| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155776 | A. BUILDING 00<br>B. WING | 08/23/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| SPRINGHILL VILLAGE | 1001 E SPRINGHILL DR<br>TERRE HAUTE, IN 47802 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey.<br><br>Survey dates: August 15, 16, 17, 18, 19, 22, and 23, 2022<br><br>Facility number: 012188<br>Provider number: 155776<br>AIM number: 200958030<br><br>Census Bed Type:<br>SNF/NF: 68<br>SNF: 8<br>Total: 76<br><br>Census Payor Type:<br>Medicare: 9<br>Medicaid: 43<br>Other: 24<br>Total: 76<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on September 6, 2022. | F 0000 | The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Post Survey Desk Review.<br>/p><br>="" p=""><br>="" p=""> | |
| F 0578<br>SS=D<br>Bldg. 00 | 483.10(c)(6)(8)(g)(12)(i)-(v)<br>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir<br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph | | | |

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

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| | should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. | | | |
| | Based on record review and interview, the facility failed to ensure a resident's preferred code status (a designation of what type of emergent treatment a resident wants if found with heart not beating and not breathing) was updated in the physician's | F 0578 | =”” b=””><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient** | 09/23/2022 |

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| | orders and care plan for 1 of 24 residents reviewed for advance directives (Resident 59).<br><br>Findings include:<br><br>Resident 59's record was reviewed on 8/17/22 at 11:06 a.m. A significant change Minimum Data Set (MDS) assessment, dated 7/15/22, indicated the resident had a moderate cognitive impairment.<br><br>An undated banner at the top of the resident's electronic record indicated the resident's code status was do not resuscitate (DNR) (no cardiopulmonary resuscitation [CPR] if found with heart not beating and not breathing).<br><br>A physician's order, dated 8/6/22, indicated the resident was a full code (initiate CPR if found with heart not beating and not breathing).<br><br>A physician's orders for scope of treatment (POST) form, signed by the resident on 8/10/22, and by the physician on 8/11/22, indicated the resident preferred a DNR status.<br><br>A care plan, goal target dated 10/25/22, indicated the resident preferred a full code status.<br><br>During an interview, on 8/18/22 at 10:59 a.m., the Director of Nursing (DON) indicated once a POST form was signed, the electronic physician's orders should have been updated that same day. The electronic banner should indicate the accurate code status. The care plan should have been updated at the next Interdisciplinary Team (IDT) meeting, which would have been the next business day following the day the POST form was signed.<br><br>On 8/18/22 at 11:58 a.m., the DON provided a | | **practice?**1. Resident 59 code status was correctly identified in all places. Order, POST, Matrix banner, Care Plan. The code status was previously correctly identified and was a current requested change. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**1. All facility residents could be impacted.2. All facility residents code status was audited to ensure it is accurately reflected in the chart.**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**1. Nursing/Social Service in-servicing being completed by DNS to re-educate all nurses and Social Workers of the multiple areas this needs to be updated when changed. 2. During the daily review of new orders, once POST is signed by physician, nursing administration/SS will ensure all areas are updated. **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?**1.QAPI audit tool, POST, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame | |

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| | document titled, "Physician's Order for Scope of Treatment (POST)," and indicated it was the policy currently being used by the facility. The policy indicated, "...Implementing/Maintaining a POST form: ...3. If a resident decides to revoke or change the POST form, the resident's attending physician should be notified and appropriate changes to the physician orders should be obtained as soon as possible to ensure that the resident's wishes are accurately reflected in the plan of care...."<br><br>3.1-4(f)(7) | | and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance. | |
| F 0585<br>SS=E<br>Bldg. 00 | 483.10(j)(1)-(4)<br>Grievances<br>§483.10(j) Grievances.<br>§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.<br><br>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.<br><br>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt | | | |

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| | resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:<br>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;<br>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;<br>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is | | | |

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| | being investigated;<br>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;<br>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;<br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. | | | |
| | Based on record review and interview, the facility failed to ensure concerns expressed by the Resident Council were addressed by the facility administration for 2 of 4 months of resident council minutes reviewed for grievance responses. | F 0585 | =""  b=""><br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**A Resident Council | 09/23/2022 |

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| | Findings include:<br><br>Resident Council minutes were provided by the Activity Director (AD) on 8/18/22 at 12:01 p.m. The AD indicated she took minutes for the Resident Council meetings.<br><br>The meeting minutes included the months of May, June, July, and August 2022 and indicated the following concerns by the Resident Council:<br><br>1. On 5/5/22 - Staff were coming into the residents' rooms, turning off the call lights and saying they would be right back and then they did not return.<br><br>2. On 6/6/22 - Residents' call lights being turned off and staff expressed they would return but did not return.<br><br>3. On 7/11/22 - Residents' call lights being turned off and staff expressed they would return but did not return. The food did not look and taste good and was not served at the appropriate temperature.<br><br>4. On 7/26/22 - Staff continued to turn off Residents' call lights and say they will be back. Resident council indicated that the staff did not return. The food did not look and taste good and was not served the appropriate temperature.<br><br>5. On 8/8/22 - Staff continued to turn off residents' call lights and say they will be back. Resident council indicated that the staff did not return. The food was not served at the appropriate temperature.<br><br>On 8/22/22 at 3:34 pm., the Executive Director (ED) indicated she was the grievance official for the | | meeting was held following the state survey and the residents did feel the issues raised previously were improved, this was documented on the most current Resident Council meeting minutes. The Nursing Administration /Executive Director will continue to monitor for concerns regarding call lights and food temperature preferences so that we can work to correct each individual's concern. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**1. All facility residents could be impacted.2. Departments are working to meet preferences of Resident Council members. Will provide details to the residents on what each department is doing to resolve.<br>**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Following a Resident Council meeting with noted concern the specific department head will attend the next meeting to review intervention and get feedback on the outcome to ensure satisfaction. Any concern will be tracked for follow-up. Executive Director will work to address or ensure concerns are | |

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| | facility and had handwritten the responses for the resident council concerns for the June and July 2022 meetings on the resident council meeting minutes form. She had not responded to the resident council concerns on the minutes form for the months of May and August 2022 meeting minutes. The ED indicated she had addressed the following concerns:<br><br>1. Regarding the residents' call lights being turned off. Response was "Spoke with staff and memo placed about this concern asking the staff to leave the light on if they cannot address the residents' needs themselves immediately."<br><br>2. Regarding the temperature of the food. The response was "Memo sent out to the staff to close the cart door between tray service. Trays leave the kitchen hot, cooling off during service. Meals served in the dining room will be served hot right off the serve line. Everyone was welcome to come down to the dining room for meals.<br><br>On 8/18/22 at 1:15 p.m., the AD provided and a identified a document as a current facility policy, titled "Resident Council," dated 2/2020. The policy indicated, " ...Policy: ...The facility will promote and support the residents' right to participate and organize resident council. The council will be used to communicate concerns, give suggestions for future programming and events, and otherwise participate in and guide facility life ...Procedure: ...Concerns or suggestions from the meeting will be addressed by the appropriate department. The Executive Director will review all minutes and concern to ensure thorough resolution of concerns ...."<br><br>3.1-7(a)(2) | | addressed to the satisfaction of the residents.**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?**QAPI audit tool, Resident Council, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance. | |

