STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155581	A. BUILDING 00 B. WING	01/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF SYRACUSE SKILLED NURSING FACILITY, THE	500 E PICKWICK DR SYRACUSE, IN 46567

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: December 27, 28, 29, 30, 2022, and January 3, 2023. Facility number: 000566 Provider number: 155581 AIM number: 100267450 Census Bed Type: SNF/NF: 30 SNF: 3 Total: 33 Census Payor Type: Medicare: 3 Medicaid: 22 Other: 8 Total: 33 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/9/23.	F 0000	The Waters of Syracuse, Syracuse Indiana does hereby request consideration for Paper Compliance for the Plan of Completion submitted for our annual survey dated January 3,2023. Attached with our plan of correction, which we believe responds to corrections and system implementation are documents that address education and audit materials used in attaining and maintaining substantial compliance with the findings. If you should need any further documentation or information, please do not hesitate to contact the facility Administration at 574-457-4401 or through the Gateways system e-mail. Thank you, Carolyn Davidson, Administrator	
F 0640 SS=D Bldg. 00	483.20(f)(1)-(4) Encoding/Transmitting Resident Assessments §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment.			

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

Carolyn Davidson | Administrator | 01/26/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	(ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.			

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	§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. Based on record review and interview, the facility failed to ensure a Discharge MDS (Minimum Data Set) Assessment was transmitted timely for 1 of 1 assessments reviewed for timeliness. (Resident 26) Finding includes: A clinical record review was completed on 12/29/2022 at 9:54 A.M. Resident 26 was admitted on 7/1/2022 and discharged on 7/21/2022. The clinical record lacked a discharge assessment for 7/21/2022. During an interview, on 12/29/2022 at 10:00 A.M., RN 5 indicated there should have been a discharge assessment completed. RN 6 indicated the facility uses the RAI (Resident Assessment Instrument) as the policy for completing MDS assessments. The LTC Facility RAI 3.0 Users Manual, Version 1.16, copyright 2018, indicated a discharge assessment was to be transmitted no later than 14 days from section Z0500B (RN signature of the completion of the current assessment).	F 0640	F640 1. It is the policy and practice of this facility to ensure resident assessments are transmitted within 14 days after completion. Res # 26 was discharged on 7/21/2022. 2. All residents who are discharged from this facility have the potential to be affected by this allegedly deficient practice. 3. A 30 day look back of discharged residents was performed to verify MDS's were performed and transmitted (exhibit #1). MDS Coordinator will be educated on transmission of discharge assessments by Regional MDS Consultant on or before 1/24/2023 (exhibit #2). Any employee who fails to meet the points of the in-service will be further educated. 4. MDS Coordinator will review records to ensure discharge MDS assessments are completed and transmitted weekly x 6 months to ensure there are no assessments that are awaiting transmission to CMS (exhibit #3). Any concerns will be addressed as discovered. All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are noted, an action plan may be	01/26/2023

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			established. 5. 1/23/2023	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that			

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	includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			
	Based on record review, and interview, the facility failed to develop a baseline careplan for psychotropic medications for 1 of 17 residents whose careplans were reviewed. (Resident 6) Finding includes: A clinical record review was completed on 12/28/2022 at 2:31 P.M. Resident 6's diagnoses included, but were not limited to: dementia, anxiety, chronic kidney disease, hypertension, anemia and hyperlipidemia. An Admission MDS (Minimum Data Set) assessment, dated 10/13/2022, indicated Resident 6 received antianxiety and antidepressant medication. A MRR (Medication Regimen Review) was completed on 10/11/2022, 11/26/2022 and 12/22/2022. A baseline antianxiety and antidepressant careplan was initiated on 12/28/2022 and indicated Resident 6 had an anxiety and depression problem as evidenced by a diagnosis of anxiety. During an interview on 12/29/2022 at 2:05 P.M., the Assistant Director of Nursing indicated the baseline careplan was initiated on 12/28/2022 and	F 0655	F655 1. It is the policy and practice of this facility to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care within 48 hours of resident admission. 2. All residents who admit to the facility have the potential to be impacted by this allegedly deficient practice. 3. A 30 day look back of all admissions for baseline care plans was performed (exhibit #4). Resident #6's care plan was reviewed and updated. A full house audit on baseline care plans was completed on or before 1/26/2023 by the MDS coordinator, or designee (exhibit # 5). Licensed Nursing staff was in-serviced on the policy and procedure entitled "Baseline Care Plans" on 01/24/2023 by the DON and/or Designee (exhibit #6). Admissions will be audited by the	01/26/2023

