STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155217	A. BUILDING 00 B. WING	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF HUNTINGBURG, THE	1712 LELAND DR HUNTINGBURG, IN 47542

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00442764 and IN00443360. Complaint IN00442764-Federal/State deficiencies related to the allegations are cited at F684, F686, F689, F760, F761. Complaint IN00443360- Federal/State deficiencies related to the allegations are cited at F880. Survey dates: September 24, 25, 26, 27, 30, October 1, 2024 Facility number: 000122 Provider number: 155217 AIM number: 100290560 Census Bed Type: SNF/NF: 49 Total: 49 Census Payor Type: Medicare: 1 Medicaid: 38 Other: 10 Total: 49 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review October 11, 2024.	F 0000	Preparation or execution of this Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusion set forth on the Statement of Deficiencies. The Plan of Correction is prepared as the position and executed solely because it is required by the position of Federal and State Law. The Plan of correction is submitted in order to respond to the allegation of noncompliance cited during an Annual Survey. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0580 SS=E	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rebecca Brown	Administrator	10/25/2024

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

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Bldg. 00	Based on observation, interview, and record review, the facility failed to notify the physician in regard to a need to alter treatment for 2 of 5 residents reviewed for unnecessary medications. The physician was not notified of resident's elevated blood sugar readings and elevated weights. (Resident 30, Resident L, Resident J, Resident F) Findings include: 1. On 9/25/24 at 3:13 P.M., Resident 30's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), diabetes mellitus type II, atherosclerotic heart disease, hypertension (HTN), and edema. Resident 30 was admitted on 5/31/24. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 9/13/24, indicated Resident 30 was cognitively intact and supervision of staff with set up for bed mobility, transfers, toileting, was on a therapeutic diet, had a significant weight gain, and was given insulin. Physician's Orders included, but were not limited to, the following: Weekly Weight in the morning every Monday for edema, start date 7/17/2024 Daily weight in the morning related to edema. Notify provider of weight >3 lbs/24 hours(greater then 3 lbs in 24 hours), start date 9/18/24 Dexcom G7 Sensor (continuous glucose system), inject 1 device subcutaneously one time a day every 10 days related to diabetes mellitus type II. Replace sensor every 10 days. Resident has	F 0580	F580 It is the policy of this facility to notify the physician in regards to alter a treatment, elevated blood sugars and elevated weights what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The DON/Designee notified the physician of Resident 30's elevated blood sugars and elevated weights on 10/4/2024 The DON Designee notified the physician of Resident L's elevated blood sugars on 10/4/2024 and new order for blood sugar parameters obtained. The DON/Designee notified the physician of Resident J's of stool culture not obtained as ordered on 10/4/2024, and order for stool culture discontinued. The DON/Designee notified the physician of Resident F's missed doses of Cefepime on 10/4/2024 and (add what he said here, new or no new orders). how other residents having the potential to be affected by the same deficient practice will be identified and what corrective	10/25/2024

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	receiver, start date 7/18/24 Lispro Insulin 100 units/ml (milliliter) solution, inject as per sliding scale: 0-100=0 unit, 101-150=1 unit, 151-200 =4 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, 401-450=22 units, subcutaneously three times a day, start date 6/9/24 and discontinued 7/17/24 Lispro Insulin 100 units/ml (milliliter) solution, inject as per sliding scale: 0-100=0 unit, 101-150=1 unit, 151-200 =4 units, 201-250=6 units, 251-300=10 units, 301-350=15 units, 351-400=20 units, 401-450=22 units, subcutaneously three times a day, start date 7/17/24 A current Diabetes Care Plan, dated 6/19/24, included, but was not limited to, the following interventions: Notify MD (Medical Doctor) as needed, initiated 6/19/24 A current Obesity/Nutritionally compromised Care Plan, dated 6/7/24, included, but was not limited to the following interventions: Monitor weight per facility protocol, initiated 6/7/24 The June 2024 MAR (Medication Administration Record) was reviewed for blood sugars from 6/6/24 through 6/30/24 and indicated the following: On 6/14/24 at 5:00 P.M., Resident 30's blood sugar was 513 mg/dL (milligrams per deciliter) and indicated to "see nurse's note". On 6/22/24 at 12:00 P.M., Resident 30's blood sugar was 450 mg/dL and indicated to "see nurse's note".		action(s) will be taken; The DON/Designee completed a 30 back look back of weights, blood sugars, orders for stool cultures and intravenous antibiotic orders for notification of physician for elevated weight and blood sugars, missed stool cultures and missed doses of Intravenous antibiotics on DATE, physician was notified of any concerns. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The DON/Designee in-serviced the nursing staff on Physician Notification and following physician orders on DATE. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The DON/Designee will audit residents with blood sugar monitoring for physician notification of elevated blood sugars 5 times a week x 4 weeks,	

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	The July 2024 MAR was reviewed for blood sugars from 7/18/24 through 7/31/24 and indicated the following: On 7/19/24, Resident 30 was out of the facility for her blood sugar reading at 12:00 P.M. At 5:00 P.M. that evening, her blood sugar was 450 mg/dL. On 7/21/24 at 12:00 P.M., Resident 30's blood sugar reading was 96 mg/dL and indicated to "see nurse's note". On 7/22/24, Resident 30 was out of the facility for her blood sugar reading at 12:00 P.M. At 5:00 P.M. that evening, her blood sugar was 302 mg/dL. The August 2024 MAR was reviewed for blood sugars from 8/1/24 through 8/31/24 and indicated the following: On 8/16/24 at 7:00 A.M., Resident 30's blood sugar reading was 458 mg/dL and indicated to "see nurse's note". On 8/26/24 at 5:00 P.M., MAR was blank. On 8/29/24 at 7:00 A.M., Resident 30's blood sugar reading was 540 mg/dL and indicated to "see nurse's note". On 8/29/24 at 12:00 P.M., Resident 30's blood sugar reading was 540 mg/dL and indicated to "see nurse's note". Resident 30's weights were reviewed from 5/31/24 through 9/25/24 and indicated the following: 5/31/24 2:36 P.M. 217.4 Lbs (pounds) 6/27/24 4:56 P.M. 256.0 Lbs (weight gain of 38.6 lbs) 7/1/24 2:12 P.M. 265.4 Lbs (weight gain of 9.4 lbs) 7/10/24 6:55 A.M. 263.0 Lbs (weight loss of 2.4 lbs) 7/11/24 5:30 A.M. 265.0 Lbs (weight gain of 2.0 lbs) 7/11/24 1:21 P.M. 266.0 Lbs (weight gain of 1.0 lbs)		then 3 times a week x 4 weeks, then once a week x 4 weeks, then once a month x 3 months. The DON/Designee will audit residents weights for elevated weights for physician notification 5 times a weeks x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 weeks, then once a month x 3 months. The DON/Designee will monitor for notification of physician for stool cultures that are unable to be obtained 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 weeks, then once a month x 3 months. The DON/Designee will audit for physician notification of any missed doses of intravenous antibiotics 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 weeks, then once a month x 3 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator	

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	7/12/24 10:26 A.M. 267.2 Lbs (weight gain of 1.2 lbs) 7/22/24 6:02 A.M. 273.4 Lbs (weight gain of 6.2 lbs) 7/25/24 10:28 A.M. 179.0 Lbs On 8/6/2024 2:07 P.M. noted "Incorrect Documentation" 8/5/24 1:09 P.M. 269.2 Lbs (weight loss of 4.2 lbs) 8/6/24 2:07 P.M. 272.6 Lbs (weight gain of 3.4 lbs) 8/6/24 2:07 P.M. 272.6 Lbs (weight gain of 3.4 lbs) 8/16/24 12:56 A.M. 278.0 Lbs (weight gain of 6.0 lbs) 8/19/24 9:44 A.M. 285.6 Lbs (weight gain of 7.6 lbs) 9/2/24 10:38 A.M. 313.8 Lbs (weight gain of 28.2 lbs) 9/9/24 11:09 A.M. 306.6 Lbs (weight loss of 7.2 lbs) 9/16/24 10:51 A.M. 340.6 Lbs (weight gain of 34 lbs) 9/18/24 10:02 A.M. 333.6 Lbs (weight loss of 7.0 lbs) 9/19/24 7:40 A.M. 334.0 Lbs (weight gain of 0.4 lbs) 9/20/24 7:54 A.M. 320.4 Lbs (weight loss of 13.6 lbs) 9/21/24 12:19 P.M. 317.6 Lbs (weight loss of 2.8 lbs) 9/22/24 9:04 A.M. 318.4 Lbs (weight gain of 0.8 lbs) 9/23/24 12:01 P.M. 317.6 Lbs (weight loss of 0.8 lbs) 9/24/24 8:53 A.M. 311.6 Lbs (weight loss of 6.0 lbs) 9/25/24 5:30 A.M. 318.4 Lbs (weight gain of 7.2 lbs) Progress notes for June 2024 were reviewed and lacked documentation in the nursing notes regarding the elevated blood sugars.		weekly until resolved. - by what date the systemic changes for each deficiency will be completed. 10/25/2024	