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| F 0641 SS=A Bldg. 00 | 483.20(g)<br>Accuracy of Assessments<br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>Based on record review and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurate for 1 of 21 residents' MDS assessments reviewed (Resident 24).<br><br>Findings include:<br><br>Resident 24's record was reviewed on 8/16/22 at 1:23 p.m. An admission Minimum Data Set (MDS) assessment, dated 9/3/21, indicated the resident had a severe cognitive impairment and was not considered by the state level II preadmission screening and resident review (PASRR) process (an assessment to determine need for long term care and presence of mental illness and/or intellectual disabilities) to have a serious mental illness and/or intellectual disability or a related condition.<br><br>Census information indicated the resident was admitted to the facility on 9/3/21.<br><br>Diagnoses on the resident's profile included, but were not limited to unspecified psychosis (a mental disorder characterized by a disconnection from reality) not due to a substance or known physiological condition and other recurrent depressive disorders.<br><br>A PASRR Level II outcome, dated 9/24/21, indicated the resident received long term approval without specialized services.<br><br>During an interview, on 8/22/22 at 9:41 a.m., the Director of Nursing (DON) indicated the resident | F 0641 | **F641 Accuracy of Assessments**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**1. MDS for resident 24 has been modified to reflect the current condition of the resident.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**1. All facility residents with a Level II could be impacted.2. Re-education of staff responsible for PASARR, Level I/II, Level of Care and MDS to review process to ensure there is not a missed recommendation documented on the MDS.**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**1. Re-education of staff responsible for PASARR, Level I/II, Level of Care and MDS to review process to ensure there is not a missed recommendation documented on the MDS. .**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality** | 09/23/2022 |

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| | was considered a PASRR Level II.<br><br>During an interview, on 8/22/22 at 10:16 a.m., the MDS Coordinator indicated the resident was considered a PASRR Level II. The resident was admitted to the facility on 9/3/21, and the Level II was received on 9/28/22. The resident's admission assessment, dated 9/3/21, should have been modified or a significant change assessment should have been completed when they became aware the resident was a PASRR Level II.<br><br>A copy of Section A of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, was provided by MDS Coordinator 14 on 8/22/22 at 10:30 a.m. The manual indicated, "...A1500: Preadmission Screening and Resident Review (PASRR)...Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition...."<br><br>3.1-31(c)(1) | | **assurance program will be put into place?**1. QAPI audit tool, MDS Accuracy, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance. | |
| F 0657 SS=D Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services | | | |

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| | staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br><br>Based on interview and record review, the facility failed to ensure care plan meetings were scheduled on a date and time when a resident was available to attend the meeting for 1 of 24 residents reviewed for care plans (Resident 68).<br><br>Findings include:<br><br>During an interview on, 8/15/22 at 1:43 p.m., Resident 68 indicated the facility scheduled his care plan meetings on days when he was at dialysis (the process of removing excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). He had not been to a meeting in quite some time.<br><br>Resident 68's record was reviewed on 8/17/22 at 1:21 p.m. The profile indicated the resident's diagnoses included, but were not limited to stage 5 chronic kidney disease (when the kidneys are severely damaged and have stopped doing their job to filter waste from the blood). | F 0657 | **F657 Care Plan**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**1. Resident 68 was interviewed by the Director of Nursing and Social Services and 68 stated that Care Plans were held on his dialysis days but also stated he did not have any interest in attending a meeting, if he had concerns he would let us know. The facility only failed to document that the resident had declined to attend. This lack of documentation was rectified to reflect he was invited and declined. The facility does offer Care Plans on days preferred by the residents or families to meet their needs. **How will you identify other residents having the potential to be affected by the same deficient** | 09/23/2022 |

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| SPRINGHILL VILLAGE | 1001 E SPRINGHILL DR<br>TERRE HAUTE, IN 47802 |

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| | A significant change Minimum Data Set (MDS) assessment, dated 7/21/22, indicated the resident had no cognitive deficit had stage 5 chronic kidney disease, and received dialysis.<br><br>A care plan, dated 6/26/17, indicated the resident received dialysis and was at risk for complications. Interventions included, but were not limited to, attend dialysis serviced Mondays, Wednesdays, and Fridays.<br><br>A physician's order, dated 5/28/21, indicated dialysis days were Mondays, Wednesdays, and Fridays.<br><br>A notice of scheduled meeting, dated 9/15/21, indicated a notice had been sent to the resident's family and the resident.<br><br>A care plan meeting summary, dated 9/20/21 at 1:56 p.m., indicated the resident and the representative had not attended the meeting and further indicated the resident was at dialysis at the time of the meeting. The record lacked documentation of the resident declining to attend or that a review of the meeting had been conducted with the resident.<br><br>A notice of a scheduled meeting dated 12/15/21, indicated a notice had been sent to the resident's family and the resident. The record lacked documentation of a care plan summary or that a meeting had been held. The record lacked documentation of a meeting being held, that the resident had declined to attend, or that a review of the meeting had been conducted with the resident.<br><br>A notice of scheduled meeting, dated 3/16/22, | | **practice and what corrective action will be taken?**1. All facility residents could be impacted.2. Social Services and Nursing Administration reviewed previous documentation of Care Plan meetings and determined additional verbiage should be included to reflect the facilities willingness to hold meetings at preferred days and times and if the resident and or family declined this also should be documented.**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**1. Social Services and Nursing Administration reviewed previous documentation of Care Plan meetings and determined additional verbiage should be included moving forward to reflect the facilities willingness to hold meetings at preferred days and times and if the resident and or family declined this also should be documented.**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?**1. QAPI audit tool, Care Plan Meeting, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued | |

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| | indicated a notice had been sent to the resident's family and the resident.<br><br>A care plan meeting summary, dated 3/17/22 at 2:32 p.m., indicated the care plan meeting invitations sent to the resident and the representative had not been responded to and had not attended the meeting. A notice of scheduled meeting, dated 3/16/22, indicated a notice had been sent to the resident's family and the resident.<br><br>A notice of scheduled meeting, dated 6/15/22, indicated a notice had been sent to the resident's family and the resident. The record lacked documentation that a meeting had been held, that the resident had declined to attend, or that a review of the meeting had been conducted with the resident.<br><br>During an interview, on 8/18/22 at 10:01 a.m., Social Services Director (SSD) 3 indicated care plan meetings were held on Wednesdays because that was when all of the Interdisciplinary Team (IDT) members were mostly available. If a resident had an appointment or other scheduled plan, the resident would need to communicate that to the IDT team and the meeting could be rescheduled. She had not spoken with the resident directly about the scheduled dates for his meetings.<br><br>During an interview, on 8/23/22 at 1:02 p.m.,the Executive Director (ED) indicated that the facility could have documented the resident's decision to attend his care plan meetings better.<br><br>On 8/18/22 at 11:20 a.m., SSD 3 provided a document, with a revision date of 10/2019, titled, "IDT Comprehensive Care Plan Policy," and indicated it was the policy currently being used | | need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance. | |

