STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155809	A. BUILDING 00 B. WING	10/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREY STONE HEALTH & REHABILITATION CENTER	10445 DUPONT OAKS BLVD FORT WAYNE, IN 46845

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00391224. Survey dates: October 3, 4, 5, 6 and 7, 2022 Facility number: 012935 Provider number: 155809 AIM number: 201207690 Census Bed Type: SNF: 16 SNF/NF: 71 Total: 87 Census Payor Type: Medicare: 5 Medicaid: 65 Private: 11 Other: 6 Total: 87 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 11, 2022	F 0000	To whom it may concern, Grey Stone Health and Rehabilitation, CMS Certification Number **155809** has received the 2567 in regards to the Recertification and State Licensure Survey. Enclosed is our Plan of Correction for all of the deficiencies we received during our Survey process. We ask that our Plan of Correction be reviewed and accepted as we strive to continue operating in compliance with CMS. We are further requesting a swift resolution in our deficiencies as we seek Desk Review for compliance. Thank you for your consideration in this matter. Sincerely, Eric Hunter, Administrator	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.			

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

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

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	§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on observation, interview, and record review, the facility failed to ensure 1 of 1 resident reviewed was able to get out of bed when requested. (Resident 68). Findings include: During an observation on 10/4/22 at 9:29 AM, Resident 68 was observed lying in bed watching television. Resident 68 indicated that she wanted to attend facility activities including church services, bingo, and exercise programs. She indicated that two staff were needed to assist her to a wheelchair because she uses a mechanical lift. She indicated that staff was not always available to help her get up in time for activities.	F 0561	1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? ***Resident 68 will be informed of each residents' rights including but not limited to: the right to choose schedules and activities, the right to make aspects of her life in the facility, and the right to interact with other members of the community. This information with be given verbally as well as a document to be given to the resident. This will be completed by the Activity Director by 10/19/22.***	10/25/2022

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	During an observation on 10/5/22 at 2:25 PM, Resident 68 was lying in bed watching television. She indicated she had not been out of bed all day. During an observation on 10/6/22 at 4:16 PM, Resident 68 was lying in bed using an activity book. She indicated she had not been out of bed all day. During an observation on 10/7/22 at 11:14 AM, Resident 68 indicated she had not been assisted out of bed yet and indicated she wanted to go to activities. During an interview conducted with Activity Aide 13 on 10/7/22 at 9:49 AM, Activity Aide 13 indicated Resident 68 enjoys the group activities that she attends, but she is frequently in bed and not available to go to many group activities. Activity Aide 13 provided activity logs and indicated the last group activity recorded as attended by Resident 68 occurred on 9/5/22. During an interview on 10/7/22 at 11:18 AM Certified Nursing Assistant (CNA) 15 indicated assisting residents to transfer out of bed was part of daily care. CNA 15 indicated any refusals are reported to the nurse. During an interview on 10/7/22 at 11:21 AM Licensed Practical Nurse (LPN) 14 indicated when she was informed of a refusal, she would wait for 30 to 45 minutes and reapproach the resident. If the resident continued to refuse, she offered an alternative activity. LPN 14 indicated refusals and alternative approaches should be documented. A record review conducted on 10/7/22 at 10:23 AM indicated Resident 68 had diagnoses		***Staffing will be educated on each residents' rights to ensure Residents right are observed, honored, and protected. This education will be completed by the Staff Development Coordinator by 10/25/22.*** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? ***All current residents has to potential to be affected as other residents have equal rights. A Resident Council meeting will be held on 10/19/22 to inform all residents of their rights. Resident who did not participate in Resident Council will be informed in smaller groups, or in room to room. This will be completed by the Activity Director by 10/19/22.*** 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ***Daily room rounds will be completed by a member of leadership and/or designee. During rounds, each and every resident will be advised of their rights while given the option to attend activities and/or interact with the facility and/or community. In addition, follow up will be conducted with all***	