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	Progress notes for July 2024 were reviewed and lacked documentation about the resident's blood sugar and insulin administration while she was out of the facility and documentation in the nursing notes regarding the elevated blood sugars. There was no documentation noting weight change/error from 7/22/24 to 7/25/24 or from 7/25/24 to 8/5/24. Progress notes for August 2024 were reviewed and lacked documentation in the nursing notes regarding the elevated blood sugars. Progress notes for September 2024 were reviewed and lacked documentation of the physician being notified of weight changes 9/18/24, 9/20/24, 9/24/24, or 9/25/24. A Care Plan Meeting Note, dated 9/11/24, lacked documentation that significant weight gain and uncontrolled blood sugars were discussed. Recent lab results from 6/26/24 were reviewed indicated Resident 30 had an A1C blood test (tests the average of resident's blood sugars over the past 3 months) of 7.9% (greater than 6.5 is considered diabetic level). On 7/24/24, Resident had a fasting glucose (blood sugar) of 426 mg/dL (normal 65-99). There was a typed note on the bottom of the blood work results from (Name of Nurse Practitioner) indicating "BS [blood sugars] out of control ... remind me to look at next time I'm there. ", dated 7/27/24 The clinical record lacked documentation that the resident's diabetes care had any changes after 7/27/24. During an observation on 9/27/24 at 8:24 A.M., RN (Registered Nurse) 3 weighed Resident 30 on a sit down chair scale. The resident's buttocks was			

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	hanging over the armrests of the chair. The scale indicated she weighed 324.0 lbs. RN 3 indicated to the resident her weight went up since the previous day. At that time, RN 3 said ideally they should weigh residents before breakfast. She indicated Resident 30 was a diabetic and had excessive weight gain so they are watching her weight closely. During an interview on 9/30/24 at 10:17 A.M., the DON (Director of Nursing) indicated she was unsure who was putting in the orders and care plans prior to her employment (8/12/24), but for her insulin sliding scale should indicate to call the physician if blood sugars were over 450 mg/dL. She would expect staff to notify the physician of a blood sugar higher then 450 mg/dL. She indicated the resident's cognition was intact and she bought food, overate, and snacked on things that she shouldn't, which was her right, so it was hard for the dietician, physician, nurse practitioner, and staff to know if the weight fluctuations were due to medications, fluid retention, error in weighing resident, or another medical condition. She indicated they tried to educate Resident 30, but she was not making better decisions about what she ate or how much. Any communication or documentation done should be put in a nurse note in progress notes. During an interview on 9/30/24 at 3:14 P.M., the DON indicated they don't have a policy, but it would be their policy to follow orders and care plans. She indicated they did not have a policy for monitoring weights of residents, but they should be weighed before they have breakfast and if the weight gain or loss was significant, more than 3 lbs, the resident should be re-weighed and physician notified during that shift. 2. On 9/25/24 at 1:46 P.M., Resident L's clinical			

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	record was reviewed. Diagnoses included, but was not limited to, anxiety disorder and diabetes mellitus. The most recent State Optional and Quarterly MDS (Minimum Data Set) Assessment, dated 7/23/24, indicated Resident L had severe cognitive impairment and received insulin injections. Current Physician Order's included, but was not limited to: "...HumaLOG Injection Solution 100 UNIT/ML [milliliter] (Insulin Lispro) Inject as per sliding scale: if 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units, subcutaneously three times a day for Diabetes related to TYPE 2 DIABETES MELLITUS WITH OTHER SPECIFIED COMPLICATION...Do not give insulin before eating. Wait to administer insulin until after eating or at least 50% of the meal is consumed. AND Inject 5 unit subcutaneously three times a day related to TYPE 2 DIABETES MELLITUS WITH OTHER SPECIFIED COMPLICATION...Pharmacy Active 8/21/2024..." "...Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 23 unit subcutaneously in the evening for Hyperglycemia related to TYPE 2 DIABETES MELLITUS WITH OTHER SPECIFIED COMPLICATION...Pharmacy Active 8/21/2024..." "...Accu-check before meals and at bedtime four times a day...Active 7/15/2024..." Resident L's clinical record lacked current blood sugar parameters to notify the Physician. Resident L's current care plans included, but was			

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	not limited to, "...Diabetes with risk for Hypo/or Hyperglycemia..." with interventions to obtain blood sugars per the order and to notify the Physician as needed. Resident L's MAR (Medication Administration Record) was reviewed for August 2024 and September 2024 and lacked notification of high blood sugars to the Physician on the following dates and times: On August 1 at 7:00 A.M., Resident L's blood sugar was 450. On August 3 at 7:00 A.M., Resident L's blood sugar was 579. On August 5 at 7:00 A.M., Resident L's blood sugar was 405. On August 9 at 4:00 P.M., Resident L's blood sugar was 500. On August 9 at 8:00 P.M., Resident L's blood sugar was 500. On August 11 at 7:00 A.M., Resident L's blood sugar was 566. On August 10 at 11:00 A.M., Resident L's blood sugar was 494. On August 15 at 7:00 A.M., Resident L's blood sugar was 568. On August 15 at 11:00 A.M., Resident L's blood sugar was 439. On August 20 at 8:00 P.M., Resident L's blood sugar was 489. On August 21 at 7:00 A.M., Resident L's blood sugar was 501. On August 21 at 4:00 P.M., Resident L's blood sugar was 499. On August 23 at 4:00 P.M., Resident L's blood sugar was 501. On August 25 at 7:00 A.M., Resident L's blood sugar was 570. On August 30 at 4:00 P.M., Resident L's blood			

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	sugar was 548. On September 1 at 11:00 A.M., Resident L's blood sugar was 215. On September 2 at 4:00 P.M., Resident L's blood sugar was 476. On September 7 at 7:00 A.M., Resident L's blood sugar was 423. On September 8 at 4:00 P.M., Resident L's blood sugar was 541. On September 9 at 7:00 A.M., Resident L's blood sugar was 600. On September 9 at 4:00 P.M., Resident L's blood sugar was 405. On September 9 at 11:00 P.M., Resident L's blood sugar was 405. On September 10 at 11:00 A.M., Resident L's blood sugar was 499. On September 12 at 11:00 A.M., Resident L's blood sugar was 458. On September 13 at 4:00 P.M., Resident L's blood sugar was 407. On September 22 at 4:00 P.M., Resident L's blood sugar was 503. On September 23 at 11:00 A.M., Resident L's blood sugar was 484. On September 24 at 4:00 P.M., Resident L's blood sugar was marked Not Applicable. During an interview on 9/27/24 at 12:26 P.M., the ADON (Assistant Director of Nursing) indicated staff should notify the Physician if Resident L's blood sugar is over 400, and document the notification in progress notes. During an interview on 9/30/24 at 10:07 A.M., the DON (Director of Nursing) indicated staff should have documented in the progress notes that they notified the Physician of a blood sugar higher than 400, and it was not done. At that time, she indicated parameters should be documented in			

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	Resident L's chart on when to notify the Physician. 3. On 10/1/24 at 10:05 A.M., Resident J's clinical record was reviewed. Diagnosis included, but were not limited to, cellulitis of the right lower limb. The most recent Quarterly and State Optional MDS (Minimum Data Set) Assessment, dated 9/23/24, indicated no cognitive impairment, always incontinent of urine, frequently incontinent of bowel, and required extensive assistance of two with toileting. Physician orders included, but were not limited to: Stool occult with culture and sensitivity if indicated, every 12 hours for infection control until completed, dated 8/30/24, and started 9/2/24. The clinical record lacked stool occult test results, or information that the stool was sent to the lab for testing. On 10/1/24 at 9:52 A.M., Registered Nurse (RN) 3 indicated a sample was collected for the occult test at some point, but the lab said it was in the wrong container and they would have to bring the correct one to the facility. It took them about a week to bring the correct container and by that time, the diarrhea was gone. On 10/1/24 at 11:08 A.M., the Director of Nursing (DON) indicated Resident J's stool sample had not been obtained when ordered because the bed sheets would soak it up when the resident had diarrhea. She indicated the physician should have been notified after a couple of missed stools that they were not able to obtain it for the test, and at			