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| | by the facility. The policy indicated, "...Procedure: ...The care plan review may be conducted face-to-face, via telephone conference...or through written communication per resident and/or representative preference...the IDT should still attempt to meet with the resident and complete the Care Plan Summary...."<br><br>3.1-35(d)(2)(B) | | | |
| F 0677 SS=D Bldg. 00 | 483.24(a)(2)<br>ADL Care Provided for Dependent Residents<br>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;<br><br>Based on observation, record review, and interview, the facility failed to ensure nail care was completed on dependent residents for 2 of 24 residents reviewed for Activities of Daily Living (ADL) (daily self-care activities) care (Residents 44 and 38).<br><br>Findings include:<br><br>1. During the initial pool observation, on 8/15/22 at 8:21 a.m., Resident 44 was observed in her room in bed eating breakfast. Resident 44 was observed eating with her bare hand, picking up the scrambled eggs and bacon with her hands that had dark debris under the long untrimmed fingernails on her bilateral (both) hands.<br><br>On 8/16/22 at 10:08 a.m., Resident 44 was observed lying in bed with long, untrimmed fingernails with dark debris underneath the nails.<br><br>On 8/17/22 at 9:18 a.m., Resident 44's fingernails | F 0677 | **F677 ADL Care**<br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?1. Resident 44 and resident 38 had their nails cleaned trimmed upon identification of the need. Hand hygiene for residents that use their hands to eat is important prior to the meal but then after the meal as needed nail care is part of that hand hygiene. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**1. All facility residents could be impacted.2. In-servicing of nursing staff on hand hygiene/nail care is being provided to ensure staff are aware of the need and expectations.**What** | 09/23/2022 |

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| | were observed with dark debris underneath the long, untrimmed fingernails on the resident's bilateral hands.<br><br>On 8/17/22 at 2:36 p.m., Resident 44's fingernails were observed with dark debris underneath the long, untrimmed fingernails on the resident's bilateral hands.<br><br>On 8/18/22 at 10:13 a.m., Resident 44 was observed lying in bed with long, untrimmed fingernails with dark debris underneath the nails.<br><br>On 8/22/22 at 12:49 p.m., Resident 44 was observed eating lunch in bed with long, untrimmed fingernails with dark debris underneath the nails.<br><br>On 8/23/22 at 9:15 a.m., Resident 44 was observed lying in bed with long, untrimmed fingernails with dark debris underneath the nails.<br><br>On 8/23/22 at 9:34 a.m., Registered Nurse (RN) 18 observed Resident 44's hands and indicated Resident 44's fingernails were too long and had dark debris underneath the nails. Staff should have cleaned the fingernails when they observed the soiled hands and during bathing.<br><br>Resident 44's record was reviewed on 8/17/22 at 11:17 a.m. Diagnoses included, but were not limited to, cognitive communication deficit (an impairment in organization/ thought organization, sequencing, attention, memory, planning, problem-solving, and safety awareness) and unspecified dementia with behavioral disturbance (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems). | | **measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**1. In-servicing/re-educating of nursing staff on hand hygiene/nail care is being provided to ensure staff are aware of the daily needs and expectations.**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?**1. QAPI audit tool, Resident Care Rounds, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance. | |

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| | A quarterly Minimum Data Set (MDS) assessment, dated 7/8/22, indicated Resident 47 had a severe cognitive impairment, had not rejected care, and required extensive assistance of one staff for eating, toilet use, and personal hygiene.<br><br>An ADL assistance required care plan, last revised on 7/14/22, indicated the resident required staff assistance in performing ADLs with interventions, included but not limited to, morning and evening tasks included bathing, dressing, and oral care.<br><br>On 8/23/22 at 10:15 a.m., the Executive Director provided the shower/bath documents and indicated, staff should complete nail care during baths and as needed. Resident 44's shower/bath sheets, dated 8/3/22, 8/6/22, 8/10/22, 8/13/22, 8/17/22, and 8/20/22, indicated the resident had received a bath and nail care was provided at the same time.<br><br>2. During the initial pool observation, on 8/15/22 at 8:50 a.m., Resident 38 was observed in her room lying in bed. Her fingernails were observed very long with dark debris underneath the nails.<br><br>On 8/16/22 at 9:54 a.m., Resident 38 was observed lying in bed with long, untrimmed fingernails with dark debris underneath the nails.<br><br>On 8/17/22 at 9:23 a.m., Resident 38 was observed lying in bed with long, untrimmed fingernails with dark debris underneath the nails.<br><br>On 8/17/22 at 2:49 p.m., Resident 38 was observed in bed visiting with her sister. Resident 38's fingernails were observed long and untrimmed with dark debris underneath the nails. | | | |

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On 8/23/22 at 9:20 a.m., Resident 38 was observed lying in bed with long, untrimmed fingernails with dark debris underneath the nails.

On 8/23/22 at 9:38 a.m., Registered Nurse (RN) 18 observed Resident 38's hands and indicated Resident 38's fingernails were too long and had dark debris underneath the nails. Staff should have cleaned the fingernails when they observed the soiled hands and during bathing.

On 8/23/22 at 9:43 a.m., Unit Manager 9 indicated residents' nails should be cleaned and trimmed on shower days and anytime they are dirty.

On 8/23/22 at 10:22 a.m., the Executive Director (ED) provided Resident 38's shower sheets and indicated staff should assist residents with hand washing, including nail care, during bathing and before meals or anytime staff observed soiled hands. Resident 38's shower/bath sheets, dated 8/6/22, 8/13/22, and 8/20/22, indicated the resident had received a bath and nail care was provided at the same time.

The ED provided and identified an undated document as a current facility policy titled, "Nursing." The policy indicated, "...Policy: ...The nursing staff shall follow infection control guidelines to prevent the spread of infection...Purpose: ...To ensure that resident(s) care is proved in a safe and sanitary manner to prevent the spread of infection...Provide and/or assist with hand hygiene before and after meals, after using the toilet and as needed...."

3.1-38(a)(3)(E)

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| F 0689 SS=D Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, record review, and interview, the facility failed to ensure doors were secured to prevent a resident from exiting the building and experiencing a fall while outside the building for 1 of 1 residents reviewed for accidents (Resident 24).<br><br>Findings include:<br><br>On 8/15/22 at 11:12 a.m., Resident 24 was observed with a sling to the right arm.<br><br>Resident 24's record was reviewed on 8/16/22 at 1:23 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 6/9/22, indicated the resident had a severe cognitive impairment.<br><br>Census information indicated the resident was admitted to the facility on 9/3/21.<br><br>Diagnoses on the resident's profile included, but were not limited to, unspecified psychosis (a mental disorder characterized by a disconnection from reality) not due to a substance or known physiological condition, unspecified fall initial encounter, and unspecified fracture of upper end of right humerus (long bone in the upper arm) subsequent encounter for fracture with routine | F 0689 | **F689 Free of Accidents**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**1.Resident 24 continues to reside in the facility, has had no additional falls, is fully recovered and remains at the same level of care prior to fall.2. Manual door inspections are being conducted following any cause when the door magnets release on the exit doors, this includes drills and times when work is being completed requiring the magnets to release or anytime a fire station is pulled.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**1. All facility residents could be impacted.2. In-servicing of nursing staff on manual door inspections are being conducted following any cause when the door magnets release on the exit | 09/23/2022 |

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| | healing.<br><br>A care plan, initiated 11/12/21, indicated the resident was at risk for falls and had a history of fracture with repair.<br><br>A nurse's note, dated 5/1/22, indicated the resident was up in the lounge and told the nurse she wanted out of this G-D--- place. The nurse attempted to tell the resident she lived here, and the resident said, "I don't f------ care."<br><br>A nurse's note, dated 5/10/22, indicated the resident came to the nurse's station and demanded to call her lawyer. The resident said they had taken everything away and she wanted to see her lawyer.<br><br>A Social Services note, dated 5/11/22, indicated the resident approached the Social Services Director (SSD) and kept talking about a meeting. The resident voiced wanting to go home and get out of here.<br><br>An elopement risk assessment, dated 5/11/22, indicated the resident was at risk for elopement related to had the ability to move about freely and easily which would allow the resident the capability of leaving the facility unassisted, often requested to go home or was searching for home, and exhibited significant cognitive impairment that impacted elopement risk. A security bracelet was not assigned. The assessment indicated the resident was being reviewed for a wander guard (a device which inhibits the resident from being able to open the exit door), was voicing wanting to go home all day and night, and was being monitored.<br><br>A Social Services note, dated 5/13/22, indicated the resident came to the SSD's office and | | doors, this includes drills and times when work is being completed requiring the magnets to release or anytime a fire station is pulled.**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**1. Manual door inspections are being conducted following any cause when the door magnets release on the exit doors, this includes drills and times when work is being completed requiring the magnets to release or anytime a fire station is pulled.**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?**1. QAPI audit tool, Exit Door Security, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance. | |