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	including paraplegia, unspecified, major depressive disorder, and morbid (severe) obesity due to excess calories. A Minimum Data Set (MDS) dated 8/24/22 indicated Resident 68 was alert and oriented. A facility census form with interviewable residents received on 10/3/22 from the Nurse Consultant identified Resident 68 as interviewable. Tracking forms titled tasks-ADL (activity of daily living) transfers indicated from 10/3/22 to 10/7/22 "not applicable" was checked. A care plan dated 7/6/21 indicated Resident 68 needed assistance with activities of daily living, including hygiene tasks. The care plan did not indicate any preference of staying in bed or any pattern of refusal to transfer out of bed. A progress note dated 9/29/22 indicated the care plan was reviewed by the Interdisciplinary Team and had no new changes. No notes indicating refusal to get up were available for review. 3.1-3(u)(1)		***residents to ensure their rights were honored. All responses and follow up will be documented on the residents' rounds records, and records will be kept in a binder dedicated to the daily rounds. Resident's participation, and/or lack thereof will also be documented via Care Plan. Daily room rounds procedure will be updated and education will be completed by the Administrator and ongoing daily beginning 10/19/22.*** 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ***An audit will be created where three (3) random residents are selected each week beginning on Monday 10/24/22, where they will be asked if they were aware of their rights as residents, if they were given the opportunity to exercise their rights, and if their preferences were honored. Each selected resident will be documented on and acted upon based on the findings. The audit tool will be updated weekly each Monday for the next six months. The Administrator/designee will ensure the Audit's completion through the duration of the audit.***	

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F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure nail care was provided for 4 of 4 residents reviewed. (Resident 28, Resident 34, Resident 38, and Resident 68). Findings include: 1.During an observation conducted on 10/3/22 at 10:06 AM, Resident 28 was observed lying on his bed with bare feet. His toenails were excessively long and thick with visible cracks and rough edges. When asked if he preferred not to wear socks and shoes, Resident 28 indicated his toenails caught on his socks and made them difficult to wear. During an observation conducted on 10/3/22 at 10:11 AM with Registered Nurse (RN) 8, RN 8 indicated due to the excessive length and thickness of Resident 28's nails, he needed to be treated by a podiatrist. She indicated she did not know why the resident had not had his feet cared for by a Podiatrist. A record review conducted on 10/5/22 at 10:17 AM indicated Resident 28 had diagnoses including uncontrolled diabetes type 2, hypertension, and hyperlipidemia. A Minimum Data Set (MDS) dated 7/25/22 indicated Resident 28 was cognitively impaired. No records of podiatry visits were available for	F 0677	1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? ***Residents 28, 34, 38, and 68 will have their ADL Care assessed, including but not limited to nail care. ADL care will be completed and will be in compliance and verified by the Assisted Director of Nursing. This documented completion was verified on 10/6/22 by the Administrator.*** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? ***All residents who are dependent with ADL Care have the opportunity to be affected. The IDT Team will identify all residents who are dependent with ADL Care (including but not limited to nail care), and will then complete ADL care if not completed prior to identification. All ADL care will be completed and will be in compliance and verified by the Assisted Director of Nursing.***	10/25/2022

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	review. No notes indicating refusal of nail care were available for review. A care plan dated 7/26/22 indicated Resident 28 had a self-care deficit related to impaired mobility, diabetes mellitus and dementia. The care plan indicated staff should assist him with completion of activities of daily living. 2. During an observation conducted on 10/4/22 at 10:58 AM, Resident 34 was observed with long, jagged fingernails. Nails were of varying lengths with dark brown debris observed under the nails. During an interview conducted on 10/4/22 at 10:58 AM, Certified Nursing Assistant (CNA) 9 indicated nails should be checked, cleaned, and trimmed on shower days. She did not know why his nails had not been trimmed. During an observation on 10/5/22 at 10:37 AM, Resident 34's nails remained of varying lengths and jagged. Brown matter was observed under the nails. A record review conducted on 10/5/22 at 10:37 AM indicated Resident 34 had diagnoses including hemiplegia/hemiparesis affecting dominant side related to cerebral vascular accident and dementia. A Minimum Data Set (MDS) dated 8/13/22 indicated resident 34 was cognitively impaired and unable to be interviewed. A care plan dated 8/15/21 indicated Resident 34 had a self-care deficit related to dementia and hemiplegia/hemiparesis affecting his dominant		***These actions were completed on 10/7/22.*** 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ***Daily room rounds will be completed by a member of leadership and/or designee. During rounds, each and every resident will be have their ADL care observed, whether independent or dependent. Resident not in compliance and dependent with ADL Care will have each ADL Care concern addressed each day. All observations and follow up will be documented on the residents' rounds records, and records will be kept in a binder dedicated to the daily rounds. Daily room rounds procedure will be updated and education will be completed by the Administrator and ongoing daily beginning 10/19/22.*** 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ***An audit will be created where three (5) random residents are selected for ADL Care observation each week beginning on Monday 10/24/22. This Audit will be conducted by a Clinical non***	