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	this point the order for the test should be discontinued as she stopped having diarrhea. 4. On 9/27/24 at 10:47 A.M., Resident F's clinical record was reviewed. Diagnosis included, but were not limited to, obstructive uropathy. The most recent Discharge MDS (Minimum Data Set) Assessment, dated 9/14/24, indicated an indwelling catheter and frequent bowel incontinence. Cognition status was not assessed. Physician orders included, but were not limited to: Cefepime HCl Infection Solution Reconstituted 1 GM (gram), use 50 ml (milliliter) intravenously every 6 hours for UTI for 7 days, reconstituted with 50 ml normal saline, dated 9/19/24 through 9/25/24. Resident F's Medication Administration Record (MAR) for September 2024 indicated Cefepime was not administered as ordered on the following dates/times: 9/19/24 at 12:00 A.M. 9/19/24 at 6:00 A.M. 9/20/24 at 12:00 P.M. 9/25/24 at 12:00 P.M. Resident F's clinical record lacked physician notification of the missed doses of Cefepime, or any investigation into why the medication was missed. On 9/30/24 at 9:50 A.M., the Director of Nursing (DON) indicated the physician had not been notified of Resident F's missed doses of Cefepime.			

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	155217	A. BUILDING 00 B. WING	10/01/2024

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	On 9/30/24 at 12:30 P.M., the DON provided a current non-dated Medication Administration Errors policy that indicated "Administration-based medication errors Examples include but are not limited to ... Missed medication ... Upon identification of a medication error the facility will ... Notify the physician and family of the medication error" On 9/30/24 at 12:30 P.M., the DON provided a current non-dated Notification policy that indicated "Notification is provided to the physician to facilitate continuity of care and to obtain input from the physician about appropriate interventions/changes which can include additions to, or discontinuation of, current care/treatments - related to the notification" On 9/30/24 at 12:30 P.M., a current Guidelines for Notification of Change in Resident's Condition/Status/Treatment policy, dated 6/29/24 indicated, "It is the intent of the facility to ensure that...their attending physician...notified of changes in the resident's condition, status, or treatment. This notification will be done promptly in order to obtain any orders needed for appropriate treatment and/or monitoring related to the change..." On 9/30/24 at 3:00 P.M., the DON provided a current, undated, Blood Glucose Monitoring policy that indicated, "...Blood sugars found to be below 70 or above 400 will be reported immediately to the physician and the resident's representative. Any orders received from the physician will be implemented...Notify physician if blood glucose is outside resident's parameters for blood glucose as ordered by their physician...Immediately notify the physician and			

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	the resident's representative any time the resident's blood sugar is outside the ordered parameter range as well as any interventions taken...complete all appropriate documentation." 3.1-5(a)(2) 3.1-5(a)(3)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 2 of 5 residents reviewed for unnecessary medications. A resident's clinical record lacked an antianxiety, antipsychotic, antiplatelet, and diabetes care plans. A resident's clinical record lacked a care plan for smoking and an order to add NAS (no added salt) to a resident's diet was not implemented. (Resident 18, Resident 30) Findings include: 1. On 9/26/24 at 2:57 P.M., Resident 18's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes mellitus type II, other arterial embolism and thrombosis of abdominal aorta, generalized anxiety disorder, borderline personality disorder, and bipolar disorder. Resident 18 was admitted 7/15/24. The most recent Admission MDS (Minimum Data Set), dated 7/22/24, indicated Resident 18 was cognitively intact, an extensive assist of 2 staff for bed mobility, transfers, toileting, and was administered antianxiety, antipsychotic, antiplatelet, and hypoglycemic medications. Current Physician's Orders included, but were not	F 0656	F 656 It is the policy of this facility to develop and implement comprehensive person-centered care plans for residents. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The MDS Nurse/Designee updated resident 18's care plans for antianxiety, antipsychotic and platelet medications and diabetes and updated physician on the dietician recommendation for a NAS diet on 10/10/2024. The MDS nurse/Designee updated residents 30's care plans for smoking/vaping on 10/10/2024. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	10/25/2024

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	limited to, the following: Latuda (antipsychotic) 20 mg (milligrams) tablet, give 20 mg by mouth one time a day related to borderline personality disorder, ordered 7/16/2024 Buspar (antianxiety) 5 mg tablet, give 5 mg by mouth three times a day for anxiety, ordered 7/15/2024 Aspirin (antiplatelet) 325 mg tablet, give 325 mg by mouth one time a day related to other arterial embolism and thrombosis of abdominal aorta, ordered 7/16/2024 Jardiance (diabetes) 10 mg tablet, give 10 mg by mouth in the morning related to diabetes mellitus type II, ordered 8/13/2024 Metformin (diabetes) HCL (hydrochloride) 1000 mg tablet, give 1000 mg by mouth every morning and at bedtime related to diabetes mellitus type II, ordered 7/16/2024 The clinical record lacked an antianxiety, antipsychotic, antiplatelet, and a diabetic care plan. 2. During an interview on 9/27/24 at 7:51 A.M., Resident 30 indicated she vaped (electronic cigarette) and had to watch her salt intake. On 9/25/24 at 3:13 P.M., Resident 30's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), atherosclerotic heart disease, hypertension (HTN), and nicotine dependence. Resident 30 was admitted on 5/31/24. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 9/13/24, indicated		The MDS Nurse/Designee completed an audit of residents receiving antianxiety, antipsychotic and platelet medications for care plans and for residents that smoke or/vape for care plan on 10-10-2024 Any concerns were addressed. The DON/Designee completed a 90 day look back of dietician recommendations for diet changes on 10/10/2024 and updated MD and diet as indicated. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The DON/Designee in-serviced the MDS Nurse on developing comprehensive person-centered care plans, and nursing staff on following dietician recommendations . Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The DON/Designee will audit 10 random residents on antianxiety, antipsychotic and platelet	

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	Resident 30 was cognitively intact and supervision of staff with set up for bed mobility, transfers, toileting, was on a therapeutic diet, and her smoking status was not indicated. Current Physician's Orders included, but were not limited to, the following: Con Cho (Consistent Carbs) diet, regular texture, thin liquids consistency, ordered 5/31/24 A current At Risk for HTN Care Plan, dated 6/18/24, included but was not limited to the following intervention: Provide diet as ordered and encourage resident to follow RD recommendations Progress notes included, but were not limited to, the following: On 9/19/24 at 2:15 P.M., a Dietary Progress Note indicated, "Monitoring for: Significant weight gain ... wt [weight] Change: gain of 27 pounds in 1 week. Diet: CCHO [Carb Consistent]; regular; thin liquids ... Resident reviewed on NAR [Nutrition Assessment Review] for significant weight gain. Gain of 27 pounds in 1 week, which may be fluid-related. Per DON, resident with increased edema and excess swelling to breast. Eating well. Plan/Monitoring: Continue monitoring the resident's weight and PO intake. Recommendation: add NAS restriction to the diet." The clinical record lacked a smoking/vaping care plan for the resident. The clinical record lacked a current NAS restriction for Resident 30's diet. During an interview on 9/30/24 at 10:17 A.M., the DON (Director of Nursing) indicated she was		medications and smoking and vaping residents for care plans weekly x 4 weeks, then 5 random residents weekly x 4 weeks, then 3 random residents weekly x weeks, then 3 random residents monthly x 3 months. The DON/Designee will audit dietician recommendations for diet changes 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 weeks the once a month x 3 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. - by what date the systemic changes for each deficiency will be completed. 10/25/2024	

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	unsure who was putting in the orders and care plans prior to her employment (8/12/24), but there should be a care plan for smoking in Resident 30's clinical record and an antianxiety, antipsychotic, antiplatelet, hypoglycemic, and diabetes care plans for Resident 18. During an interview on 9/30/24 at 2:40 P.M., the DON indicated the NAS diet recommendation from the dietician's note on 9/19/24 should have went into effect immediately, but it was missed. She indicated the physician would not have to sign off on that order before it would go into effect. The current process was that an email would be sent from the dietician to the DON/ADON (Assistant Director of Nursing) to put that order in and notify dietary. At that time, the DON indicated they don't have a policy, but it would be their policy to follow orders and care plan interventions. On 9/30/24 at 12:30 P.M., a current Baseline/Comprehensive Care Plan Policy, revised 9/18/18, was provided by the DON and indicated, " ... The comprehensive Care Plan will further expand on the resident's risks, goals, and interventions using the "Person-Centered" Plan of Care approach for each resident that includes measurable objectives and timetables [sic] to meet the resident's medical, nursing, physical functioning, mental and psychosocial needs ... The facility Interdisciplinary Team in conjunction with the resident, resident's family, surrogate or representative as appropriate along with a "hands on" caregiver, such as a Certified Nursing Assistant will discuss and develop quantifiable objectives along with appropriate interventions in an effort to achieve the highest level of functioning and the greatest degree of comfort/safety and overall well-being attainable			