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| | requested a meeting. The SSD called the resident's sister in law, who told the resident she was unable to take her home.<br><br>A fall risk assessment, dated 6/9/22, indicated the resident was a high risk for falls.<br><br>An elopement risk assessment, dated 6/9/22, indicated the resident was not at risk for elopement and answered no to all risk factor questions.<br><br>A nurse's note, dated 7/19/22, indicated the writer and Certified Nursing Assistants (CNAs) immediately responded to the 200 hall door alarm and noted the resident to be exiting the door and walking onto the sidewalk. As the writer got to the door, the writer observed the resident tripping on the pavement and falling to her buttocks and from the sitting position, fell further onto her back. The resident stated she was trying to go home. The resident was assessed and unable to move right arm at the shoulder. The resident was not able to flex or extend the right shoulder. The physician was notified and ordered a STAT (immediate) x-ray to the right shoulder. An order for a wander guard was also obtained.<br><br>An elopement risk assessment, dated 7/19/22, indicated the resident was at risk for elopement related to had the ability to move about freely and easily which would allow the resident the capability of leaving the facility unassisted, often requested to go home or was searching for home, and exhibited significant cognitive impairment that impacted elopement risk. The resident was assigned a security bracelet.<br><br>An x-ray report, dated 7/21/22, indicated the resident had a recent comminuted (a bone broken | | | |

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| | in at least two places) fracture to the proximal (nearer to the center of the body) humerus.<br><br>A nurse's note, dated 7/21/22, indicated the x-ray was completed related to the recent fall, and findings of a fractured humerus. The physician ordered the resident to go to the fracture clinic on 7/22/22.<br><br>Current care plans lacked documentation the resident was at risk for elopement or exhibited exit seeking behaviors.<br><br>During an interview, on 8/17/22 at 10:14 a.m., Unit Manager 9 indicated residents with wander guards would cause the door to automatically lock. If a resident did not have a wander guard, they were able to open the exit doors by putting a code. When Resident 24 opened the door, she was able to put the code in at the 200 hall door so the alarm did not go off. The staff saw her open the door and go out. She did not normally walk that far from her room. Elopement risk assessments were used to find out what residents were exit seeking. If they exhibited exit seeking behaviors they would place a wander guard.<br><br>During an interview, on 8/17/22 at 10:31 a.m., the Director of Nursing (DON) indicated the wander guard systems were effective for the front entrance, moving forward dining room, and north door of main dining room, near the front of the building. This did not include the door the resident exited from. The staff followed the resident out of the door, but were unable to get to her before she fell.<br><br>On 8/17/22 at 11:33 a.m., the 200 hall exit door was observed with a door code number posted next to the key pad. This code was the same as the front | | | |

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| | door code.<br><br>During an interview, on 8/17/22 at 11:53 a.m., Unit Manager 9 indicated she was not sure if the door code was changed after the resident got out of the building.<br><br>During an interview, on 8/17/22 at 11:38 a.m., the DON indicated she did not think the door code was changed after the resident got out of the building, but she was not sure. She thought all the exit door codes were the same.<br><br>During an interview, on 8/17/22 at 2:06 p.m., the DON indicated they were not required to place a wander guard on residents who were at risk for elopement. They had not considered this incident to be an elopement because the staff were able to see the resident when she exited the building. There was a fire safety drill the night before the incident, so she thought there may have been an issue with the door. The maintenance staff checked the door after the incident and did something to it, but she was not sure exactly what. She was not sure if the resident put the door code in the door to exit or if the door malfunctioned. It was possible the resident was able to put in the door code, but they were required to keep to code posted. The code to all exterior doors was the same, and had not been changed since the incident on 7/19/22.<br><br>During an interview, on 8/17/22 at 2:50 p.m., the Maintenance Director indicated there was a full system trip earlier in the day on 7/19/22. This caused water to flow into the fire system to set off the alarms to verify their functioning. When completed, the 200 hall door showed it was functional on the control panel, but it had not engaged with the magnet on the door, which | | | |

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| | enabled the resident to open the door. The alarm sounded when the resident opened the door. He did not think the resident had to put the code in to exit. Once drills were completed, the exit doors should have been visually inspected for functionality, but this had not been completed.<br><br>On 8/17/22 at 1:26 p.m., the DON provided a document titled, "Elopement Prevention and Response Program," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: It is the policy of the facility that staff who have residents under their care are responsible for knowing the location of those residents...Procedure: ...ELOPEMENT PREVENTION PROGRAM: 1. Resident identified to be at risk for elopement will be identified as follows: a. The facility will utilize an ELOPEMENT RISK ASSESSMENT to identify residents at risk for elopement...c. Resident will be identified as an 'Elopement Risk,' 'Wanderguard,' 'Electronic Monitoring Device,' 'Security Bracelet,' etc on direct care staff communication method (ie Matrix profile, resident care sheets, etc.). d. Care plans will be developed and individualized for residents who are at risk for elopement. 2. Residents who are at risk for elopement may utilize a security bracelet (if the facility utilizes an electronic monitoring system and need for device is present on the care plan) per physician's order that will be checked for placement and function no less often than daily...3. Alarm system will be checked by Maintenance to ensure it is functioning and recorded in Preventative Maintenance Logs...."<br><br>3.1-45(a)(2) | | | |
| F 0692<br>SS=D<br>Bldg. 00 | 483.25(g)(1)-(3)<br>Nutrition/Hydration Status Maintenance<br>§483.25(g) Assisted nutrition and hydration. | | | |

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| | (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-<br><br>§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;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br><br>Based on record review and interview, the facility failed to ensure a re-weight was completed for a resident with potential significant weight change for 1 of 6 resident reviewed for nutrition (Resident 63).<br><br>Findings include:<br><br>Resident 63's record was reviewed on 8/19/22 at 10:38 a.m. The resident had been admitted to the facility on 7/11/22.<br><br>The profile indicated the resident's diagnoses included, but were not limited to, iron deficiency anemia (too few healthy red blood cells in the body) and gastro-esophageal reflux disease (GERD-when stomach acid repeatedly flows back | F 0692 | **F692 Nutrition**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**1. Resident 63 has since been weighed and continues to be monitored for any nutritional concerns.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**1. All facility residents could be impacted.2. In-servicing of nursing staff on accurate weights and re-weighs is being conducted. Designated staff are being assigned as the Weight | 09/23/2022 |