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	side. The care plan indicated hygiene assistance should be provided as needed. No records indicating nail care refusals were available for review. 3. During an observation conducted on 10/3/22 at 10:11 AM, Resident 38 had long, jagged fingernails of varying lengths. Brown matter was observed under the fingernails. An interview conducted with Director of Nursing (DON) on 10/4/22 at 8:49 AM indicated she was unaware the nails had not been cut and indicated she would provide the care. The DON indicated nail care was a part of routine care and nails should be checked, cleaned, and trimmed by nursing staff. A record review conducted on 10/4/22 at 3:29 PM indicated Resident 38 had diagnoses including primary generalized arthritis, anxiety, and Alzheimer's disease. A Minimum Data Set (MDS) dated 8/15/22 indicated Resident 38 was cognitively impaired. A care plan dated 8/12/22 indicated Resident 38 had a self-care deficit related to impaired mobility, weakness, osteoarthritis, and Alzheimer's. The care plan indicated she should receive assistance with activities of daily living. No notes indicating refusal of nail care were available for review. 4. During an observation conducted on 10/7/22 at 10:11 AM, Resident 68's fingernails were of varying lengths, with some about an inch beyond the nailbed. Brown matter was observed underneath the nails. Grey, chipped nail polish		***member of the Leadership team. Each observation will be documented and acted upon based on the findings. The audit tool will be updated weekly each Monday for the next six months. The Administrator/designee will ensure the Audit's completion through the duration of the audit.***	

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	was observed on part of each nail, with no polish on new growth portion of the nail, encompassing about one half inch from the base of the nail. An interview with Resident 68 conducted on 10/7/22 at 10:11 AM indicated she is unable to perform her own nail care and had not had her nails done in a long time. A record review conducted on 10/7/22 at 10:23 AM indicated Resident 68 had diagnoses including paraplegia, unspecified, major depressive disorder, and morbid (severe) obesity due to excess calories. A Minimum Data Set (MDS) dated 8/24/22 indicated Resident 68 was alert and oriented. Resident 68 had her nails done by activity staff on 9/7/22. No further nailcare records were available for review. A care plan dated 7/6/21 indicated Resident 68 had a self-care deficit related to dementia and impaired mobility. The care plan indicated Resident 68 needed assistance with activities of daily living, including hygiene tasks. No notes indicating refusal of nail care were available for review. A policy titled Morning Care/AM Care dated 9/1/22 indicated fingernail care should be provided during am care. Toenail care was not addressed in the policy. No further policies were received by the time of exit. 3.1-38(a)(3)			
F 0684 SS=D	483.25 Quality of Care			

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Bldg. 00	§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed ensure a cervical collar was applied correctly for 1 of 1 resident reviewed. (Resident 57). Findings include: During an observation conducted on 10/4/22 at 11:53 AM, Resident 57 was observed sitting in a reclining wheelchair in the dining area. Resident 57's nose was resting on the chin plate of the cervical collar. During an interview with Licensed Practical Nurse (LPN) 6, conducted on 10/4/22 at 11:53 AM, LPN 6 indicated she did not know who applied the cervical collar in the morning, but it was not applied correctly. LPN 6 indicated Resident 57's chin should rest on the chin plate. During an observation conducted on 10/6/22 at 11:05 AM, Resident 57 was observed with her bottom lip resting on the chin plate and her chin inside the collar. During an observation conducted on 10/6/22 at 12:28 PM, Resident 57 was observed with her chin inside the collar and her lips were not visible.	F 0684	1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? ***Resident 57 will have all treatment and care in accordance with professional standards of practice, including but not limited to: the correct application of their cervical collar. This practice was completed by the Registered Nurse on duty on 10/7/22.*** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? ***All residents who have cervical collars have the potential to be affected. All residents with cervical collars were assessed and the collars were in accordance with professional standards of practice on 10/7/22.*** 3. What measures will be put into place and what systemic changes will be made to ensure	10/25/2022

