder recurrent. The initial Minimum Data Set (MDS) assessment, completed on 11/8/2022, indicated the resident required supervision for eating needs and had a weight of 181 pounds. .			

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The most recent MDS assessment, competed on 11/30/2022 , indicated the resident required supervision for eating needs and had a weight of 173 pounds.

Review of the weight records for Resident 37 indicated he had weighed 181 pounds upon admission November 4, 2022. The resident's weight, December 4, 2022 was noted to be 167.6 pounds. The resident's 30 day weight loss was 9.25 %.

Resident 37 did incur a ground level fall and was also diagnosed with metabolic encephalopathy and pneumonia and was admitted to an acute care facility on 11/17 and readmitted to the facility on 11/23/2022.

The current health care plan related to Resident 37's nutritional needs indicated the following: "(Resident's name) does not have any nutrition/meal intake concerns." The plan also indicated it was unclear what the resident's base weight range was "160's, 170's or 180's" The goal was for the resident to experience "weight maintenance" The interventions included: "Monitor weights as ordered. ,Regular diet. Monitor intakes. Record consumption.* dislikes pork, soup, spaghetti, peas."

The most recent nutritional assessment, completed for Resident 37 on 11/30/2022 indicated the resident's weight was 170 pounds. The weight at 30 days was documented as "Unknown." The Usual Body Weight (UBW) was marked as "Large weight discrepancies 160's to 180's." The resident's BMI was marked as 25.0 and Weight status was marked "No significant weight change." The estimated caloric needs, protein

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	needs and fluids needs were assessed. The resident's diet was indicated to be Regular. The only nutritional intervention indicated on the assessment was "Weekly weights." The assessment did not mention the resident's recent hospitalization. During an interview with the Director of Nursing, conducted on 1/19/2023 at 9:50 A.M. she indicated the dietician only made quarterly notes for residents. When asked if there were any notes regarding the significant weight loss for Resident 37, she provided a nursing progress notes, titled " Weight Warming" which indicated the resident had a 7.4% weight change in the past 30 days. At the bottom of the form, the dietician had written the following: "Reweights being done but correct base weight is still unknown. Per NP, no edema gains or losses have occurred. Meal intakes are mostly 75%. Will use 172.6 pounds on the MDS since the 170's was (Resident's name) discharge weight in hospital." Review of the facility policy and procedure, titled, "Weight Monitoring" provided by the Director of Nursing on 1/19/2023 at 10:50 A.M. indicluded the following: "...Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) made indicate a nutritional problem...1. The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes: c. Developing and consistently implementing pertinent approaches. d. Monitoring the effectiveness of interventions and revising them as necessary...3. Interventions will be identified, implemented, monitored and modified (as appropriate) consistent with the resident's assessed needs, choices, preferences,			

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	goals and current professional standards to maintain acceptable parameters of nutritional status....." 3.1-46			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to monitor pain level of a resident taking an as needed narcotic for 1 of 4 residents reviewed for pain management. (Resident 78) Finding includes: The clinical record for Resident 78 was reviewed on 1/12/2023 at 4:29 P.M. The diagnoses included, but not limited to, chronic systolic and diastolic congestive heart failure, pleural effusion, and edema. A Physician Order, dated 1/4/2023, indicated Percocet tablet 5-325 milligrams (mg) give 2 tablets by mouth every 6 hours as needed for moderate pain doc alt: 1. back rub 2. activity,3. reposition r. rest 5. lights out. A Physician Order, dated 1/4/2023, indicated Percocet tablet 5-325 mg give 1 tablet by mouth every 6 hours as needed for mild pain doc alt: 1. back rub 2. activity 3. reposition 4. rest 5. lights off.	F 0697	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 78's electronic medical record was updated to include pain level that was missing. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken:** All residents with pain medication have the potential to impacted by the deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** All licensed nurses have been inserviced on the facility's Pain	03/03/2023