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| | into the tube connecting your mouth and stomach).<br><br>An admission Minimum Data Set (MDS) assessment, dated 7/17/22, indicated the resident had moderate cognitive deficit, required supervision with setup with meals, had no nutritional or swallowing issues and no oral/teeth issues documented.<br><br>A care plan, dated 7/11/22, indicated the resident was at risk for altered nutritional status with a current goal to maintain current weight. Interventions included, but were not limited to, notify physician and family of significant weight changes.<br><br>Review of the resident's weight monitoring indicated the resident had weighed 185 pounds on 8/1/22 and 174 pounds on 8/8/22.<br><br>During an interview, on 8/19/22 at 11:29 a.m., the Director of Nursing (DON) indicated the resident should have been weighed weekly for one month, as a new admission. If there was a significant weight change noted, a re-weight should have been completed.<br><br>During an interview, on 8/19/22 at 11:35 a.m., Unit Manager 10 indicated she felt with the significant discrepancy with the resident's weight, from 8/1/22 to 8/8/22, there should have been a re-weight and it just did not get done.<br><br>During an interview, on 8/22/22 at 9:00 a.m., the DON indicated the Registered Dietician (RD) had come into the building late afternoon of 8/19/22, and had indicated the resident should have been re-weighed on 8/8/22, but it was never completed. At the same time, the DON indicated there was | | Team to have consistency and accuracy in obtaining weights.**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**2. In-servicing of nursing staff on accurate weights and re-weighs is being conducted. Designated staff are being assigned as the Weight Team to have consistency in obtaining weights. Unit Managers will oversee this process and ensure accuracy.**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?**1. QAPI audit tool, Resident Weights, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance. | |

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| | not a specific policy for re-weights, but the policy would be that if a resident's weight had significantly changed from the previous weight, staff were to re-weigh the resident to ensure the weight taken was accurate.<br><br>On 8/22/22 at 9:39 a.m., the DON provided a document, with a revision dated of 4/2018, titled, "IDT Weight Review," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: It is the policy...to identify resident's who are at nutritional risk or have a significant weight change...Follow Up IDT Weight Reviews...wight reviews should be completed weekly...."<br><br>3.1-46(a)(1) | | | |
| F 0740<br>SS=D<br>Bldg. 00 | 483.40<br>Behavioral Health Services<br>§483.40 Behavioral health services.<br>Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.<br>Based on record review and interview, the facility failed to ensure a resident's exit seeking behaviors were monitored for 1 of 1 residents reviewed for elopement risk (Resident 24).<br><br>Findings include:<br><br>Resident 24's record was reviewed on 8/16/22 at | F 0740 | **F740 Behavioral Health Services**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**1. Resident 24 behavior was added into the Care Plan for | 09/23/2022 |

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| | 1:23 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 6/9/22, indicated the resident had a severe cognitive impairment and exhibited a behavior of delusions (fixed, false beliefs).<br><br>Census information indicated the resident was admitted to the facility on 9/3/21.<br><br>Diagnoses on the resident's profile included, but were not limited to, unspecified psychosis (a mental disorder characterized by a disconnection from reality) not due to a substance or known physiological condition and other recurrent depressive disorders.<br><br>A physician's order, dated 3/26/22 and discontinued 8/3/22, indicated fluoxetine (an antidepressant) 10 milligrams (mg) once a day for other recurrent depressive disorders.<br><br>A behavior symptom monthly summary form, dated 4/1/22, indicated the resident was being monitored for delusions and hallucinations (a perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there) due to psychosis, but lacked documentation the resident exhibited exit seeking behaviors.<br><br>A nurse's note, dated 5/1/22, indicated the resident was up in the lounge yelling. The resident said she wanted out of this, "G-- d--- place." The nurse attempted to tell the resident she lived at the facility, and the resident responded, "I don't f------ care." The day before, the resident asked to contact her sister in law and a message was left with her. The resident stated she was mad because they took her house and she was going to stay mad. Resident had not attempted to get out any exit doors at that time. | | monitoring. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**1. All facility residents with exit seeking behavior are at risk and could be impacted.2. In-servicing of IDT on new Behavior Monitoring Program.**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**1. In-servicing/re-educating of IDT on new Behavior Monitoring Program.**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?**1. QAPI audit tool, Behavior Management, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance. | |

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| | A behavior symptom monthly summary form, dated 5/3/22, indicated the resident was being monitored for delusions and hallucinations (a perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there) due to psychosis, but lacked documentation the resident exhibited exit seeking behaviors.<br><br>An interdisciplinary team (IDT) behavior review note, dated 5/5/22, indicated the resident cussed at staff, talked about her home being in foreclosure, and was in an agitated state. The immediate intervention was staff redirection. Potential root cause was the resident's sister in law came in to the facility the week prior and noted the resident's home was no longer hers and the resident was upset to be at the facility for long term care. A preventative intervention was the Social Services Director (SSD) and Business Office Manager (BOM) were to speak with the resident regarding her financial situation. Resident to be provided reassurance. Resident had a guardian in place.<br><br>A social services note, dated 5/6/22, indicated the resident was seen by psychiatric services and received a gradual dose reduction (GDR) of olanzapine (an antipsychotic) from 20 mg to 15 mg for psychosis.<br><br>A nurse's note, dated 5/10/22, indicated the resident came up to the nurse's station and demanded to call her lawyer. The resident said they had taken everything away from her and she wanted to see her lawyer. The resident had a phone number written down. The nurse explained to the resident that her legal needs could be solved at the facility. The payroll coordinator was also at the nurse's station, and heard the resident state she wanted her money. The payroll | | | |

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| | coordinator took the resident with her and she had not yet returned to the nurse's station.<br><br>A social services note, dated 5/11/22, indicated the resident came to the SSD's door and talked about having a meeting. The resident and SSD met and phoned the resident's guardian. The resident wanted to go home and, "get out of here." The resident was noted to have a hard time forming sentences and was provided reassurance and redirection.<br><br>An elopement risk assessment, dated 5/11/22, indicated the resident was at risk for elopement related to had the ability to move about freely and easily which would allow the resident the capability of leaving the facility unassisted, often requested to go home or was searching for home, and exhibited significant cognitive impairment that impacted elopement risk. A security bracelet was not assigned. The assessment indicated the resident was being reviewed for a wander guard (a device which inhibits the resident from being able to open the exit door), was voicing wanting to go home all day and night, and was being monitored.<br><br>A social services note, dated 5/13/22, indicated the resident came to the SSD's office and requested a meeting. The resident wanted to call her sister. SSD and resident called her sister in law, and the sister in law told the resident she was unable to take her home. SSD confirmed this with the resident.<br><br>A nurse's note, dated 5/13/22, indicated the nurse practitioner (NP) increased the resident's olanzapine to 20 mg daily related to a failed GDR.<br><br>A social services note, dated 5/19/22, indicated the resident was out in the hallway crying and | | | |

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| | highly upset. Staff attempted to reassure and give resident food and coffee, but resident denied. Will continue to follow resident.<br><br>A physician's order, dated 5/20/22, indicated olanzapine 20 mg by mouth daily related to unspecified psychosis not due to a substance or known physiological condition.<br><br>An IDT behavior review note, dated 5/27/22, indicated the resident was in the lobby, becoming increasingly agitated with staff. Resident was not able to be redirected. The potential root cause was residents family informed her she would not return home. Resident's sister in law informed the resident she was not able to return home related to her home was sold by the bank. Resident was not able to find the answers she wanted regarding her home, and a phone call to the guardian was attempted, but provided little help. Resident had a diagnosis of psychosis not due to a substance or known physiological condition. Potential interventions included reassurance and redirection.<br><br>A behavior symptom monthly summary form, dated 6/1/22, indicated the resident was being monitored for delusions and hallucinations (a perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there) due to psychosis, but lacked documentation the resident exhibited exit seeking behaviors.<br><br>An elopement risk assessment, dated 6/9/22, indicated the resident was not at risk for elopement and answered no to all risk factor questions.<br><br>A nurse's note, dated 6/21/22, indicated the resident was exit seeking, and the Director of | | | |