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	it was late and should have been completed. On 12/30/2022 at 2:20 PM., the Administrator provided a policy titled, "Baseline Care Plan Assessment/Comprehensive Care Plans", dated 3/23/2021, and indicated the policy was the one currently used by the facility. The policy indicated "...It is the policy of the facility to ensure that every Resident has a Baseline Care Plan completed and implemented within 48 hours of Admission...." 3.1-30(a)		IDT the next day to ensure that a Baseline Care Plan was initiated per policy. Any concerns will be addressed as discovered. Any employee who fails to meet the points of the in-service will be further educated. 4. Baseline care plans will be audited by DON and/or Designee 5 times a week x 4 weeks, weekly x 4 weeks, then monthly x 4 months (exhibit #7). Any concerns will be addressed as discovered. All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are noted an action plan may be established. 5. 01/26/2023	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be			

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	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, record review, and interview, the facility failed to develop person-centered care plans for 3 of 17 residents whose care plans were reviewed (Residents 9, 27, and 135.) Findings included: 1. During an observation, on 12/27/2022 at 2:11 P.M., both of Resident 9's legs were very swollen.	F 0656	F656 1. It is the policy and practice of this facility to ensure all comprehensive care plans are created and updated per regulatory requirements. Resident 9's care plans have been reviewed and updated to include: current diagnosis of edema and current treatment orders (exhibit # 8).	01/26/2023

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	During an observation on 12/28/2022 at 2:00 P.M., no ace wraps were in place on Resident 9. During an observation on 12/29/2022 10:50 A.M., Resident 9 had no ace wraps in place. The documentation indicated the resident had refused ace wraps. A clinical record review was completed on 12/29/2022 at 2:12 P.M. Resident 9's diagnoses included, but were not limited to, chronic kidney disease, morbid obesity, and congestive heart failure. A Quarterly MDS Assessment, dated 12/2/2022, indicated the resident had a BIMS score of 12, indicating intact cognition. She required extensive assist of 2 staff for bed mobility, extensive assist of 1 for transfers, dressing, toileting, personal hygiene and eating. A physician's order, dated 10/4/2022, was to wrap legs with ace wrap from toes to knees. A care plan problem, dated 5/31/2022, indicated Resident 9 had edema. Interventions included, but were not limited to, administer medication as ordered; assist to elevate legs; float heels in bed; observe edema and notify MD as needed. The care plan was not updated with the new intervention of wrapping the legs on 10/4/2022. During an interview, on 12/30/22 at 10:47 A.M., the ADON indicated that the ace wraps were not on the care plan and should have been. 2. A clinical record review was completed on 12/28/2022 at 11:23 A.M. Resident 27 had pressure ulcers on her right great toe bunion, left		2. Any resident who has or needs care plans for edema or wounds, has the potential to be impacted by this allegedly deficient practice. 3. A house wide audit of all care plans with residents experiencing edema or wounds and/or on antidepressants was completed by 1/26/2023 by the MDS coordinator, or designee (exhibit 9). This audit included the accuracy of residents who have edema or wounds. DON or designee will educate staff who complete Care Plans on the policy "Baseline Care Plan/Comprehensive Care Plan" on or before 1/24/2023 (exhibit # 6). Any employee who fails to meet the points of the in-service will be further educated 4. Admissions will be audited 5 times weekly x 4 weeks, then weekly x 5 months for appropriate care plans for wounds, edema, and antidepressants (exhibit #10). Any concerns will be addressed as discovered. All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are noted, an action plan may be established. 5. 1/26/2023	