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	for the resident ... The Comprehensive Care Plan will be finalized within 7 days of completion of the Full Comprehensive MDS assessments ... " 3.1-35(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and a comprehensive person-centered care plan for 1 of 1 residents reviewed for bowel and bladder incontinence. Physician orders were not followed, physician was not notified related to change in condition, treatments were being done without an order, care plans were not updated, and wound assessments were not completed. (Resident J) Findings include: On 10/1/24 at 10:05 A.M., Resident J's clinical record was reviewed. Diagnosis included, but were not limited to, cellulitis of the right lower limb. The most recent Quarterly and State Optional MDS (Minimum Data Set) Assessment, dated 9/23/24, indicated no cognitive impairment, always incontinent of urine, frequently incontinent of bowel, and required extensive assistance of two with toileting. Physician orders included, but were not limited to: Stool occult with culture and sensitivity if indicated, every 12 hours for infection control until completed, dated 8/30/24, and started 9/2/24.	F 0684	F 684 It is the intent of this facility to follow physicians' orders, notify the physician of a change in condition, provide treatments with an order, update care plans, and complete wound assessments. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The DON/Designee notified Resident J's physician of stool specimen not being collected on 10/4/2024, no new orders. The DON/Designee notified Resident J's physician for treatment orders, completed a wound assessment and updated care plans on 10-4-2024. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	10/25/2024

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	Linezolid Oral Tablet 600 mg (milligram) every morning and at bedtime for bacterial skin infection to the leg/cellulitis, from 8/20/24 through 8/29/24. Triad Hydrophilic Wound Dress External Paste (Wound Dressings), apply to buttocks topically every shift for MASD (moisture-associated skin damage), apply with every incontinent episode, dated 5/1/24. Aquaphor Advanced Therapy External Ointment (Emollient), apply to bilateral legs and face topically at bedtime for extremely dry skin, , dated 5/1/24. Apply Miconazole powder to right gluteal fold every shift for skin integrity until healed, dated 4/24/24. A current impaired skin integrity care plan for maceration/moisture to abdominal folds, under breasts, and coccyx, dated 4/23/24, indicated to notify physician as needed, treatments as ordered, and weekly skin checks, all dated 4/23/24. A current risk for skin impairment care plan related to bilateral lower extremity cellulitis, dated 9/27/24, indicated resident was dependent on staff assistance for bed mobility and transfers. Interventions included, but were not limited to, keep clean and dry, skin assessment per facility policy, and treatments as ordered, all dated 9/27/24. Progress notes indicated Resident J was in the hospital from 8/17/24 through 8/20/24 and diagnosed with sepsis and cellulitis of right lower extremity. Resident J was re-admitted with an antibiotic order of Linezolid 600 mg twice a day for		The DON/Designee completed an audit of all residents with alterations in skin integrity for treatment orders, care plans and wound assessments on 10-4-2024. The DON/Designee completed an audit for residents with stool culture orders for collection and notified the physician as indicated on 10-4-2024. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The DON/Designee in-serviced the nursing staff on Physicians Orders and obtaining stool specimens as ordered, completing weekly wound assessments for residents with alterations in skin integrity, obtaining a treatment orders, notification of physician and updating care plans on DATE. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. 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;	

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	bacterial skin infection to the leg/cellulitis, dated and administered from 8/20/24 through 8/29/24. Progress notes included, but were not limited to, the following: 8/20/24 at 11:35 A.M. A nures's note indicated Resident J had returned from the hospital with no new skin issues noted. Redness continued to folds with powder and Interdry (fabric type dressing) in place. 8/29/24 at 8:11 A.M. A nurse's note indicated Resident J was noted to have an adverse reaction to an antibiotic evidenced by loose stool with frequent slimy consistency. The Nurse Practitioner (NP) was notified. 8/30/24 at 9:45 A.M. An Interdisciplinary Team (IDT) note indicated a new skin area was identified related to maceration, diarrhea, and current cellulitis infection. New skin orders were in place. 8/30/24 at 10:29 A.M. A nurse's note indicated a new order was received from the NP for a stool occult specimen with culture and sensitivity if indicated. 8/30/24 at 11:47 A.M. A nurse's note indicated Resident J was having frequent loose stools, and the recommendation from the resident's provider was to keep clean and dry, and follow wound care orders. 9/4/24 at 2:11 A.M. A physician note indicated Resident J had experienced recent episodes of loose stool causing gaulding to peri/buttock area. 9/4/24 at 11:13 A.M. A physician note indicated		The DON/Designee will monitor new orders for stool culture and collection 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 weeks, then once a month x 3 months. The DON/Designee will audit current residents, new admissions and re-admissions with alterations in skin integrity for treatment orders, weekly wound evaluation and care plans 5 times a week x 4 weeks, then 3 times a week for 4 weeks, then once a week x 4 weeks, then once a month x 3 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. - by what date the systemic changes for each deficiency will be completed. 10-25-2024	

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	Resident J was noted to have increased fungal appearance rash to buttocks following diarrhea related to antibiotic use. Resident J's Medication Administration Record (MAR) for September 2024 indicated a stool sample was ordered and not obtained (not signed off on) with no indication why on the following dates/times: 9/2/24 at 6:00 P.M. 9/3/24 at 6:00 A.M. 9/11/24 at 6:00 A.M. 9/18/24 at 6:00 A.M. 9/25/24 at 6:00 A.M. and 6:00 P.M. Resident J's September 2024 MAR indicated a stool sample was obtained on 9/6/24 at 6:00 A.M. and on 9/30/24 at 6:00 P.M. The clinical record lacked stool occult test results, or information that the stool was sent to the lab for testing. Resident J's September 2024 MAR for the remaining dates from 9/2/24 through 9/30/24 indicated a stool sample was not obtained with an indicator to see nurse's notes. Progress notes related to e-mar administration included the following: 9/5/24 at 5:17 A.M. waiting for collection vial for lab. 9/5/24 at 5:13 P.M. no BM			

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	9/7/24 at 5:56 P.M. sample not obtained. 9/8/24 at 5:44 P.M. specimen not obtained. 9/10/24 at 5:49 P.M. no BM. 9/11/24 at 6:03 P.M. no BM on this shift. 9/12/24 at 6:12 A.M. no stool noted. 9/13/24 at 6:05 P.M. specimen not obtained. 9/14/24 at 5:39 P.M. no BM this shift. 9/15/24 at 6:05 P.M. no BM this shift. 9/16/24 at 6:14 P.M. specimen not obtained. 9/17/24 at 6:30 P.M. no sample. 9/18/24 at 5:41 P.M. no BM this shift. 9/19/24 at 5:36 A.M. no bm this shift. 9/19/24 at 5:22 P.M. no BM. 9/20/24 at 6:42 A.M. no BM observed this shift. 9/21/24 at 5:40 P.M. specimen not obtained. 9/22/24 at 6:26 P.M. no sample. 9/24/24 at 5:33 P.M. no BM. 9/26/24 at 6:33 A.M. no stool noted. 9/27/24 at 6:25 A.M. no BM noted. 9/28/24 at 5:15 P.M. no BM noted.			

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	9/29/24 at 5:32 P.M. no BM noted. Resident J's clinical record lacked a nurse's note for the following dates: 9/3/24 at 6:00 P.M. 9/4/24 at 6:00 A.M. and 6:00 P.M. 9/6/24 at 6:00 A.M. and 6:00 P.M. 9/7/24 at 6:00 A.M. 9/8/24 at 6:00 A.M. 9/9/24 at 6:00 A.M. and 6:00 P.M. 9/10/24 at 6:00 A.M. 9/12/24 at 6:00 P.M. 9/13/24 at 6:00 A.M. 9/14/24 at 6:00 A.M. 9/15/24 at 6:00 A.M. 9/16/24 at 6:00 A.M. 9/17/24 at 6:00 A.M. 9/18/24 at 6:00 A.M. 9/20/24 at 6:00 P.M. 9/21/24 at 6:00 A.M. 9/22/24 at 6:00 A.M. 9/23/24 at 6:00 A.M. and 6:00 P.M.			