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| | Nursing (DON) alerted the nurse to the front door. The resident stated she wanted to "go east." The Executive Director (ED) took the resident to the east dining room, and the nurse got coffee for the resident. The resident requested to go back to bed and stated she was in pain. An as needed (PRN) pain medication was administered. The resident was taken to the lounge to drink coffee, and the resident removed the lid from the coffee, threw it across the room, and stated, "Now you can go get me another cup of coffee." The Certified Nursing Assistant (CNA) attempted to assist the resident back to bed, but the resident stiffened her body and stated, "If I get in that bed I'll die." Resident sat in wheelchair repeating, "I need to get to the east side."<br><br>An IDT behavior review note, dated 6/22/22, indicated the resident was exit seeking, threw coffee, and repeatedly asked to be taken, "east." The immediate interventions were redirection, staff assisted to east side of the building, but were ineffective. The resident was given another drink. The potential correlation to the root cause was resident was out in the halls and lounge with noisy environment, and the resident had been asleep most of the morning. The root cause was resident had a diagnosis of unspecified psychosis not due to a substance or known physiological condition. Preventative interventions included continued to redirect and reassure, review for wander guard based on exit seeking behaviors, and continued to provide coffee to resident.<br><br>A physician's note, dated 6/27/22, indicated the resident had some issues with mood instability over the last couple of weeks and had thrown a cup of coffee at the nurse the prior week. The resident had been fine the last couple of days. | | | |

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| | A behavior symptom monthly summary form, dated 7/1/22, indicated the resident was being monitored for delusions and hallucinations (a perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there) due to psychosis, but lacked documentation the resident exhibited exit seeking behaviors.<br><br>A nurse's note, dated 7/19/22, indicated the writer and Certified Nursing Assistants (CNA's) immediately responded to the 200 hall door alarm and noted the resident to be exiting the door and walking onto the sidewalk. As the writer got to the door, the writer observed the resident tripping on the pavement and falling to her buttocks and from the sitting position, fell further onto her back. The resident stated she was trying to go home. The resident was assessed and unable to move right arm at the shoulder. The resident was not able to flex or extend the right shoulder. The physician was notified and ordered a STAT (immediate) x-ray to the right shoulder. An order for a wander guard was also obtained.<br><br>An elopement risk assessment, dated 7/19/22, indicated the resident was at risk for elopement related to had the ability to move about freely and easily which would allow the resident the capability of leaving the facility unassisted, often requested to go home or was searching for home, and exhibited significant cognitive impairment that impacted elopement risk. The resident was assigned a security bracelet.<br><br>An x-ray report, dated 7/21/22, indicated the resident had a recent comminuted (a bone broken in at least two places) fracture to the proximal (nearer to the center of the body) humerus.<br><br>A nurse's note, dated 7/21/22, indicated the x-ray | | | |

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| | was completed related to the recent fall, and findings of a fractured humerus. The physician ordered the resident to go to the fracture clinic on 7/22/22.<br><br>A Medication Administration Record (MAR), dated August 2022, indicated the resident was being monitored for behaviors of delusions and hallucinations, but lacked documentation the resident was being monitored for exit seeking behaviors.<br><br>A behavior symptom monthly summary form, dated 8/1/22, indicated the resident was being monitored for delusions and hallucinations (a perception of having seen, heard, touched, tasted, or smelled something that wasn't actually there) due to psychosis, but lacked documentation the resident exhibited exit seeking behaviors.<br><br>A physician's order, dated 8/4/22, indicated sertraline (an antidepressant) 50 mg by mouth daily for major depression.<br><br>Current care plans lacked documentation the resident was at risk for elopement or exhibited exit seeking behaviors.<br><br>During an interview, on 8/17/22 at 10:14 a.m., Unit Manager 9 indicated elopement risk assessments were used to assess who was an elopement risk and which residents were exit seeking. If residents exhibited exit seeking behaviors, a wander guard should have been placed. This included if residents were talking about wanting to leave the facility or go home. There should also have been a care plan developed. The resident was upset about her home being in foreclosure, but they thought she had settled down. | | | |

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| | 155776 | A. BUILDING 00<br>B. WING | 08/23/2022 |

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| SPRINGHILL VILLAGE | 1001 E SPRINGHILL DR<br>TERRE HAUTE, IN 47802 |

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| | During an interview, on 8/17/22 at 1:35 p.m., SSD 3 indicated exit seeking behaviors were new for this resident, and they started around May 2022. The biggest issue was when the resident spoke with her sister in law. The resident's nephew was living in her home, and the home went into foreclosure. Around the same time, a guardian was appointed to the resident. The resident was agitated wanting to know where her things were, what was going on with her house, her car, and her lawyer. When a resident exhibited a new behavior, they should have been referred to psychiatric services, and put interventions in place. They provided interventions of one on one staff with resident and taking her to the lounge were provided to the resident. This should have been put in a care plan. Staff becomes aware of what interventions to attempt with a resident's behavior through the care plan. She should have initiated the care plan, put interventions in place, and clicked the flow button. The flow button would cause the monitoring to go over to the behavior monitoring area on the MAR to prompt staff to monitor for it. The exit seeking and agitation care plan should have been initiated in May 2022 when the behavior was first exhibited. There was behavior monitoring in place for delusions, however this situation was not a delusion, as it was actually happening to the resident.<br><br>During an interview, on 8/17/22 at 2:06 p.m., the DON indicated they were not required to put a wander guard on all residents who were at risk for elopement.<br><br>On 8/17/22 at 1:26 p.m., the DON provided a document titled, "Behavior Management Policy," and indicated it was the policy currently being used by the facility. The policy indicated, "...Policy: It is the policy of...to provide behavior | | | |

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| | interventions for residents with problematic or distressing behaviors. Interventions provided are both individualized and non pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's distressed behavior. Procedure: 1. Care plans should be initiated for any behavioral issue that affects, or has the potential to affect, the resident or other residents...2. When a behavior occurs, the staff communicates to the nurse what behavior occurred. The nurse records the behavior on the monitoring form, if the resident is being monitored for the behavior, including what interventions were attempted during the episode and whether or not they were effective. 5. All residents who are on the behavior monitoring program will have a summary monthly that includes a review of behaviors and interventions...."<br><br>3.1-43(a)(1) | | | |
| F 0757 SS=E Bldg. 00 | 483.45(d)(1)-(6)<br>Drug Regimen is Free from Unnecessary Drugs<br>§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-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications | | | |

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| | for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br><br>Based on record review and interview, the facility failed to ensure pain assessments were completed for residents who were administered pain medication for 4 of 5 residents reviewed for unnecessary medication (Residents 34, 58, 59, and 24).<br><br>Findings include:<br><br>1. Resident 34's record was reviewed on 8/16/22 at 1:08 p.m. The record indicated the resident had been admitted to the facility on 4/15/22.<br><br>The profile indicated the resident's diagnoses included, but were not limited to, displaced trimalleolar fracture of left lower leg (a break of the lower leg sections that form the ankle joint and helps with movement of the foot and ankle).<br><br>An admission Minimum Data Set (MDS) assessment, dated 4/21/22, indicated the resident had no cognitive deficit, reported frequent moderate pain, received as needed (PRN) opioid (substances that act on opiod receptors to produce morphine-like effects) pain medications.<br><br>A care plan, dated 4/18/22, indicated the resident was at risk for pain related to trimalleolar fracture with surgical repair and history of low back pain. Interventions included, but were not limited to, | F 0757 | **F757 Drug Regimen is Free from Unnecessary Drugs**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**1. Resident 24, 34, and 59, all have had pain assessments completed. Resident 58 no longer resides in the facility.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**1. All facility residents could be impacted.2. Audit being completed to identify residents with orders for scheduled pain medication for appropriate monitoring. In-servicing/re-educatin g of nursing staff completing and documenting for pain assessments when administering PRN pain medication. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**1. In-servicing/re-educating of nursing staff completing and | 09/23/2022 |