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	A record review conducted on 10/4/22 at 12:20 PM indicated Resident 57 had diagnoses including unspecified dementia, hemiplegia and hemiparesis following cerebral infarction affecting dominant side, and nondisplaced fracture of the fifth cervical vertebra, sequela. A Minimum Data Set (MDS) dated 8/7/22 indicated Resident 57 was cognitively impaired and unable to be interviewed. An order dated 7/28/22 indicated a cervical collar should be applied as the resident allowed. The cervical collar was not addressed on the care plan. No records indicating refusals of cervical collar care were available for review. An in-service record dated 7/26/22 included a document titled How to Use the Aspen Cervical Collar, 2019 by University Health Network. The document provided detailed instructions on applying the cervical collar, including ensuring the collar sits under the chin and supports the jawbone. It indicated the chin should not slip down into the collar. No facility policy specific to cervical collar application was available for review. 3.1-37		that the deficient practice does not recur? ***All Nursing staff will be educated by the Staff Development Coordinator on cervical collar application and treatment. The education will be accompanied with an online video, https://youtu.be/jqxv4L9CZbq . All Nurses will be educated by 10/21/22.*** 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ***The DON/designee will assess every resident with an order for a cervical collar to ensure placement is in accordance with professional standards. This assessment will take place 3 times a week for four weeks, and then weekly for the next 5 months. All findings will be documented in an Audit binder. The Administrator will ensure the binders are filled out it their entirety. This will begin on 10/19/22.***	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience			

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	reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, assessment and record review, the facility failed to ensure range of motion was maintained for 1 of 2 residents reviewed. (Resident 38). Findings include: During an observation conducted on 10/3/22 at 11:04 AM, Resident 38 was seated in her wheelchair with deformation and limited range of motion in both hands. Both hands were in a fist position with thumbs extended. No splints, braces, or other assistive devices were observed. Resident 38 was unable to open either hand more than one inch when asked. During an observation conducted on 10/6/22 at 11:19 AM, Resident 38 was observed lying in bed. Assistant Director of Nursing (ADON) 10 partially extended Resident 38's fingers. Fingers were extended with very little flexibility, and the lower joints of each hand had less than 90- degree range of motion.	F 0688	1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? ***Resident 38 has been picked up by Restorative Therapy Services to receive range appropriate treatment and service to ensure they do not experience reduction in range of motion. This practice was completed by the Director of Rehab on 10/11/22.*** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? ***Current residents who have limited range of motion will be assessed by the DON/Director of Rehab/designee. All devices and/or Restorative Services***	10/25/2022

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	A record review conducted at 3:29 PM on 10/4/22 included a Minimum Data Set (MDS) dated 8/15/22. The MDS indicated she was cognitively impaired and unable to be interviewed. The MDS indicated Resident 38 had diagnoses including primary generalized osteoarthritis and Alzheimer's disease. Occupational Therapy notes dated 8/12/22 indicated Resident 38 had impaired range of motion in both hands. An interview with Occupational Therapist (OT) 11 on 10/ 6/22 at 2:25 PM indicated splints are not indicated because Resident 38 was able to use her hands, but she should have been receiving gentle range of motion exercises to prevent range of motion from worsening. A care plan dated 8/12/22 did not address any interventions for range of motion management. A Kardex (form used to indicate care needs for Certified Nursing Assistant staff) dated 10/4/22 did not address range of motion management. A current policy, dated 10/12, titled Range of Motion, Active and Passive indicated a range of motion program should be used to prevent any further loss of range of motion in a joint that is limited or contracted. 3.1-42(a)(2)		***recommended to increase or limit a decrease in range of motion will be applied as recommended. This practice was completed by the IDT Team on 10/18/22.*** 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ***The Rehabilitation Department, Nursing, Restorative, and the MDS Coordinators will work together in unison to ensure all opportunities for range of motion on all residents where applicable will be maintained. These disciplines will meet weekly to discuss maintenance and opportunity. And changes and observed opportunities will be added to the Resident's Care Plan and Kardex. Current staff and new hires upon orientation will be educated by the Staff Development Coordinator/Designee on device usage, Restorative therapy, and following orders and recommendations from the rehab department beginning on 10/19/22.*** 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ***The***	

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			DON/designee will assess five (5) current residents with limited Range of Motion to ensure they receive appropriate treatment and service and they do not experience reduction in Range of Motion. The audit will be created to also monitor Restorative Services and/or adaptive devices. This Audit will be updated weekly for the next 6 months.	
F 0757 SS=E Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 0757	1. What corrective action will	10/25/2022