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	During an interview, on 1/17/2023 at 3:24 P.M., the Director of Nursing (DON) indicated residents are assessed for pain level in the vital sign order and when given a PRN or a routine pain medication. The Percocet did not have the pain level monitor in the order and it should have been. On 1/17/2023 at 3:30 P.M., the DON provided a policy titled, "Healthwin-Pain Management", revised 10/22, and indicated the policy was the one currently used by the facility. The policy indicated "...2. c. Asking the patient to rate the intensity of his/her pain using a numerical scale , a verbal or visual descriptor that is appropriate and preferred by the resident. Monitoring, Reassessment and Care Plan Revision a. Facility staff will reassess resident's pain management at established intervals for effectiveness and/or adverse consequences...."		Management policy and procedure specifically using the PRN pain med template when entering PRN pain medication orders. The template includes pain level, site, and alternatives attempted. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.; what quality assurance program will be put into place** The Director of Nursing/designee will audit the PRN pain medications to assure that the components are present in the documentation. Audits will be completed for 4 consecutive weeks and monthly thereafter for 5 months. Audit results will be shared with at the monthly QAPI meetings.	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review and interviews, the facility failed to ensure 1 of 1 residents reviewed for dialysis services had communication between the facility and the dialysis center and had documentation the dialysis access site was visually observed for complications after treatments. (Resident 26)	F 0698	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** The communication book for Resident 26 has been reinstated	03/03/2023

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	Finding includes: The clinical record for Resident 26 was reviewed on 1/10/2023 at 2:50 P.M. Resident 26 was admitted to the facility with diagnosis, included but were not limited to: encephalopathy- acute 1/4/2023, Urinary tract infection 1/5/2023,, e coli, end stage renal, dm. chronic obstructive pulmonary disease, congestive heart failure-diastolic chronic, dementia, sleep apnea, hypothyroidism, history of COVID 19, Major Depressive Disorder, hypertension, hyperlipidemia, history of malignant neoplasm of the breast, gastroesophageal reflux disease and Anemia. The most recent Minimum Data Set (MDS) assessment, conducted as a quarterly assessment on 11/02/2022 indicated Resident 26 received dialysis treatments. The physician's orders for Resident 26 included orders for the resident to go to a dialysis center three days a week for treatments and for the facility to check the "thrill and Britt in the mornings. There were no specific physician orders to check the resident's dressing and dialysis access site when she returned from her dialysis treatments. Review of the Medication and Treatment records for Resident 26 indicated there was documentation of the resident's dialysis treatments, medications and documentation of the daily check for the thrill and bruit of the resident's fistula, but there was no documentation regarding assessing the resident's dialysis access site and dressing after she returned from her treatments.		on the resident's unit. The Director of Nursing/designee reviewed the resident's care plan to reflect all orders and interventions related to dialysis. All staff responsible for the resident were informed of the changes to the resident's care plan. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken:** The facility has determined that all resident who receive dialysis have the potential to be affected. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** An in-service education program was conducted by the Director of Nursing/designee will all nursing staff regarding the use of the communication binder between the facility and dialysis center. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.; what quality assurance program will be put into place** The Director of Nursing/designee will audit/review the batch orders and communication binder for	

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	Resident 26 was not observed in her room on 1/9/2023 during the morning and early afternoon. During an interview with LPN 25, conducted on 1/9/2023 he indicated the resident was at her dialysis treatment. Resident 26 was observed on 1/10/23 at 11:38 A.M. seated on the side of the bed in her room. The resident was noted to have a dressing on her upper left arm. During an interview, conducted on 1/17/23 at 11:46 A.M. . with LPN 25 and 26, they indicated they were currently not utilizing a dialysis"binder" for Resident 26. They indicated the dialysis center "kept" the binder. They indicated it had not been in use for "a few months.' During an interview with the Medical Records Manager, Employee 26, conducted on 1/18/2023 at 3:14 P.M. she indicated she sets up dialysis binders for any resident receiving dialysis. She indicated the staff were to fill out the report prior to sending the resident to the dialysis center and the dialysis center was to document specific information about the resident's condition and/or treatment when they sent the resident back. She indicated she did not know why the nurses were no utilizing the dialysis binder for Resident 26. Employee 26 indicated the facility requested the actual treatment records from the dialysis center be faxed to the facility. These records, requested approximately every other week, were then scanned into the resident's electronic record. Employee 26 indicated these records were not coming back in the binders so the facility just had the dialysis center fax the requested documentation. The current care plan for Resident 26, current		each resident receiving dialysis weekly for 4 weeks then monthly thereafter for 5 months. Audit results will be shared as part of the monthly QAPI meetings.	