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| | administer medications as ordered.<br><br>A physician's order, dated 4/18/22, Tramadol (medication used to relieve moderate to moderately severe pain). Schedule IV tablet (drugs with a low potential for abuse and low risk of dependence), 50 milligrams (mg). Administer 50 mg, by mouth, every 4 to 6 hours, PRN, for mild to moderate pain.<br><br>Review of the April 2022 Medication Administration Record (MAR), indicated the medication had been administered 30 times: 29 administrations lacked documentation of the pain intensity, 9 lacked documentation of the location of the pain, and 3 lacked documentation of the effectiveness of the pain medication.<br><br>Review of the May 2022 MAR, indicated the medication had been administered 30 times: 26 administrations lacked documentation of the pain intensity and 12 administrations lacked documentation of the location of the pain.<br><br>Review of the June 2022 MAR, indicated the medication had been administered 5 times: 4 administrations lacked documentation of the pain intensity and 1 administration lacked documentation of the location of the pain.<br><br>Review of the July 2022 MAR, indicated the medication had been administered 7 times: 2 administrations lacked documentation of the pain intensity and 4 administration lacked documentation of the location of the pain.<br><br>Review of the August 2022 MAR, indicated the medication had been administered 2 times. The MAR lacked any documentation of the pain intensity or of the location of the pain.2. Resident | | documenting for pain assessments when administering PRN pain medication.<br><br>**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?** 1. QAPI audit tool, Pain Management, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance. | |

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| | 58's record was reviewed on 8/17/22. The profile indicated diagnosis included but were not limited to, diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired), major depression (persistently depressed mood or loss of interest in activities), venous insufficiency, basil cell carcinoma (type of skin cancer that begins in the basal cells) of skin of scalp and neck.<br><br>A physician order, dated 7/25/22, indicated Tramadol 50 milligrams (mg) (medication used to relieve moderate to moderately severe pain) by mouth routinely twice a day.<br><br>Review of the July and August 2022, Medication Administration Record (MAR), indicated the pain medication was administered 13 times in July and 35 in August. The record lacked documentation of effectiveness and no documentation of severity of pain for the doses administered.<br><br>During an interview, on 8/19/22, the Director of Nursing (DON) indicated that the pain assessments should have been ordered but got missed and were not done.3. Resident 24's record was reviewed on 8/16/22 at 1:23 p.m. A quarterly Minimum Data Set (MDS) assessment, dated 6/9/22, indicated the resident had a severe cognitive impairment, received scheduled and as needed (PRN) pain medication, and reported occasional mild pain during the assessment period.<br><br>Diagnoses on the resident's profile included, but were not limited to, history of fracture of unspecified part of neck of right femur (thigh bone) initial encounter for closed (broken bone but skin is intact) fracture, dated 9/3/21, and unspecified fracture of upper end of right humerus | | | |

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| | (long bone of upper arm) subsequent encounter for fracture with routine healing, dated 7/22/22.<br><br>A care plan, initiated 9/7/21, indicated the resident was at risk for pain related to right hip hemiarthroplasty (surgical fracture repair). Interventions included, but were not limited to, administer medications as ordered, notify the physician if pain was unrelieved or worsening, and observe for non verbal signs of pain.<br><br>A physician's order, dated 9/7/21, indicated hydrocodone-acetaminophen (a pain medication) 5-325 milligrams (mg) every four hours by mouth PRN for moderate pain related to history of fracture of unspecified part of neck of right femur initial encounter for closed fracture.<br><br>A medication administration record (MAR), dated July 2022, indicated the resident received 23 administrations of hydrocodone-acetaminophen 5-325 mg: 11 administrations lacked documentation of the location and severity of the resident's pain at the time of administration.<br><br>A MAR, dated August 2022, indicated the resident received 8 administrations of hydrocodone-acetaminophen 5-325 mg one tablet: 6 administrations lacked documentation of the location and severity of the resident's pain at the time of the medication administration.<br><br>4. Resident 59's record was reviewed on 8/17/22 at 11:06 a.m. A significant change Minimum Data Set (MDS) assessment, dated 7/15/22, indicated the resident had a moderate cognitive impairment, received scheduled and as needed (PRN) pain medication, and reported occasional moderate pain during the assessment period. | | | |

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| | Diagnoses on the resident's profile included, but were not limited to, unilateral primary osteoarthritis (stiffness and chronic pain in joints) left knee and primary generalized osteoarthritis.<br><br>A physician's order, dated 5/10/22, indicated hydrocodone-acetaminophen (a pain medication) 5-325 milligrams (mg) one tablet by mouth every six hours PRN for mild to moderate pain related to pain in right lower leg.<br><br>A medication administration record (MAR), dated July 2022, indicated the resident received 8 administrations of hydrocodone-acetaminophen 5-325 mg one tablet: 7 administrations lacked documentation of the location and severity of the resident's pain at the time of the medication administration.<br><br>A MAR, dated August 2022, indicated the resident received 5 administrations of hydrocodone-acetaminophen 5-325 mg one tablet: 3 administrations lacked documentation of the location and severity of the resident's pain at the time of the medication administration.<br><br>During an interview, on 8/17/22 at 9:35 a.m., the Director of Nursing (DON) indicated documentation on intensity, location of the resident's pain, and the effectiveness of the pain medication, should be completed, whenever a pain medication was administered.<br><br>On 8/17/22 at 10:24 a.m., the DON provided a document titled, "Pain Management," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: 1. Residents are assessed for pain upon admission, weekly and during medication administration as outlined below...3. Interviewable | | | |

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| | Resident-Pain medications will be prescribed and given based upon the intensity of the pain as follows using the verbal descriptive, numerical scale (1-10) or Wong-Baker FACES Scale...No-Interviewable Resident-Pain medications will be prescribed and given based upon nursing assessment of the following...6. Physician orders for pain medication will be prescribed based upon the resident's intensity of pain, for example: Tylenol for mild to moderate pain, Vicodin for severe to very severe pain. 7. Residents receiving routine pain medication should be assessed each shift by the charge nursing during rounds and/or medication pass...9. Additional information including, but not limited to reasons for administration, and effectiveness of pain medication will be documented on the Medication Administration (MAR), or on the facility specific pain management flow sheet...."<br><br>3.1-48(a)(3) | | | |
| F 0759<br>SS=D<br>Bldg. 00 | 483.45(f)(1)<br>Free of Medication Error Rts 5 Prcnt or More<br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% based on medication errors observed during 2 of 29 opportunities for errors resulting in a medication error rate of 6.9% (Resident 45).<br><br>Findings include:<br><br>During an observation, on 8/16/22 at 10:06 a.m., Licensed Practical Nurse (LPN) 21 administered | F 0759 | **F759 Free of Medication Error**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**1. Resident 45 remains in the facility and has had no change s in condition from medication administration.**How will you identify other residents having the potential to be** | 09/23/2022 |