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	Based on record review and interview, the facility failed to ensure medication side effects were monitored for 5 of 5 residents reviewed for opioid/opiate medications. (Residents 14, Resident 32, Resident 46, Resident 67, and Resident 71). Findings include: 1. On 10/4/22 at 10:13 AM, Resident 14's record was reviewed.The resident's diagnoses included accidental poisoning by 4-aminophenol, cervical radiculopathy, pain in left elbow and arm, and uncomplicated opioid dependence. A physician order dated 9/7/22 indicated the resident was to be administered 7.5-325mg Percocet tablet every 6 hours for pain. There was no order to monitor for the side effects of Percocet. Resident 14's comprehensive Minimum Data Set (MDS) assessment, dated 6/28/22, was reviewed. The MDS indicated his Brief Interview for Mental Status (BIMS) score was 12, he was alert, oriented and could understand and be understood. A review of the resident's current care plan, last reviewed 7/21/22, indicated he was at risk for side effects from opiate therapy with a goal to have no side effects through the next review of 12/27/22. Interventions for this risk included: administer medications as ordered, monitor side effects, and review medications for gradual dose reduction. A review of Resident 14's MAR, dated 9/7/22 through 10/4/22, indicated the resident was administered a 7.5-325mg Percocet tablet by mouth every 6 hours for pain. Resident 14's antidepressant medications were monitored for		be accomplished by those residents found to have been affected by the deficient practice? ***Residents 14, 32, 46, 67, and 71 will have their physicians orders followed to track the side effects of the Opioid medications. Medications will not be in excessive duration, excessive dosage, without adequate monitoring, without adequate indications for use, or in indications of discontinuation or reduction. The Staff Development Coordinator added Opioids to the process of monitoring side effects of and Nurses are now required to sign out if there are any side effects. The practice began in 10/14/22.*** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? ***All Residents with Opioid medications have the potential to be affected by this deficient practice. Therefore all Residents receiving Opioid medication will be monitored for its side effects, and Nursing will sign out any side effects. This practice began on 10/14/22.*** 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not	

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	side effects. The MAR did not indicate the resident was being monitored for side effects of Percocet. 2. On 10/3/22 at 4:06 PM, Resident 71's record was reviewed. The resident's diagnoses included a closed fracture of the neck of left femur, wound of left great toe, artificial opening of gastrointestinal tract, adult failure to thrive, diabetes mellitus type 2, severe protein-calorie malnutrition, chronic obstructive pulmonary disease, and hepatitis. A physician order dated 9/14/22 indicated the resident was to be administered 5mg oxycodone HCl tablet every 6 hours as needed for mild to moderate pain. There was no order to monitor for side effects of oxycodone HCl. Resident 71's quarterly MDS assessment, dated 8/25/22, was reviewed. The MDS indicated her BIMS score was 6, she was alert, oriented to self, and could understand and be understood. A review of the resident's current care plan, last reviewed 7/15/22, indicated she was at risk for potential pain related to left quadrant pain, open wound of great toe and fracture of neck of left femur. Her care plan made no reference to opioid side effect monitoring. A review of Resident 71's MAR, dated 9/7/22 through 10/4/22, indicated the resident was administered a 5mg oxycodone HCl tablet every 6 hours as needed for mild to moderate pain on twelve occassions. The MAR did not indicate the resident was being monitored for side effects of oxycodone HCL. 3. On 10/5/22 at 10:15 AM, Resident 32's record was reviewed. The resident diagnoses included		recur? ***The charting in the Medication Administration Record will include side effects for Opioid medications which will have to be documented before closing each record. Staff Development Coordinator will educate current Nursing staff and new hires upon orientation on documenting the side effects of Opioids in the electronic medical record. Education will be completed by 10/21/22, and will be ongoing for new hires.*** 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ***The DON/designee will audit five (5) residents who receive Opioid medications for side effects. The DON/designee will also ensure Nursing the tracking and documenting Opioid side effects accurately. The Audit finding will be recorded on an Audit from weekly for the next 6 months.***	

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	diabetes, end stage renal disease, dependence on dialysis, atrial fibrillation and low back pain. A physician order dated 8/10/22 indicated the resident was to be administered hydrocodone-acetaminophen 5-325 milligrams (mg) every 12 hours as needed for pain. There was no order to monitor for side effects of hydrocodone. . A comprehensive MDS assessment dated 8/2/22 indicated the resident had no cognitive deficit and required extensive staff assistance for activities of daily living. The MAR for 9/2022 indicated the resident received hydrocodone-acetaminophen on 9/2/22 and 9/16/22. The MAR did not indicate the resident was being monitored for side effects of hydrocodone. 4. On 10/5/22 at 10:00 AM, Resident 46's record was reviewed. The resident's diagnoses included chronic kidney disease, diabetes, and chronic pain syndrome. A physician order dated 6/11/22 indicated the resident was to be administered tramadol 50 mg every 24 hours as needed for chronic pain syndrome. There was no order to monitor for side effects of tramadol. A physician order dated 8/14/22 indicated the resident was to be administered methadone hydrochloride 10 mg 3 times a day for chronic pain syndrome. There was no order to monitor for side effects of methadone hydrochloride. A quarterly MDS assessment dated 8/9/22 indicated the resident was severely cognitively			