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	hip, and left outer ankle. Diagnoses included, but were not limited to, multiple sclerosis, scoliosis, muscle weakness, and abnormal posture. A Quarterly Minimum Data Set (MDS) Assessment dated 11/16/2022, indicated Resident 27 had a BIMS (Brief Interview for Mental Status) of 8, indicating moderate cognitive impairment. She required extensive assist of 1 staff for bed mobility, dressing, eating, and toileting; set up assist for personal hygiene; and assist of 1 staff for bathing. Had a Stage 1 pressure ulcer. A care plan problem, dated 8/23/2022, indicated the resident was at risk for skin breakdown related to reduced mobility, left inner ankle and right bunion rub against each other. Interventions included, but were not limited to, assist to toilet and/or check and change frequently; monitor skin daily during care; and pad bony prominence's. Physician orders included, but were not limited to, mepilex on left hip area, apply only at bedtime one time a day for protection. The order was discontinued on 11/10/2022 due to an order changed. A new order, dated 11/10/2022, indicated to use skin prep to pressure area on right great toe bunion and skin prep to outer left ankle twice daily until resolved. A new order, dated 11/11/2022, indicated to use skin prep to left hip two times a day and booties to bilateral feet daily. The clinical record lacked a current and or resolved care plan for the wounds on right great toe bunion, left outer ankle, and left hip. During an interview, on 12/30/2022 at 11:12 A.M., the Director of Nursing indicated the wounds were healed and were not on the care plan. 3. A clinical record review was completed on			

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	12/28/2022 at 1:57 P.M. Resident 135's diagnoses included, but were not limited to: diabetes, cirrhosis of liver and anxiety. Physician orders, dated 12/22/2022, included Bupropion (antidepressant) 100 mg (milligram) daily and 150 mg at bed time and Nortriptyline (antidepressant) 25 mg 2 capsules at bedtime for depression. The clinical record lacked a comprehensive care plan for the use of the psychotropic medications. During an interview, on 1/3/2023 at 9:48 A.M., RN 6 indicated there should have been a care plan for the medications. On 12/30/2022 at 2:20 P.M., the Administrator provided the policy titled, "Baseline Care Plan/Comprehensive Care Plans", undated and indicated the policy was the one currently used by the facility. The policy indicated"... The Baseline Care Plan will be discontinued upon the completion of the Comprehensive Care Plan. The Comprehensive Care Plan will further expand on the residents risks, goals, and interventions using the "Person- Centered " Plan of care approach for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs...." 3-1.35(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good			

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	nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to ensure showers were provided timely and failed to provide personal hygiene needs for 2 of 3 residents reviewed for ADL (Activities of Daily Living) , (Residents 8 & 6) Findings include: 1. During an observation on 12/27/2022 at 11:00 A.M., Resident 8 was observed with whiskers to her chin and had greasy hair with her shirt pulled up exposing her abdomen. During an observation on 12/28/2022 at 9:30 A.M., Resident was observed with greasy hair and her shirt pulled up exposing the abdomen. A clinical record review was completed on 12/29/2022 at 9:17 A.M. Resident 8's diagnoses included but were not limited to: Alzheimer's disease, diabetes, and osteoarthritis. A Quarterly MDS (Minimum Data Set) Assessment, dated 11/23/2022, indicated the resident had severe memory and cognitive impairments. Required extensive assist of 2 staff for bed mobility, transfers and toilet use and was dependant for bathing. A current care plan, dated 12/27/2022, indicated the resident had a "Self Care Deficit" and required assistance with ADL's to maintain the highest possible level of functioning. Bathing and Dressing: usually required extensive assistance. Provide assistance with all ADL's as required per her dependence needs: Eating, Transferring, Bed Mobility, Bathing, Dressing, Personal Hygiene,	F 0677	F677 1. It is the policy and practice of this facility to provide the necessary care and services, including good nutrition, grooming, and personal and oral hygiene, for those residents who are unable. ADLs were performed for Resident 8 that included shaving facial hair, shampooing of hair, and covering exposed abdomen. Resident 6 had facial hair shaved. Their care plans have been subsequently updated to reflect ADL care preferences. All female residents were observed for the presence of facial hair and shaved if noted. 2. All residents have the potential to be affected by this allegedly deficient practice. 3. Nursing staff were educated on the policy “Activities of Daily Living, Routine Care” by the DON and or designee on 1/24/2023 (exhibit # 6). Anyone who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. A facility wide review was done related to resident care as far ADLs (to include showering and shaving of facial hair) by ADON and any concerns were immediately addressed (exhibit # 11). 4. The DON and or designee will audit showers and shaving of facial hair five days a week x 4	01/26/2023