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	9/24/24 at 6:00 A.M. 9/25/24 at 6:00 A.M. and 6:00 P.M. 9/26/24 at 6:00 P.M. 9/27/24 at 6:00 P.M. 9/28/24 at 6:00 A.M. 9/29/24 at 6:00 A.M. 9/30/24 at 6:00 P.M. A weekly skin check, dated 8/30/24, indicated resident did not have current loss of skin integrity, but had experienced a new loss of skin integrity. The form indicated a weekly wound evaluation was required for each area of loss of skin integrity. The clinical record lacked a weekly wound evaluation for the new areas listed on the 8/30/24 weekly skin check. A change in condition evaluation, dated 8/30/24, indicated Resident J had a new skin wound identified on 8/29/24 due to having loose stools related to the antibiotic Linezolid. A wound evaluation, dated 8/22/24, indicated Resident J had maceration to the left lower leg fold that was identified on 8/20/24 with a current treatment of Interdry daily. The clinical record lacked a current or discontinued order for Interdry. The clinical record lacked a notification to the			

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	155217	A. BUILDING 00 B. WING	10/01/2024

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	physician related to inability to get a stool sample. On 10/1/24 at 9:48 A.M., Certified Nurse Aide (CNA) 9 indicated Resident J used a bedpan for bowel movements and usually went once a day. He indicated he was unaware of any stool tests that needed to be completed, and that was something nursing would take care of. On 10/1/24 at 9:52 A.M., Registered Nurse (RN) 3 indicated she was aware of the stool test for Resident J, but the resident was no longer having diarrhea. She indicated the CNAs were supposed to notify the nurses if Resident J had a bowel movement. She indicated a sample was collected for the occult test at some point, but the lab said it was in the wrong container and they would have to bring the correct one to the facility. It took them about a week to bring the correct container and by that time, the diarrhea was gone. She indicated the loss of skin integrity that Resident J experienced on 8/30/24 was from moisture associated with incontinence and diarrhea, would notify staff when she needed to be changed, and used a bed pan for bowel movements. On 10/1/24 at 11:08 A.M., the Director of Nursing (DON) indicated Resident J had been in the hospital from 8/17/24 through 8/20/24 and came back to the facility on an antibiotic that caused diarrhea which then resulted in her skin getting macerated. She indicated staff was using barrier cream on the areas, then changed to powder which has helped. She indicated the stool sample had not been obtained when ordered because the bed sheets would soak it up when the resident had diarrhea as she was not using a bed pan. She indicated the physician should have been notified after a couple of missed stools that they were not able to obtain it for the test, and at this point the			

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	order for the test should be discontinued as she stopped having diarrhea. She indicated the wound evaluation on 8/22/24 reflected areas behind both knees as well as gluteal folds. All areas had Interdry to keep them dry and were currently being changed daily and/or when soiled. She indicated there should have been an order in place for the Interdry, and was unsure why there was not a current order. She indicated she was unsure what area the weekly skin check dated 8/30/24 was for as there were no new areas at that time that hadn't been already identified. She indicated Resident J's skin integrity care plans should have been updated when she came back from the hospital on 8/20/24 with the new skin issues. At that time, the DON indicated there was no current facility policy related to wound management, but that it would be the facility's policy to follow physician orders, and to receive an order prior to implementing a treatment. On 9/30/24 at 12:30 P.M., the DON provided a current non-dated Notification policy that indicated "Notification is provided to the physician to facilitate continuity of care and to obtain input from the physician about appropriate interventions/changes which can include additions to, or discontinuation of, current care/treatments - related to the notification" This Federal tag relates to Complaint IN00442764. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on interview and record review, the facility failed to ensure measures to heal existing pressure ulcers and prevention of additional pressure	F 0686	F 686 It is the intent of this facility to	10/25/2024

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	ulcers for 1 of 3 residents reviewed for pressure ulcers. Care plan interventions were not followed, orders were not placed, pressure ulcers were not staged correctly, and dressings were not completed as ordered for a resident with chronic pressure ulcers. (Resident D) Findings include: On 9/26/24 at 11:48 A.M., Resident D's clinical record was reviewed. Diagnosis included, but were not limited to, paraplegia, diabetes mellitus, anxiety, and depression. The most recent Annual and State Optional MDS (Minimum Data Set) Assessment, dated 8/23/24, indicated no cognitive impairment, extensive assistance of one with bed mobility, extensive assistance of two with toileting, total dependence of two with transfers, and two stage 4 pressure ulcers. Current physician orders included, but were not limited to: Dakins (1/4 strength) External Solution (Sodium Hydrochloride), apply to right and left ischium topically one time a day for wound healing, dated 7/24/24. Cleanse wound bed with Dakins flush and gently pack ulcers with plain packing strips, cover with bordered foam. Change daily, dated 6/6/24. Weekly skin assessments to be completed every Wednesday, dated 4/5/23. Continue protective dressing of border foam to coccyx, change three times a week on Tuesday, Friday and Sunday, dated 9/16/22.		ensure measures are in place to heal existing pressure ulcers, care plan interventions are being followed, orders in place, correct staging of pressure ulcers, and dressings are completed as ordered. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The DON/Designee assessed resident D and completed weekly wound assessment, treatment orders and updated the care plans on 10-4-2024. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The DON/Designee skin sweep of the facility and any areas of concern were addressed to include a weekly wound assessment, treatment orders and care plan updated on 10-4-2024. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	

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	A current pressure ulcer care plan, dated 4/25/24, indicated the resident had pressure ulcers to bilateral buttocks. Interventions included, but were not limited to: Assess/record/monitor wound healing weekly, measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the physician, dated 6/19/24. Treatment as ordered, dated 2/7/24. Weekly skin check, dated 2/7/24. Resident D's Medication Administration Record (MAR) from June 2024 indicated wound treatment was not done on 6/3/24 with an indicator to see nurse notes. The progress/nurses notes lacked documentation related to treatment on that date. Resident D's MAR from July 2024 indicated the resident went to a wound clinic appointment on 7/17/24 at 11:00 A.M. Wound clinic notes from July indicated the resident went for an appointment that month on 7/24/24. The MAR also indicated a wound treatment was not done on 7/24/24 with an indicator to see nurse notes. The progress/nurses notes lacked documentation related to treatment on that date. Resident D's MAR from August 2024 indicated no treatments were performed on buttock wounds on 8/30/24 with no indication why. The MAR also indicated wound treatment was not done on 8/21/24 with an indicator to see nurse notes. The progress/nurses notes lacked documentation related to treatment on that date.		The DON/Designee in-serviced the nursing staff on weekly skin assessments, wound care and treatment orders, completing a weekly wound assessment to include current treatment orders and wound identification on 10-4-2024. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The DON/Designee will monitor weekly skin assessments weekly x 6 months. The DON/Designee will audit weekly wound assessments for correct wound identification and treatment orders documented in assessment, treatments completed as ordered, prevention interventions being followed and care plan updated weekly x 6 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any	

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	Resident D's Medication Administration Record (MAR) from June 2024 through September 2024 indicated skin assessments were completed every Wednesday with a checkmark. The record lacked skin assessment documentation in June 2024. Documentation of skin assessments from July 2024 through September 2024 were not completed on Wednesdays as ordered or indicated in the MAR, and were completed on the following dates: 7/1/24 (Monday) 7/8/24 (Monday) 7/15/24 (Monday) 7/22/24 (Monday) 7/29/24 (Monday) 8/5/24 (Monday) 8/5/24 (Monday) 8/16/24 (Friday) 8/22/24 (Thursday) 8/29/24 (Thursday) 9/5/24 (Thursday) 9/13/24 (Friday) 9/20/24 (Friday)		written Action Plan will be monitored by the Administrator weekly until resolved. by what date the systemic changes for each deficiency will be completed.	