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	through 4/6/2023, related to her diagnoses of End Stage Renal Disease (ESRD) and need for dialysis included but were not limited to the following interventions: "Assess and record every shift; type of access device, location of access, condition of dressing, date of last dialysis treatment, any post dialysis s/sx resident is exhibiting and any treatment given to alleviate symptoms....send communication book to dialysis with (resident's name) for each visit...." Review of the facility policy and procedure, titled "(facility name) Care Planning Special Needs - Dialysis policy), provided by the Director of Nursing on 1/18/2023 at 9:45 A.M., included the following: "...2. The care plan will reflect the coordination between the facility and the dialysis provider and will identify nursing home and dialysis responsibilities. 3. Interventions will include, but not limited to: ...b. Pre and post weights c. Assessing, observing, and documenting care of access sites, as applicable...g. Provision of medications on dialysis treatment days, such as which medications are: i. Administered during dialysis ii. Held prior to dialysis iii. Given prior to dialysis iv. Administered by dialysis staff...4. Nursing staff will provide a report to the dialysis provider regarding the resident's condition and treatment provisions each dialysis treatment day, and as needed. 5. The Dialysis Communication book for communication between nursing and center includes: face sheet, order summary, labs, transfer/discharge paperwork, blank telephone orders if needed, and progress notes forms for written communication on the dialysis session. 6. If no written report is received upon return from dialysis, nursing staff will call the dialysis provider to receive a report...."			

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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 a current indication for use was present for an antibiotic for 1 of 5 residents reviewed for unnecessary medications (Resident 151). Findings include: The clincal record for Resident 151 was reviewed on 1/11/2022 at 9:00 A.M. Resident 151 was originally admitted to the facility on 12/16/2022 and discharged to the hospital on 1/2/2023. He was readmitted to the facility on 1/6/2023. The resident's diagnosis, include but are not limited to:	F 0757	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 151's medical record could not be updated for the medication indication due to the resident expiring. Resident 72's antianxiety side effect monitoring order was added to the resident's orders. **How other residents having the potential to be affected by the**	03/03/2023

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	fracture of the lower end of the left humerus, parkinson's disease, heart failure, atroventricular block, chornic atrial fibrillation, obstructive sleep apnea, anemia, anxiety disorder, depression, hyperlipidemia, and s/p cardiac pacemaker, hypertension, edema and benign prostatic hypertrophy. The current physician's orders for medications included the antibiotic, Vibramycin 100 mg one capsule twice a day for infection. There was no specific documentation of any infection in the nursing progress notes and there was no care plan regarding infections for Resident 151. During an interview with MDS coordinator, RN 14, on 1/18/2023 at 3:00 P.M., she indicated the resident did not have an "infection." She indicated on most recent hospital transfer orders, the medication was ordered but no reason or diagnosis was indicated for the medicaiton. She indicated she thought the nurse transcribing the order added "infection." RN 14 indicated the resident had incurred a shoulder surgery just prior to his first admission and the antibiotics were ordered to prevent infection of the surgical site and the antibiotic use was listed as an intervention in the care plan referring to the shoulder surgery and surgical incision. She indicated there was no stop date for the antibiotic and the reason for the order had not been clarified when the resident was readmtited on 1/6/2023. 3.1--48(a)(3)(4)		**same deficient practice will be identified and what correction action(s) will be taken?** The facility has determined all residents receiving the prescribed drug have the potential to be affected. A review of all medication orders and indications for use was reviewed by February 25, 2023. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** All licensed nurses will be in serviced on unnecessary drugs with emphasis on the proper diagnosis for each medication as well as side effects to be included in the orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.; what quality assurance program will be put into place?** The Director of Nursing/designee will complete audits for 4 weeks then monthly thereafter for 5 months. The audit results will be shared at the monthly QAPI meetings to determine the effectiveness of the re-education. IDR: Resident 151 was place on Doxycycline by IU Health in 2016. He had a history of a periprosthetic infection growing enterococcus per the notes from	

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	155153	A. BUILDING 00 B. WING	01/19/2023