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	Ambulation and Personal Hygiene. A current care plan for preferences, dated 9/28/2018, indicated per family the resident expresses, during the assessment process, that it is important to them to: choose between shower, tub, bed, or sponge bath. Resident preference for bathing: Shower Frequency of bath 2x's. The shower schedule indicated the Resident 8 was to receive showers on Wednesdays and Saturdays on the day shift. Resident 8's shower documentation, dated 12/5/2022 through 1/3/2023, indicated Resident 8 had one shower on 12/21/2022. Her hair had been washed on 12/13/2022 and 12/18/2022. Resident 8 had received a complete bed bath by hospice staff on 12/18/2022 and 12/28/2022. During an interview, on 1/3/2023 at 9:38 A.M., CNA 7 indicated the residents should get 2 showers a week and more if they request it, and indicated Resident 8 had not received 2 showers a week. 2. During an observation on 12/28/2022 at 9:45 A.M., Resident 6 was observed with facial hair on her chin. During an observation on 12/29/2022 at 9:30 A.M., Resident 6 was observed with facial hair on her chin. A clinical record review was completed on 12/28/2022 at 2:31 P.M., Resident 6's diagnoses included, but were not limited to: Dementia, anxiety, chronic kidney disease, hypertension, anemia and hyperlipidemia. An Admission MDS (Minimum Data Set)		weeks and three days a week x 4 weeks, then monthly x 4 months (exhibit # 12). Any concerns noted will be immediately addressed and corrected. All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are noted, an action plan may be established. 5. 1/26/2023	

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	155581	A. BUILDING 00 B. WING	01/03/2023

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	assessment, dated 10/13/2022, indicated Resident 6 had a BIMS (Brief Interview for Mental Status) score of 0, indicating severe cognitive impairment. On 12/28/2022 at 2:40 P.M., Resident 6 Self Care Deficit careplan was reviewed and indicated, I have a "Self Care Deficit" and I require assistance with ADL's to maintain the highest possible level of functioning AEB the following limitations and potential contributing factors: Orthopedic Aftercare, Dementia, Osteoarthritis, Weakness, Use of Psychotropic Medications. Provide assistance with all ADL's as required per my dependence needs: Eating, Transferring, Bed Mobility, Bathing, Dressing, Personal Hygiene, Ambulation and Personal Hygiene. Personal Hygiene and Oral Care: I usually require Extensive assistance and 1 person support for Personal Hygiene and Oral Care. (Wt. Bearing Support of 1-99% of Staff Support) During an interview on 12/29/2022 at 1:15 P.M., the ADON indicated the Resident should be provided with ADL care during showers and as needed. ADON was not sure when her last shower was. On 12/30/2022 at 3:00 P.M., the Administrator provided the policy titled, "Activities of Daily Living Routine Care", undated, and indicated the policy was the one currently used by the facility. The policy indicated "...Residents are given routine daily care and HS care by a C.N.A. or a Nurse to promote hygiene, provide comfort and provide a homelike environment. ADL is provided throughout the day, evening and night as care planned and/or as needed...." On 1/3/2023 at 9:57 A.M., the Administrator provided the policy titled," Activities of Daily			

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	Living (Routine Care), undated, and indicated the policy was the one currently used by the facility. The policy indicated"... ADL care of the resident includes: Assisting the resident in personal care such as bathing, showering, dressing, eating, hair care, oral care, nail care, appropriate skin care(as indicated and as per care plan)...." 3.1-38(a)(3)			
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 review, the facility failed to follow Physician's Orders for applying bilateral heel protectors for1out of 17 records reviewed for Physician Orders. (Resident 8) Finding includes: During an observation, on 12/27/2022 at 12:00 P.M., Resident 8 was in her wheelchair with no heel protectors on. During an observation, on 12/28/2022 at 2:34 P.M., Resident 8 was in bed with no bilateral heel protectors on. During an observation, on 12/29/2022 at 9:15 A.M., Resident 8 was in the wheel chair with no	F 0684	F684 1. It is the policy and practice of this facility to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choices. Resident #8's record was audited to ensure that they are receiving care/treatment per preferences and person-centered care plan. 2. All residents have the potential to be affected by the allegedly deficient practice. 3. A full house record review was completed on 1/24/2023 by	01/26/2023