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	All skin assessments indicated a current loss of skin integrity, but no new loss of skin integrity. Resident D experienced the following pressure ulcers from June 2024 through September 2024: Pressure ulcer 1: A wound clinic note, dated 6/5/24, indicated a stage 3 pressure ulcer to the left lateral buttock that was closed. Wound was identified 2/7/24. Orders placed included, but were not limited to, cleanse and fill wound space (of other two wounds) with dry plain packing strip and cover with border foam, and apply skin prep to area around those wounds. The order for skin prep was not placed or initiated at the facility. A weekly wound evaluation, dated 6/7/24, indicated a left buttock stage 3 pressure ulcer, measuring .8 cm (centimeters) x 1.1 cm x .1 cm that was identified 3/26/19, and treatment was ordered 6/5/24 (the form did not indicate what the treatment was). A weekly wound evaluation, dated 6/14/24, indicated a left buttock stage 3 pressure ulcer, measuring .6 cm x .8 cm x .5 cm. A weekly wound evaluation, dated 6/21/24, indicated a left buttock stage 3 pressure ulcer, measuring 0 cm x 0 cm x 0 cm. Wound was identified 3/24/19 and healed 6/21/24. Pressure ulcer 2: A wound clinic note, dated 6/5/24, indicated a stage 4 pressure ulcer to the left buttock,			

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	measuring 1 cm x 1.1 cm x 1.2 cm that was identified 9/16/20. At that time, a recommendation of a protective dressing of border foam over the sacrum to be changed weekly and pulled back and assessed daily was placed. An order was placed to cleanse wound beds with Dakin's flush at each dressing change, fill wound space with dry plain packing strip, and cover with border foam daily and as needed. A weekly wound evaluation, dated 6/7/24, indicated a left buttock stage 4 pressure ulcer, measuring 1.2 cm x 1.4 cm x 1 cm. Wound was identified 3/26/19, and treatment was ordered 6/5/24 (the form did not indicate what the treatment was). A weekly wound evaluation, dated 6/14/24, indicated a left buttock stage 4 pressure ulcer, measuring 1.2 cm x 1.4 cm x 1 cm. A weekly wound evaluation, dated 6/21/24, indicated a left buttock stage 4 pressure ulcer, measuring 1 cm x 1.4 cm x 1.2 cm. Wound was identified 3/24/19. A wound clinic note, dated 6/26/24, indicated a stage 4 pressure ulcer to the left buttock, measuring 1 cm x 1.4 cm x 1.2 cm. A weekly wound evaluation, dated 6/28/24, indicated a left buttock stage 4 pressure ulcer, measuring .9 cm x 1.3 cm x 1.2 cm. Wound was identified 3/26/19. A weekly wound evaluation, dated 7/5/24, indicated a left buttock stage 4 pressure ulcer, measuring 1 cm x 1.2 cm x 1.2 cm. A wound clinic note, dated 7/24/24, indicated a			

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	stage 4 pressure ulcer to the left buttock, measuring .5 cm x .6 cm x 1 cm. A wound clinic note, dated 8/21/24, indicated a stage 4 pressure ulcer to the left buttock, measuring .2 cm x .3 cm x .3 cm. A weekly wound evaluation, dated 8/23/24, indicated a stage 4 pressure ulcer to the left ischium, measuring .2 cm x .3 cm x .3 cm. The form indicated a treatment was ordered 8/21/23 (did not indicate what the treatment was). A wound clinic note, dated 9/11/24, indicated a stage 4 pressure ulcer to the left buttock, measuring .5 cm x .6 cm x .5 cm. The clinical record lacked wound assessments after 7/5/24. The clinical record lacked weekly wound assessments from 7/5/24 through 8/23/24, and after 8/23/24. Pressure ulcer 3: A wound clinic note, dated 6/5/24, indicated a stage 4 pressure ulcer to the right buttock, measuring 1 cm x 1 cm x .8 cm that was identified 9/16/20. At that time, a recommendation of a protective dressing of border foam over the sacrum to be changed weekly and pulled back and assessed daily was placed. An order was placed to cleanse wound beds with Dakin's flush at each dressing change, fill wound space with dry plain packing strip, and cover with border foam daily and as needed. A weekly wound evaluation, dated 6/7/24, indicated a stage 4 pressure ulcer to the right			

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	buttock, measuring 1 cm x 1 cm x .8 cm. Wound was identified 3/26/19, and treatment was ordered 6/5/24 (the form did not indicate what the treatment was). A weekly wound evaluation, dated 6/14/24, indicated a stage 4 pressure ulcer to the right buttock, measuring 1 cm x 1 cm x 1 cm. A weekly wound evaluation, dated 6/21/24, indicated a stage 4 pressure ulcer to the right buttock, measuring 1 cm x 1 cm x 1 cm. Wound was identified 3/24/19. A wound clinic note, dated 6/26/24, indicated a stage 4 pressure ulcer to the right buttock, measuring .9 cm x 1 cm x .9 cm. A weekly wound evaluation, dated 6/28/24, indicated a stage 3 pressure ulcer to the right buttock, measuring .9 cm x .9 cm x .9 cm. Wound was identified 3/26/19. A weekly wound evaluation, dated 7/5/24, indicated a stage 3 pressure ulcer to the right buttock, measuring .8 cm x .8 cm x 1 cm. A wound clinic note, dated 7/24/24, indicated a stage 4 pressure ulcer to the right buttock, measuring .5 cm x .9 cm x .5 cm. A wound clinic note, dated 8/21/24, indicated a stage 4 pressure ulcer to the right buttock, measuring .8 cm x .9 cm x .6 cm. A weekly wound evaluation, dated 8/23/24, indicated a stage 4 pressure ulcer to the right ischium, measuring .8 cm x .9 cm x .6 cm. The form indicated a treatment was ordered 8/21/24 (did not indicate what the treatment was).			

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	A new treatment order was not placed on 8/21/24. A wound clinic note, dated 9/11/24, indicated a stage 4 pressure ulcer to the right buttock, measuring 1 cm x .5 cm x .5 cm. The clinical record lacked weekly wound assessments from 7/5/24 through 8/23/24, and after 8/23/24. Pressure ulcer 4: A weekly wound evaluation, dated 9/19/24, indicated a stage 1 pressure ulcer to the right buttock, measuring .5 cm x .5 cm x 0 cm was identified 9/17/24. The form indicated a new treatment to monitor; cleanse bilateral buttock, pat dry, apply skin prep to surrounding area and cover with border foam was dated 9/17/24. The new treatment order on 9/17/24 was not placed or initiated. Pressure ulcer 5: A wound evaluation, dated 9/19/24, indicated a stage 1 pressure ulcer to the left buttock, measuring 3 cm x 1.7 cm x 0 cm was identified 9/17/24. The form indicated a new treatment to monitor; cleanse bilateral buttock, pat dry, apply skin prep to surrounding area and cover with border foam was dated 9/18/24. The new treatment order on 9/18/24 was not placed or initiated. Pressure ulcer 6: A wound evaluation, dated 9/23/24, indicated an			

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	additional open area of existing wound on the left buttock measuring 2 cm x 2.5 cm x 1.5 cm was identified on 9/22/24. The wound was not staged and indicated a current treatment to cleanse the area daily with normal saline, pat dry, apply skin prep around the wound, cover with border foam, and change when soiled or dislodged, dated 9/18/24. The new treatment order on 9/18/24 was not placed or initiated. Resident D's clinical record lacked Interdisciplinary Team (IDT) meetings or notes related to the resident's pressure ulcers from June 2024 through September 2024. On 9/26/24 at 11:57 A.M., The Director of Nursing (DON) provided wound management logs for Resident D and indicated they were not part of the clinical record. The forms were hand written and included the following information: Wound log for a stage 4 pressure ulcer on the left ischium/left distal buttock, identified on 9/16/20: On 8/23/24, the wound measured .2 cm x .3 cm x .3 cm. On 9/6/24, the wound measured .5 cm x .6 cm x .3 cm. On 9/13/24, the wound measured .5 cm x .6 cm x .3 cm. On 9/20/24, the wound measured 2 cm x 2.5 cm x 1.5 cm. Wound log for a stage 4 pressure ulcer on the left ischium/right buttock, identified on 9/16/20:			

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	On 8/23/24, the wound measured 1 cm x .5 cm x .5 cm. On 9/6/24, the wound measured 1 cm x .5 cm x .5 cm. On 9/13/24, the wound measured 1 cm x .5 cm x .5 cm. On 9/20/24, the wound measured 1 cm x .5 cm x .5 cm. On 9/26/24 at 2:35 P.M., the DON indicated wound assessments were not in the resident's clinical records and had not been when she started at the facility on 8/12/24, and she had started handwritten weekly wound assessments on paper beginning 8/23/24. She indicated since Resident D's areas on her buttocks had not been documented appropriately, and the areas were not separated on documentation, only one care plan was in place for pressure ulcers, although a separate care plan should be in place for each area. She indicated a quality improvement plan was needed for documentation including wound documentation. On 9/30/24 at 10:00 A.M., the DON indicated Resident D's treatment order from 9/16/22 for the bordered foam to coccyx three times a week should have been discontinued when a new order was placed for a new dressing, and had been checked off on the MAR without actually completing it because it was a current order. She indicated the right buttock pressure ulcer was mis-staged on the 6/28/24 and 7/5/24 evaluations and should have been marked as a stage 4 instead of a stage 3 pressure ulcer. She indicated wound evaluations should have been done in house			