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			IU Health. The shoulder was removed and an antibiotic cement spacer was placed. Subsequently had reconstruction with a left reverse shoulder arthroplasty. He fell in 2016 and ended up with a left shoulder periprosthetic fracture. When Resident 151 was admitted on 12/16/22, there was an order and indication in the medical record. Resident 151 went out to the hospital on 1/2/23 and then returned 1/6/23 and there was an indication for the medication entered as infection. The medication had been found to be prophylactic for several years based on the medical record information present in the chart. It is not considered unnecessary. Regarding Resident 72, the pharmacist is part of the interdisciplinary team that contributes in the care of each resident. The pharmacist completes monthly medication reviews to determine if the medication is at a therapeutic level and any adverse reactions. A notation is present the medical record when the chart has been reviewed. Additional comments are documented if there is a concern with next steps. This policy is part of InTouch Pharmacy. See attached policy and procedure.	

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F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review and interviews, the facility failed to ensure warm food was served at a palatable temperature for residents eating on the second floor dining room and in resident rooms. Finding includes: During interviews with alert and oriented residents, conducted on 1/9/2023 and 1/10/2023, 3 alert and oriented residents indicated the hot food items were served cold. During a Resident Council group meeting, conducted on 1/12/2023 at 1:44 P.M., six of 15 alert and oriented residents indicated the hot food was often served cold. The residents indicated this most often occurred when they were eating in their rooms. The residents indicated the facility had recently had a COVID 19 outbreak and had spent a few days being asked to eat in their rooms. The resident council minutes were reviewed and the council was noted to have not met for the last meeting due to the facility's COVID outbreak and there were no patterns of Resident Council concerns regarding cold food.	F 0804	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** An audit of food temperatures was found not be consistently completed throughout the facility. The Dietary Manager purchased additional thermometers for dietary to have available as well as placed on the units. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken:** All residents who eat an oral diet have the potential to be affected by the deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient**	03/03/2023

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	During the meal service for breakfast, observed on the West 2 dining room, conducted on 1/11/2023 at 9:25 A.M., the dietary cook was noted to place plates of food, covered with clear plastic dome type covers onto an open three tiered cart. The cook had placed the first plate of food onto the open cart at 9:29 A.M. and had continued to place a total of 6 plates of food onto the open cart. The first plate of food was not served from the cart to a resident, until 9:42 A.M., thirteen minutes later. The plated, covered food was served to residents on the hall and in the solarium living area adjacent to the assisted dining room. During an observation of the noon meal service, conducted on 1/17/2023 at 12:24 P.M. indicated the cook pushed her portable steam table into the dining room at 12:27 P.M. The last meal tray was prepared at 12:43 P.M., Dietary Employee 28 was asked to assess the temperatures of the food. The noodles were 140.3 degrees, after the cook moved some of the food from the back of the pan up to the front, the baked chicken was 144.3 degrees Fahrenheit, again after she selected chicken pieces from the back of the steam table pan and the mixed vegetables were 120 degrees, even after she attempted to stir up the vegetables in the pan. The steam table was plugged in but the front of the steam table pans were noted to be much cooler to touch than the back of the steam table pans. Employee 28 indicated she had reported her steam table as "broken" several times. Employee 28 indicated the chicken had been 165 degrees prior to the meal service. Review of the facility policy and procedure, titled "(facility name) Record of Food Temperatures policy" provided by the Director of Nursing on 1/18/2023 at 9:45 A.M., indicated the following:		**practice does not recur** The Dietary Manager/designee provided an in-service and required return demonstration regarding the appropriate way to temp food. The policy on food temp was reviewed with the department. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.; what quality assurance program will be put into place** The Dietary Manager/designee will observe/audit staff across meals to ensure that appropriate technique for taking temperatures is completed correctly. The Dietary Manager/designee will complete observations/audit staff on taking temperatures is completed for 4 consecutive weeks and monthly thereafter for 5 months. Daily temperature logs will be reviewed by the Dietary Manager/designee and copies given to the Administrator for review for the next 4 weeks and monthly thereafter for next 5 months.	