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	heel protectors on. During an observation, on 12/30/2022 at 5:40 A.M., Resident 8 was in bed with no heel protectors on. A clinical record review was completed on 12/29/2022 at 9:17 A.M. Resident 8's diagnoses included but were not limited to: Alzheimer's disease, diabetes, and osteoarthritis. A Quarterly MDS (Minimum Data Set) Assessment, dated 11/23/2022, indicated the resident had severe memory and cognitive impairments. Required extensive assist of 2 staff for bed mobility, transfers and toilet use and was dependant for bathing. A Physicians order, dated 12/6/2022, indicated Resident 8 was to have Bilateral heel protectors on at all times every shift. A current care plan problem, dated 4/27/2022, indicated the resident had the potential for skin breakdown related to chronic disease, incontinence, impaired mobility, and dependent for turning/repositioning. Interventions included, but were not limited to: Assist to check and change at least every 2 hours. Bilateral heel protectors at all times as tolerated. Notify physician and family of any change in skin integrity. Prevent skin/skin contact. During an interview, on 12/30/2022 at 1:50 P.M., QMA 3 indicated the resident did not wear boots in bed and had a pillow to keep her heels up, and does not wear anything when in her wheelchair. During an observation, on 1/03/2023 at 9:42 A.M., with QMA 3, the resident was in the bed with no		DON and/or Designee for physician's orders for heel protectors and corresponding care plans (exhibit # 13). Residents with active orders for heel protectors were observed for compliance with orders and care plans. Any issues identified were immediately corrected. Nursing staff were educated, by the DON, on 1/24/2023 on the use of heel protectors in accordance with physician orders (exhibit # 6). Any employee who fails to meet the points of the in-service will be further educated. 4. DON and/or Designee, will review records for pressure ulcer interventions to include resident observation validating interventions are in place 5 times a week x 4 weeks, weekly x 4 weeks, then monthly x 4 months (exhibit #14). Any concerns will be addressed as discovered. All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are identified, an action plan may be implemented. 5. 1/26/2023	

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	booties on and with her heels resting on the mattress. QMA 3 indicated her heels should have been elevated and she does not wear booties. On 1/3/2023 at 1:00 P.M., the Administrator provided the policy titled," Physician Orders--(Following Physician Orders", undated, and indicated the policy was the one currently used by the facility. The policy indicated"...It is the policy of the facility to follow the orders of the physician...The facility will have orders to provide essential care to the resident...." 3-1-37			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review, interview, and observation, the facility failed to assess a resident's skin to prevent pressure ulcers for 1 of 2 residents reviewed for pressure ulcers (Resident 27.) Finding includes:	F 0686	F686 1. It is the policy and practice of this facility to provide treatment and services aimed at preventing and healing pressure ulcers. Resident 27's wounds have healed as of 12/30/2022.	01/26/2023