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	weekly, and the skin assessment on 9/20/24 should have identified a new area identified on 9/17/24. The DON indicated all wound clinic orders should have been transferred to the facility, and the skin prep order should have been put in the treatment orders. She further indicated Resident D had been to the wound clinic on 7/24/24, not on 7/17/24, and should have been changed in the clinical record to reflect the correct appointment date. On 9/30/24 at 3:00 P.M., the DON indicated the facility did not have a current policy for the prevention and/or treatment of pressure ulcers or wounds, or a policy related to wound assessments. On 9/30/24 at 12:30 P.M., the DON provided a current non-dated Comprehensive Care Plan policy that indicated "The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues ... The MDS/Care Plan Coordinator and/or ancillary MDS staff will attend the Morning /CQI meetings where in-depth review of the 24 Hour Report(s) since the prior Morning/CQI meeting are reviewed and discussed as well as new or changed orders, new admissions, readmissions, falls and other pertinent circumstances regarding the residents. They will then see that the care plans for these residents are revised and updated as necessary" This Federal tag relates to Complaint IN00442764. 3.1-40(a)(2)			

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	155217	A. BUILDING 00 B. WING	10/01/2024

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to provide adequate supervision and prevent falls for 1 of 2 residents reviewed for accidents. Fall risk assessments and neuro (neurological) assessments were not completed after a resident fell. The care plan was not updated after a fall. (Resident L) Findings include: On 9/25/24 at 1:46 P.M., Resident L's clinical record was reviewed. Diagnoses included, but was not limited to, unsteadiness on feet, anxiety disorder, and diabetes mellitus. The most recent State Optional and Quarterly MDS (Minimum Data Set) Assessment, dated 7/23/24, indicated Resident L had severe cognitive impairment and required supervision of 1 staff member for bed mobility, and supervision and setup help for transfer and toileting. Current Physicians Orders included, but was not limited to, "OLANZapine [psychotropic] Oral Tablet Disintegrating 5 MG (Olanzapine). Give 5 mg by mouth at bedtime related to MOOD DISORDER DUE TO KNOWN PHYSIOLOGICAL CONDITION WITH MIXED FEATURES..." dated 8/23/2024 Resident L's care plan included, but was not limited to, "[Resident] is at risk for falls r/t [related to] dementia with behavioral disturbance, convulsions, unsteadiness on feet...date initiated 7/18/24...Interventions Attempt to keep areas free of clutter Date Initiated: 7/18/24. Keep call light in reach Date Initiated 7/18/24. Move resident to a location to provide more assistance Date Initiated:	F 0689	F 689 It is the intent of this facility to ensure fall risk assessment and neurological checks and care plan updated with fall interventions after a fall. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The DON/Designee completed a fall risk assessment for resident L and care plan reviewed and updated with current interventions on 10-10-2024 how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The DON/Designee completed a Fall Risk Assessment for current residents on DATE, any resident that trigger to be high risk, care plan reviewed and updated with current interventions on 10-10-2024 what measures will be put into place and what systemic	10/25/2024

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	7/18/24. Notify and update MD [medical doctor] as needed Date Initiated 7/18/24. Therapy screen as indicated, quarterly and prn [as needed] Date Initiated 7/18/24. A review of Resident L's falls since admission on 7/15/24 included, but was not limited to, the following: On 7/28/24 Resident L had an unwitnessed fall in the hallway. The facility failed to complete neuro checks, update Resident L's care plan, and failed to complete a fall risk assessment. On 9/14/24 Resident L had an unwitnessed fall in the dining room. The facility failed to complete neuro checks, and the fall risk assessment lacked that Resident L received psychotropic and was completed incorrectly. During an interview on 9/26/24 at 8:57 A.M., RN (Registered Nurse) 3 indicated if a resident had an unwitnessed fall, neuro checks should be completed. During an interview on 9/27/24 at 11:19 A.M., the DON (Director of Nursing) indicated Resident L should have had a new care plan intervention and fall risk assessment completed after every fall, and the fall risk assessment on 9/14 should have indicated Resident L received psychotropic's. At that time, she indicated Resident L should have had neuro checks after the falls on 7/28 and 9/14. On 9/30/24 at 12:30 P.M., the DON provided a current, undated, Baseline Care Plan Assessment/ Comprehensive Care Plans policy that indicated, "...The Comprehensive Care Plans will be reviewed...more often based on changes in the resident's condition..."		changes will be made to ensure that the deficient practice does not recur; The DON/Designee in-serviced the nursing staff on completing a fall risk assessment after a resident falls, completing neuro checks and updating care plan with new intervention. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The DON/Designee will monitor Resident Falls for Completion of Fall Risk Assessment, Neuro Checks, and care plan updated with new interventions 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 weeks hen once a month x 3 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any	

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	On 9/30/24 at 12:30 P.M., the DON provided a current Guidelines for incidents/ accidents/ falls policy, dated 6/30/23 that indicated, "...Neuro checks will be completed after...any unwitnessed fall...each fall needs a new care plan intervention rolled out...Residents are assessed for FALL RISK upon admission, re-admission, quarterly and when there is a change of condition to include a fall..." This Federal Tag relates to Complaint IN00442764. 3.1-45(a)		written Action Plan will be monitored by the Administrator weekly until resolved. by what date the systemic changes for each deficiency will be completed. 10-25-2024	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview, and record review, the facility failed to provide respiratory care consistent with professional standards of practice and a comprehensive person-centered care plan for 1 of 2 residents reviewed for respiratory care. The resident was receiving oxygen without monitoring oxygen saturation (O2 sat) levels (level of oxygen in the blood) or monitoring how often and what LPM (Liter Per Minute) of oxygen was being used by the resident. The order lacked perimeters for the staff to determine accurate LPM needed and a care plan was not developed for oxygen use. (Resident 30) Finding includes: On 9/26/24 at 11:15 A.M., Resident 30 was observed asleep in her bed wearing O2 per nasal cannula at 3 LPM. On 9/27/24 at 7:22 A.M., Resident 30 was observed eating breakfast wearing oxygen (O2) per nasal cannula at 3 LPM with the right nasal	F 0695	F 695 It is the intent of this facility to have perimeters for the staff to determine accurate LPM needed for residents using oxygen and develop a care plan for oxygen use. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The DON/Designee obtained an order for oxygen LP with perimeters and monitoring O2 sats every shift for Resident 30 and care plan updated on DATE. how other residents having the potential to be affected by the same deficient practice will be	10/25/2024

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	cannula on the outside of her nose. At that time, the resident indicated she wore her oxygen all the time. On 9/27/24 at 7:51 A.M., Resident 30 was observed laying in bed wearing her O2 per nasal cannula at 3 LPM and the nasal cannula was still out of her right nostril. On 9/27/24 at 12:42 P.M., RN (Registered Nurse) 5 was observed delivering a meal to Resident 30 in her room. Resident 30 had her right nasal cannula outside her right nostril and RN 5 did not bring it to Resident 30's attention or adjust the nasal cannula. On 9/25/24 at 3:13 P.M., Resident 30's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD). The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 9/13/24, indicated Resident 30 was cognitively intact and supervision of staff with set up for bed mobility, transfers, toileting, and was on oxygen but did not specify if it was continuous or intermittent use. Current Physician's Orders included, but were not limited to, the following: O2 at 1-3 LPM (Liters Per Minute) via NC (Nasal Cannula) as needed for SOB (Shortness of Breath) as needed, ordered 9/24/2024 The clinical record lacked a care plan for oxygen use. The following were the documented O2 sats for the month of September 2024: 9/12/24 11:04 A.M. 98.0% Oxygen via Nasal		identified and what corrective action(s) will be taken; The DON/Designee completed an audit for residents receiving oxygen for perimeters, O2 monitoring and care plan on 10-10-2024. Any concerns were addressed. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The DON/Designee in-serviced the nursing staff on oxygen therapy, perimeters for LPM, and monitoring O2 sats every shift and as needed on 10-10-2024. The DON/Designee in-serviced the MDS nurse for completing a care plan for residents on oxygen therapy on 10-10-2024. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The DON/Designee will audit	