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| | buspirone (an antianxiety medication) 10 milligrams (mg) and gabapentin (a medication for nerve pain) 300 mg by mouth to Resident 45.<br><br>Resident 45's record was reviewed on 8/19/22 at 2:57 p.m. A physician's order, dated 6/27/22, indicated gabapentin 300 mg by mouth three times daily.<br><br>A physician's order, dated 6/28/22, indicated buspirone 10 mg by mouth three times daily.<br><br>A medication administration record (MAR), dated August 2022, indicated the buspirone and gabapentin were scheduled for administration at 8:00 a.m., 2:00 p.m., and 8:00 p.m.<br><br>During an interview, on 8/19/22 at 2:48 p.m., the Director of Nursing (DON) indicated if a medication was scheduled at a specific time it should have been administered an hour before or an hour after the scheduled administration time.<br><br>On 8/22/22 at 8:50 p.m., the DON provided a document titled, "Medication Administration Times," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...2. Facility should commence medication administration within sixty (60) minutes before the designated times of administration and should be completed by sixty (60) minutes after the designated times of administration...."<br><br>3.1-25(b)(9) | | **affected by the same deficient practice and what corrective action will be taken?**1. All facility residents receiving medication could be impacted.2. In-servicing of nursing staff on medication administration times and medication scheduling.**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**1. In-servicing/re-educating of nursing staff on medication administration times and medication scheduling.**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?**1. QAPI, Medication Administration skills validation will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance. | |
| F 0761 SS=D Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility | | | |

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| | must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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.<br><br>§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.<br>Based on observation, record review, and interview, the facility failed to ensure injectable diabetic medications were dated when opened for 2 of 2 medication carts reviewed (Resident 45).<br><br>Findings include:<br><br>During an observation, on 8/16/22 at 10:06 a.m., Licensed Practical Nurse (LPN) 21 administered Victoza (a non-insulin, injectable medication to treat diabetes) 0.6 milligrams (mg) subcutaneous (SQ) to Resident 45. The Victoza pen and packaging lacked documentation of a date the medication was opened. At the same time, LPN 21 indicated there should have been an opened date | F 0761 | **F761 Medication StorageWhat corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**1. Resident 45 remains in the facility and has had no change in condition from medication administration. The identified insulin pen was immediately dated.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be** | 09/23/2022 |

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| | on the Victoza.<br><br>During an observation of the 100 hall medication cart, on 8/19/22 at 2:21 p.m., with Qualified Medication Aide (QMA) 23 an insulin glargine kwikpen was observed with no opened date. The date of arrival on the package was 7/25/22.<br><br>During an interview, on 8/19/22 at 2:50 p.m., the Director of Nursing (DON) indicated insulin pens should have opened dates.<br><br>On 8/22/22 at 8:50 a.m., the DON provided a document titled, "General Dose Preparation and Medication Administration," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...3.11: Facility staff should enter the date opened on the label of medications with shortened expiration dates (e.g. insulins....)"<br><br>3.1-25(k)(6) | | **taken?**1. All facility residents receiving medication could be impacted.2. In-servicing of nursing staff on proper medication storage being completed.**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**1. In-servicing/re-educating of nursing staff on proper medication storage being completed.**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?**1. QAPI audit tool, Medication Storage, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance. | |
| F 0804 SS=E Bldg. 00 | 483.60(d)(1)(2)<br>Nutritive Value/Appear, Palatable/Prefer Temp<br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; | | | |

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|---|---|---|---|
| | 155776 | A. BUILDING 00<br>B. WING | 08/23/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| SPRINGHILL VILLAGE | 1001 E SPRINGHILL DR<br>TERRE HAUTE, IN 47802 |

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| | §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on interview, observation, and record review, the facility failed to ensure the temperature and palatability of food served for 1 of 1 test tray reviewed for temperature and palatability (Residents 59, 47, and 27).<br><br>Findings include:<br><br>During an interview, on 8/15/22 at 10:24 a.m., Resident 59 indicated she ate meals in the dining room and the food, at times, was not good and was cold.<br><br>During an interview, on 8/15/22 at 10:36 a.m., Resident 47 indicated she ate meals in her room and the food was often cold, when her meal came to her room.<br><br>During an interview, on 8/15/22 at 11:21 a.m., Resident 27 indicated she ate meals in her room. The food was "lousy," their combinations were not good, and often the food temperatures were not good.<br><br>On 8/18/22 at 12:01 p.m., the Activity Director (AD) provided 4 months of Resident Council meeting minutes. The minutes from the 7/11/22 meeting indicated the food did not look nor taste good and the temperature of the food was not appropriate. The minutes from the 7/26/22 Resident Council meeting indicated the temperature of the food was not appropriate. The Executive Director (ED) had responded on the minutes and indicated a memo was sent out to staff to close the cart door between tray service. | F 0804 | **F804 Nutritive Value/Palatable**<br>**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**1. Resident 59 and 47 are being asked routinely if their food is satisfactory ie..does it need heated, replaced? Resident 27 no longer resides resides in the facility.**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**1. All facility residents could be impacted.2. In-servicing of nursing staff on meal service and the expectations for heating or exchanging the meal if deemed unsatisfactory by the resident.**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**1. In-servicing/re-educating of nursing staff on meal service and the expectations for heating or exchanging the meal if deemed unsatisfactory by the resident.**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** | 09/23/2022 |

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| | The trays leave the kitchen hot and are cooling off during service. Meals served in the dining room would be served hot right off the serving line. Everyone was welcome to come to the dining room to eat. The 8/8/22 Resident Council minutes indicated the food looked fine but tasted terrible and was not the appropriate temperature. The ED had responded on the minutes and indicated had been reviewing with hall staff to keep food cart door closed between trays as much as possible.<br><br>During an interview, on 8/22/22 at 10:48 a.m., Dietary Manager (DM) indicated food temperatures would be taken when food came out of the oven, after being placed onto the steam table, and prior to being plated. Hall trays would be placed into the hall carts and covered with insulated lids and heated bases.<br><br>During a random kitchen observation, on 8//22/22 at 11:04 a.m., food temperatures were taken after placement onto the steam table. The chicken patties temperatures measured at 155 degrees Fahrenheit and the sweet potatoes temperatures measured at 160 degrees Fahrenheit.<br><br>On 8/22/22 at 12:39 p.m., test tray food temperatures were measured by the DM. The chicken patty temperature measured at 116 degrees Fahrenheit and the sweet potatoes temperature measured at 117 degrees Fahrenheit. DM indicated the food temperatures should be between 115 degrees Fahrenheit to 140 degrees Fahrenheit.<br><br>On 8/22/22 at 3:08 p.m., DM provided an email correspondence document, dated 8/22/22, between herself and the Sr. Regional Dietician, which indicated, "...Hey guys have a question. Where is or do, we have a policy on what temp | | **into place?**1. QAPI audit tool, Meal Preferences, will be utilized to ensure compliance weekly for one month and monthly for four months. Following this time frame and review the QAPI team will re-evaluate the continued need for the audit tool. If 100% accuracy is not achieved an Action Plan will be developed. Executive Director to monitor for compliance. | |

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| | the food can or should be for hall trays/after leaves the kitchen? Like a test tray ...of the end of the hall...." The Sr. Regional Dietician had responded, "...Hi there! There is no set temperature other than "palatable" which is determined by the resident eating the food. The food needs to be at hot and cold holding temps before leaving tray line...."<br><br>On 8/22/22 at 3:30 p.m., the DM provided and identified a document as a current facility policy, titled "Food Temperatures," dated 06/21. The policy indicated, "...Procedure: ...Hot food will be held at or above 135 degrees Fahrenheit. If the minimum temperature requirements are not maintained, food will need to be reheated to a minimum of 165 degrees Fahrenheit before serving...."<br><br>3.1-21(a)(2) | | | |