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	A clinical record review was completed on 12/28/2022 at 11:23 A.M. Resident 27 had pressure ulcers on her right great toe bunion, left hip, and left outer ankle. Diagnoses included, but was not limited to, multiple sclerosis, scoliosis, muscle weakness, and abnormal posture. The pressure ulcers were documented on the Weekly Skin Assessments, dated 11/10/2022 and 11/17/2022. The clinical record lacked weekly skin assessments after 11/17/2022. A Quarterly Minimum Data Set (MDS) Assessment dated 11/16/2022, indicated Resident 27 had a BIMS (Brief Interview for Mental Status) of 8, indicating moderate cognitive impairment. She required extensive assist of 1 staff for bed mobility, dressing, eating, and toileting, and had a Stage 1 pressure ulcer. A care plan problem, dated 8/23/2022, indicated the resident was at risk for skin breakdown related to reduced mobility, left inner ankle and right bunion rub against each other. Interventions included, but were not limited to, assist to toilet and/or check and change frequently; monitor skin daily during care; and pad bony prominence's. Physician orders included, but were not limited to, mepilex on left hip area, apply only at bedtime one time a day for protection. The order was discontinued on 11/10/2022 due to an order changed. A new order, dated 11/10/2022, indicated to use skin prep to pressure area on right great toe bunion and skin prep to outer left ankle twice daily until resolved. A new order, dated 11/11/2022, indicated to use skin prep to left hip two times a day and booties to bilateral feet daily.		2. Any residents with pressure wounds could be affected by this allegedly deficient practice. 3. The ADON performed a skin sweep of all residents on 1/2/2023 and 1/17/2023 (exhibit 15). Nursing staff will be in-serviced on the policy "S.W.A.T-Skin, Weight Assessment Team Guidelines for Pressure Ulcers" to include weekly skin assessments, on 1/24/2023 (exhibit # 6). Any employee who fails to comply with the points of the in-service will be further educated. 1. DON and/or designee will audit weekly skin assessments for completion, 5 days a week x 4 weeks, 3 times a week x 4 weeks, then weekly x 4 months (exhibit # 16). Any concerns noted in the audit will be addressed immediately and corrected All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are noted, an action plan may be established. 4. 1/26/2023.	

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	During an interview, on 12/30/2022 11:12 A.M., the DON (Director of Nursing) indicated the wounds were healed and the resident had no open areas. During an observation, on 12/30/2022 1:05 P.M. with QMA 7 and the ADON (Assistant Director of Nursing), no red or open areas were observed on hips, coccyx, buttocks, ankles, heels, or bunion areas. During an interview, on 12/30/2022 1:05 P.M., the ADON indicated when she discontinues a treatment order, she states in the order that the area is healed. On 1/3/2023 at 9:41 A. M., the DON provided the policy titled, "S.W.A.T. ---Skin Weight Assessment Team--- Guidelines Pressure Ulcers." The policy indicated " ... as well as a weekly skin assessment as part of the QAPI process of the S.W.A.T. program ...." The policy further states, " ...A complete skin assessment is to be done weekly as part of the Skin Breakdown Prevention QAPI ...." 3.1-40(a)(2)			
F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.			

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	§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on observation, record review, and interview, the facility failed to provide 8 consecutive hours of registered nurse coverage for 1 out of 7 days. Finding includes: A record review of daily schedules was completed, on 1/3/2023 at 1:11 P.M. The daily schedule indicated, on 1/1/2023, a registered nurse (RN) was not scheduled. During an interview with Scheduler 8, on 1/3/2023 1:11 P.M., she indicated the schedule was correct as written and no RN was scheduled. She also indicated an RN was on call for 1/1/2023. During an interview with the Assistant Director of Nursing, on 1/3/2023 at 1:11 P.M., she indicated that she was the RN on call for 1/1/2023. On 1/3/2023 at 1:44 P.M., the Administrator provided a policy titled, "Registered Nurse Coverage." The policy indicated, " ...8 consecutive hours of RN services are scheduled each 24 hour day, 7 days per week ...." 3.1-17(b)(3)	F 0727	F727 1. It is the policy and practice for a Registered Nurse to be scheduled 8 consecutive hours, 7 days per week. 2. All residents have the potential to be affected by the allegedly deficient practice. 3. The Administrator educated the facility Nurse Administration Team (DON, ADON, and Scheduler) on the policy "Registered Nurse Coverage" on 1/24/2023 (exhibit # 17). Any employee who fails to meet the points of the in-service will be further educated. 4. The daily schedule will be reviewed, during morning meeting, 5 times per week x 4 weeks, weekly x 4 weeks then monthly x 4 months, ensure RN coverage is conducted 7 days each week (8 consecutive hours) (exhibit # 18). Any concerns will be addressed as discovered. All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are noted, an action plan may be established. 1/26/2023	01/26/2023

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F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be			