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	impaired and required extensive staff assistance for activities of daily living. A MAR for 9/2022 indicated the resident was administered methadone hydrochloride 3 times a day every day for the month of September. The MAR did not indicate the resident was being monitored for side effects of methadone hydrochloride. 5. On 10/4/22 at 12:13 PM, Resident 67's record was reviewed. The resident's diagnoses included diabetes, end stage renal disease, stroke, and dependence on dialysis. A physician order dated 6/28/22 indicated the resident was to be administered oxycodone-acetaminophen 7.5-325 mg 5 times a day for pain management. A physician order dated 3/15/22 indicated the resident was to be administered buprenorphine 30 micrograms per hour via transdermal patch every week. The physician's orders did not indicate the resident was to be monitored for opioid side effects. A quarterly MDS assessment dated 8/24/22 indicated the resident had no cognitive deficit and required minimal staff assistance for activities of daily living. A MAR for the month of 8/2022 indicated the resident was administered buprenorphine 30 micrograms per hour via transdermal patch every week. The MAR for 8/22 indicated the resident was administered oxycodone-acetaminophen 7.5-325 mg 5 times a day.			

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	The MAR for 8/2022 did not indicate the resident was to be monitored for side effects of opioids. During an interview with LPN 10 on 10/7/22 at 11:40 am, she indicated was not aware the facility was required to monitor for side effects of opioids that were managed by a pain specialist. During an interview with the Nurse Consultant on 10/6/22 at 9:37 am she indicated the resident should have been monitored for side effects of opioid medications. She indicated side effects of opioid medications could include sedation, increased falls, and constipation. On 10/6/22 at 11:30 AM, a current policy titled "Pain Management Protocol," revised 8/25/21, provided by the Nurse Consultant, indicated the purpose of the policy was to ensure residents admitted with pain or potential pain reach or maintain his/her highest practicable level of physical, mental and psychosocial well-being. The policy indicated documentation of the administration of medication and the response of the medication would be documented in the electronic medication admistration record (eMAR). On 10/6/22 at 11:30 AM, a "Pain Decision Tree," date unknown, provided by the Nurse Consultant, indicated pain management prototol should be re-evaluated if the resident's pain relief goal was not met. The Pain Decision Tree did not reference monitoring the side effect of opioids. 3.1-48(a)(3)			
F 0812 SS=D	483.60(i)(1)(2) Food			

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Bldg. 00	Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review the facility failed to ensure proper hand hygiene was performed while serving residents beverages in 1 of 2 observations in dining room. Findings include During an observation on 10/6/22 at 12:09 PM, LPN 10 wiped her hands on her pants on three occasions and adjusted her surgical mask while passing out beverages to the residents in the main dining room. LPN 10 did not perform hand hygiene between touching her pants/mask and touching the clean cup. In an interview on 10/5/22 at 2:36 PM, LPN 10	F 0812	1. What corrective action will be accomplished by those residents found to have been affected by the deficient practice? ***LPN 10 will be educated on hand hygiene when passing drinks and/or food in the Dining Room. This education was completed 10/17/22.*** 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? ***All residents have the potential to be affected as all residents have food and***	10/25/2022

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	indicated she unaware of a policy related to dining room hand hygiene. In an interview on 10/6/22 at 4:06 PM, the nurse consultant indicated staff should touch the outer surface of the cup and not touch any other surface including the resident or themselves without hand hygiene. On 10/7/22 at 10:30 AM, a current policy titled " Handwashing in the Kitchen, " last revised 3/6/20, provided by the nurse consultant, indicated when staff engaged in any activity that contaminate their hands, they should perform hand hygiene. 3.1-21(i)(1) -(2)		***drinks delivered to them, so all Staff will be educated on Hand Hygiene. All Staff will be educated by 10/21/22.*** 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ***LPN 10 will be given a course to complete regarding hand hygiene and passing drinks and trays of food in the dining room. All staff will be educated as well on all aspects of hygiene including dining room service. Leadership will provide meal management each meal to oversee and also assist to ensure practices are followed in compliance.*** 4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? ***The Administrator will monitor two (2) meals each week to ensure and hand hygiene and food handling practices are in compliance and that Leadership is assisting. A record of each monitoring event will be documented in and Audit tool and will be updated for the next six (6) months.***	