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	"... 2. Hot foods will be held at 135 degrees Fahrenheit or greater. 3. Hot foods will be stirred during holding to redistribute heat throughout the food product...." During an interview with the Food Service Supervisor, on 1/19/2023 at 9:30 A.M., she indicated she had not been made aware of pattern of resident complaints regarding cold food and she was not aware of any steam table malfunctioning. She indicated if a resident complained of cold food their plate would be either reheated or a new plate served. 3.1-21(a)(2)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional			

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	standards for food service safety. Based on observation, interview and record review the facility failed to serve chicken at the appropriate temperature which had potential to affect approximately 20 - 30 people that are served from the the dining room, and resident's ice packs in the unit nourishment kitchen refrigerators that effect 28 that live on Bridgeview Lane and NorthWest 1. Findings include: 1. During an observation on 1/13/2023 at 11:30 A.M., food was being served from the kitchen off the main dining room employee 6 temped the food and the iso chicken was 120 degrees and the chicken tenders were at 99 degrees. Employee 6 indicated that the chicken was not at the correct temperature and would be taking it back to the kitchen to get up to temp. Review of the temperature log prior to meal service the entree iso chicken temped at 150 degrees and employee 7 indicated it was not at the correct temperature. 2. During an observation on 1/18/2023 at 11:00 A.M., the nourishment refrigerator on Bridgeview Lane had an ice pack in a cloth sleeve in the freezer compartment. During an interview at 1/18/2023 at 11:03 A.M., employee 12 indicated that she did not know who that belonged to and it should not have been in the nourishment freezer. 3. During an observation at 1/18/2023 at 11:05 A.M., at NorthWest 1's nourishment refrigerator Resident 152 had two ice packs labeled with her name on them in freezer compartment. During an interview at 1/18/2023 at 11:08 A.M.,	F 0812	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** As stated in F804 plan of correction, an audit of food temperatures was found not be consistently completed throughout the facility. The Dietary Manager purchased additional thermometers for dietary to have available as well as placed on the units. The food temperatures were not consistently completed in all locations throughout the facility. The freezers were emptied and cleaned immediately when the ice packs were discovered. **How other residents having the potential to be affected by the same deficient practice will be identified and what correction action(s) will be taken:** All residents who eat an oral diet and/or use ice packs have the potential to be affected by the deficient practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur** The Dietary Manager/designee provided an in-service and required return demonstration regarding the	03/03/2023

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	employee 27 indicated patients ice packs should not be in a freezer with food she believes it should be placed in a bag with the residents name on it. On 1/13/2023 at 12:10 P.M., the Dietary Manager provided a policy titled, "Healthwin-Food Safety Requirements", revised 10/22, and indicated the policy was the one currently used by the facility. The policy indicated "...4. d. Holding - staff shall monitor food temperatures while holding for delivery to ensure proper hot and cold holding temperatures are maintained. Staff shall refer to the current FDA Food Code and facility policy for food temperatures as needed. 5. Foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone. Strategies include, but not limited to: b. Using tray lines, mobile food carts or portable steam tables transported to dining areas. f. Timely distribution of all meals/snacks...." On 1/18/2023 at 12:11 P.M., the Director of Nursing provided a policy titled, "Healthwin - Residents Nourishment Refrigerators," revised 11/19, and indicated the policy was the one currently used by the facility. The policy indicated"...PURPOSE: To outline and maintain the facility's policy as it relates to maintaining and cleaning the Residents Nourishment Refrigerators on each nursing unit. Procedure: 3. All resident's items must be identified with name and date. 6. No medicine should ever be in the refrigerator...." 3.1-21(i)(3)		appropriate way to temp food. The policy on food temp was reviewed with the department. Nursing staff have been educated on placing ice packs in a zip lock bag with the resident's name and date and placing the zip lock bag in a plastic container within the freezer. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.; what quality assurance program will be put into place** The Dietary Manager/designee will observe/audit staff across meals to ensure that appropriate technique for taking temperatures is completed correctly. The Dietary Manager/designee will complete observations/audit staff on taking temperatures is completed for 4 consecutive weeks and monthly thereafter for 5 months. Daily temperature logs will be reviewed by the Dietary Manager/designee and copies given to the Administrator for review for the next 4 weeks and monthly thereafter for next 5 months. Director of Nursing/designee will audit nourishment freezers for 4 consecutive weeks and monthly thereafter for next 5 months.	