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	extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review, interview and observation, the facility failed to monitor for side effects for an antidepressant medication, failed to have an appropriate diagnoses for the use of an antipsychotic medication and failed to complete a gradual dose reduction on a antipsychotic medication for 3 of 5 residents reviewed for unnecessary medications. (Residents 135 and 15) Findings include: 1. A clinical record review was completed on 12/28/2022 at 1:57 P.M. Resident 135's diagnoses included but were not limited to encephalopathy, diabetes, cirrhosis of liver, anxiety, depression, and hypothyroidism. Physician orders, dated 12/22/2022, indicated Resident 135 was to receive Buproprion (antidepressant) 100 mg (milligram) daily, and Nortriptyline (antidepressant) 25 mg at bedtime for depression. The clinical record lacked the documentation to show the resident had been monitored for adverse side effects of the psychotropic medications. A Physician's order, dated 12/30/2022, indicated to observe for signs and symptoms of antidepressant side effects.	F 0758	F758 1. It is the policy and practice of this facility to ensure residents are free from unnecessary psychoactive medications. 2. All residents receiving psychoactive medications have the potential to be affected by the allegedly deficient practice. 3. Resident #135 was discharged on 1/2/2023. Chart review of resident #15 was conducted on 1/20/2023 for unnecessary psychoactive medication. A 30- day look back record review was performed on all residents with active psychoactive medication order were reviewed for side effect monitoring and diagnoses on 1/24/2023 for appropriateness of psychoactive medication (exhibit #19). DON or designee will educate Licensed Nursing staff on the policy "Behavior Management, Psychotropic Medication Protocol (exhibit # 6). Any employee who fails the points of the in-service will be further educated. 4. Audits of physician orders	01/26/2023

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	During an interview, on 1/03/2023 at 9:48 A.M., RN 6 indicated she should have been monitored for side effects, and indicated there was an order now to monitor for side effects. 2. A clinical record review was completed, on 12/30/2022 at 1:17 P.M., and indicated Resident 15 was admitted on 9/13/2019. His current diagnosis included, but were not limited to: Dementia, hydrocele, diaphragmatic hernia, major depressive disorder, suicidal ideation's, hypertension, gerd, anxiety disorder. A Quarterly MDS (Minimum Data Set) assessment, dated 9/27/22, indicated Resident 15 had a BIMS (Brief Interview for Mental Status) score of 9, indicating moderately impaired. Current physician orders, dated 1/3/2023, indicated Resident 15 had received Zyprexa (antipsychotic)2.5 mg (milligrams) daily for the suicidal ideation since 2/15/2022. During an interview, on 01/03/2023 at 11:49 A.M., the Administrator indicated the facility was following physicians orders. On 1/3/2023 at 11:35 A.M., the Administrator provided the policy titled, "Behavior Management Psychotropic Medication Protocol" and indicated the policy was the one currently used by the facility. The policy indicated"...Residents will be reviewed routinely for effectiveness and monitored for side effects of these medications and will receive gradual dose reductions, unless clinically contradicted, in an effort to discontinue these drugs...." 3.1-48(b)		regarding psychoactive medications documentation of side effect monitoring and diagnosis will be performed 5 times per week x 4 weeks, 1 time per week x 4 weeks and monthly x 4 months by the DON and/or Designee (exhibit # 20). Any deficiencies will be corrected immediately, and the findings of the audit will be submitted monthly to QAPI; If patterns or concerns are identified, and action may be implemented. 5. 1/26/2023	

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure unused/refused medications were removed and destroyed from the medication cart and failed to ensure medication and treatment carts were looked when unattended during medication storage reviews for 2 of 2 medication carts observed and 1 of 1 treatment cart observed. (100 and 300 medication carts and facility treatment cart) Findings include:	F 0761	F761 1. It is the policy and practice of this facility to store all drugs and biologicals in locked compartments, and inactive/discontinued medications removed from medication carts. All medication carts were inspected on 12/30/2022 and all inactive/discontinued medications were removed and disposed of as	01/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155581	A. BUILDING 00 B. WING	01/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	1. A medication storage observation was completed on, 12/29/2022 at 1:13 P.M., with RN 6 on the 300 hall medication cart. In a drawer was a large cylinder with 45 individual pill packets dated from 12/3/2022 to 12/28/2022 for numerous different residents. During an interview, on 12/29/2022 at 1:14 P.M., RN 6 indicated if a resident refuses a medication or if the medication had been discontinued they put them in the medication cart and then take to the medication room to destroy, and they should have been destroyed. 2. During a random observation, on 12/30/2022 at 3:45 A.M., both medication carts and a treatment cart were unlocked while not in use. During an observation on 12/30/2022 at 4:15 A.M., both medication carts and treatment cart remain unlocked while not in use. During an interview, on 12/30/2022 at 4:15 A.M., LPN 2 indicated the carts should have been locked. During an observation, on 12/30/2022 at 5:01 A.M., LPN 2 locked the treatment cart as he walked by it. On 12/30/2022 at 2:20 P.M., the Administrator provided the policy titled,"Medication Storage In The Facility", dated March 2018, and indicated the policy was the one currently used by the facility. The policy indicated"... 3. Medication rooms, carts, and medication supplies are locked or attended by person with authorized access...14. Outdated, contaminated, or deteriorated drugs and those in containers, which are cracked, soiled		per pharmacy procedures. 2. All residents have the potential to be affected by the allegedly deficient practice. 3. All licensed nurses, and QMAs were in-serviced on the policy “Medication Storage in the Facility” on 1/24/2023 (exhibit # 6). On 12/29/2022, RN #6 verbally educated on removing refused meds from medication carts. Agency #2 has not returned to the facility since survey and will not be scheduled until education has been completed. Any employee who fails the points of the in-service will be further educated. 4. DON and or Designee, will inspect medication carts for any inactive/discontinued medications and to ensure medication carts are locked when unattended, 5 days a week for 4 weeks, weekly for 4 weeks and then monthly for 4 months (exhibit # 21). Any concerns will be addressed as discovered. All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are noted an action plan may be implemented. 01/26/2023	

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	or without secure closures will be immediately withdrawn from stock by the facility. They will be disposed of according to drug disposal procedures, and reorder from pharmacy if a current order exists...." 3.1-25(m) 3.1-25(r)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a clean, safe, functional and sanitary environment was maintained for 5 of 33 rooms of the facility. (Room 107, 205, 206, 209, and 211). Finding includes: During the environmental tour with the Maintenance Director on, 1/03/2023 at 11:28 A.M., the following was noted: Room 107 had black marks on the walls, chair rail, and window trim. Room 205, the wall was marred and had gouges. Room 206, the toilet paper holder was broken, and the walls were scuffed and dirty. Room 209 had numerous spackled areas that were not painted and missing plaster on walls. Room 211, the walls had peeling paint and scuff	F 0921	F921 1. It is the policy and practice of this facility to maintain a safe, functional, sanitary, and comfortable environment. 2. All residents have the potential to be affected by this allegedly deficient practice. 3. Maintenance Director was verbally in-serviced on the inspection of resident rooms for missing plaster, gouges, and areas needing paint on 1/20/2023 by the Facility Administrator. Failure to comply may result in further education. All resident rooms were inspected on 1/24/2023 for needed repairs (exhibit # 22). Rooms 107, 205, 206, 209, and 211 are in the process of being repaired with a completion date of 1/26/2023. 4. Rooms will be inspected for maintenance needs 5 times per week x 4 weeks, 3 times per week	01/26/2023

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	marks. There is also a small hole about the size of a quarter in wall. During an interview with the Maintenance Director on, 1/03/2023 at 11:28 A.M., he indicated that missing plaster, holes in the walls, and gouges should be fixed, and he works on them as he has time. Housekeeping and nursing staff fill out a maintenance request form and put it on a clipboard that hangs on his office door, which is checked daily. When a resident is discharged there is a checklist that he completes for repairs needed in that room. A routine maintenance policy was requested from the maintenance director on 1/03/2023 at 2:41 P.M. and a policy was not provided. 3.1-19(f)		x 4 weeks, and 3 times per month x 4 months (exhibit # 23). All concerns will be addressed as needed in the monthly QAPI meeting. If patterns or concerns are noted, an action plan may be established. 5. 1/26/2023	