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	Cannula 9/11/24 7:22 A.M. 90.0% Oxygen via Nasal Cannula 9/10/24 8:43 P.M. 90.0% on Room Air 9/10/24 8:10 A.M. 90.0% Oxygen via Nasal Cannula 9/9/24 10:40 A.M. 92.0% on Room Air 9/8/24 10:43 A.M. 100.0% Oxygen via Nasal Cannula 9/8/24 6:46 A.M. 92.0% Oxygen via Nasal Cannula 9/7/24 8:09 A.M. 94.0% on Room Air 9/7/24 10:02 P.M. 96.0% Oxygen via Nasal Cannula 9/6/24 9:04 P.M. 91.0% Oxygen via Nasal Cannula 9/6/24 11:56 A.M. 92.0% on Room Air 9/6/24 7:09 A.M. 91.0% on Room Air 9/5/24 11:55 P.M. 91.0% Oxygen via Nasal Cannula The clinical record lacked documentation of staff checking the resident's oxygen concentrator to make sure it was on the correct LPM. During an interview on 9/30/24 at 10:17 A.M., the DON (Director of Nursing) indicated she was unsure who was putting in the orders and care plans prior to her employment (8/12/24), but there should be a care plan and an order for the staff to be checking Resident 30's O2 sats on room air at least every shift and as needed for shortness of breath, and if the resident was wearing the O2, there should be an order to monitor the LPM and O2 sats while she is on O2. In the current order for her to wear oxygen, there should be perimeters for the amount of oxygen to be administered based on her O2 sats. The DON indicated Resident 30 did not wear oxygen all the time, it was to be used as needed, and the resident was aware of that. At that time, the DON indicated Resident 30 was		residents receiving oxygen therapy for care plan, monitoring O2 sats every shift and perimeters orders and accurate LPM 5 times a week x 4 weeks, then 3 times a weeks x 4 weeks, then once a week x 4 weeks, then once a month x 3 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. - by what date the systemic changes for each deficiency will be completed. 10-25-2024	

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	getting her vitals, including her O2 sat, checked once every shift but that was discontinued and she wasn't sure why. On 9/30/24 at 12:30 P.M., a current non dated Oxygen Administration Policy was provided by the DON and indicated " ... It is the policy of this facility to provide oxygen to maintain levels of saturation to residents as needed and as ordered ... Resident with oxygen orders, routine and PRN [as needed], will have oxygen saturation levels measured by oximetry per physician order indicating clinical oxygen saturation to be maintained. Oxygen saturation will be checked and documented every shift to meet order specifications ... Residents who have oxygen orders, whether scheduled or PRN will have oxygen saturation levels measured no less than daily. If MD [Medical Doctor] order states 'to maintain sat' then oxygen saturation will be checked and documented every shift. MD will be notified whenever titration is required to maintain a saturation ..." 3.1-47(a)(6)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information Based on observation, interview, and record review, the facility failed to ensure posted nurse staffing sheets were posted and contained the correct information daily for 1 of 6 days reviewed during the survey. (September 24) Findings include: On 9/24/24 at 9:14 A.M., Posted Nurse Staffing was observed hanging on the wall next to the nurse's station by the entrance dated 9/19/24.	F 0732	F 732 – Posted Nurse Staffing Information It is the intent of this facility to post nursing staffing information daily. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. There were no residents affected	10/25/2024

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	During an interview on 9/30/24 at 10:13 A.M., the DON (Director of Nursing) indicated the ADON (Assistant Director of Nursing) filled out the Posted Nurse Staffing form and checked it daily. Night shift changed the Posted Nurse Staffing form out each night. The Posted Nurse Staffing form should be current. On 9/30/24 at 12:30 P.M., DON provided an undated BIPA (Benefits Improvement and Protection Act of 2000) Staffing Posting Requirements policy which indicated "1. SNFs (Skilled Nursing Facilities) and NFs (Nursing Facilities) must post daily, at the beginning of each shift, the facility specific shift schedule for the 24 hour period...3. Other required posted data includes: ...b) Current date..."		by this alleged deficient practice. 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 that currently reside in the facility have the potential to be affected by the alleged deficient practice, therefore this plan of correction applies to all residents that reside in the facility. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The Administrator/designee completed education with facility scheduler, Director of Nursing and Assistant Director of Nursing on posting nursing staffing information daily on 10/2/2024. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. The Administrator/designee will complete daily staffing posting audits 5x's a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 weeks, then once a month x 3 months for	

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			current daily staffing posted. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. 10/25/2024.	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 3 residents reviewed for Urinary Tract Infections (UTI). A resident with a UTI missed 4 of 28 ordered doses of an intravenous (IV) antibiotic. (Resident F) Finding includes: On 9/27/24 at 10:47 A.M., Resident F's clinical record was reviewed. Diagnosis included, but were not limited to, obstructive uropathy. The most recent Discharge MDS (Minimum Data Set) Assessment, dated 9/14/24, indicated an indwelling catheter and frequent bowel incontinence. Cognition status was not assessed.	F 0760	**F-760 Residents are Free from Significant Med Errors** **It is the policy of the facility to ensure all residents are free of any significant medication errors.** **The medication error for resident F was addressed accordingly.** **All residents who reside in the**	10/25/2024

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	Physician orders included, but were not limited to: Cefepime HCl Infection Solution Reconstituted 1 GM (gram), use 50 ml (milliliter) intravenously every 6 hours for UTI for 7 days, reconstituted with 50 ml normal saline, dated 9/19/24 through 9/25/24. Resident F's Medication Administration Record (MAR) for September 2024 indicated Cefepime was not administered as ordered on the following dates/times: 9/19/24 at 12:00 A.M. (indicated "other/see nurse notes") 9/19/24 at 6:00 A.M. (indicated "other/see nurse notes") 9/20/24 at 12:00 P.M. (indicated "other/see nurse notes") 9/25/24 at 12:00 P.M. (indicated "other/see nurse notes") Resident F's clinical record lacked a nurse note related to why Cefepime was not administered. Resident F's clinical record lacked physician notification of the missed doses of Cefepime, or any investigation into why the medication was missed. On 9/30/24 at 9:50 A.M., the Director of Nursing (DON) indicated there should have been a nurses note in the clinical record to explain why the doses of Cefepime were not given to Resident F. The DON further indicated the physician had not been notified of the missed doses, nor had an investigation been conducted related to the missing doses.		**facility have the potential to be affected by this finding.** **A 30 day look back of antibiotic orders was completed by DON/Designee on 10/10/2024 to ensure there were no missed administrations.** **DON/Designee will monitor medication administration for 10 residents, 5 days weekly for a period of 4 weeks. The tool will then be used for 5 residents, 3 days weekly for a period of 4 weeks, then weekly for 1 resident ongoing for a period of no less than 4 months. If the facility is within 95 % compliance at the end of 6 months; then monitoring can be stopped.** **At an in-service held by the DON/Designee on 10/10/2024 for all nursing staff the following was reviewed:** **1. Medication administration** **2. Mar documentation** **3.physician notification**	

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	On 9/30/24 at 12:30 P.M., the DON provided a current non-dated Medication Administration Errors policy that indicated "Administration-based medication errors Examples include but are not limited to ... Missed medication ... Upon identification of a medication error the facility will ... Complete medication error report form ... Notify the physician and family of the medication error ... Conduct an investigation regarding how the error occurred ... Institute interventions to prevent further recurrence of medication error" This Federal tag relates to Complaint IN00442764. 3.1-48(c)(2)		**4. medication error report form** **Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated.** **At the monthly QAPI meeting, the monitoring of the DON/Designee be reviewed. Any concerns will have been corrected as found. Any patterns will be identified. If necessary, an Action Plan will be written by the committee. Any written Action Plan will be monitored by the Administrator weekly until resolution.** **By what date the systemic change for the deficiency will be completed?** **Date of Compliance 10/25/2024**	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals			

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	Based on observation, interview and record review, the facility failed to maintain safe and secure storage of medications for 1 of 2 medication carts observed. A narcotic box was unlocked. (100/200 Hall) Findings include: During an observation on 9/24/24 at 9:38 A.M., the medication cart on the 100/200 hall was reviewed. The narcotic lock box was observed unlocked. At that time, the ADON (Assistant Director of Nursing) indicated it should have been locked. On 9/30/24 at 12:30 P.M., the DON (Director of Nursing) provided a current Medication Storage in the Facility policy, dated February 2017 that indicated, "...All drugs classified as Schedule II of the Controlled Substances Act will be stored under double locks..." This Federal Tag relates to Complaint IN00442764. 3.1-25(n)	F 0761	F 761 It is the intent of this facility to ensure narcotic boxes on the medication cart are locked. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were identified to be affected by this alleged deficient practice. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The DON/Designee completed an audit of medication carts to verify narcotic boxes locked appropriately on 10-10-2024. Any concerns were immediately addressed. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The DON/Designee in-serviced the nursing staff on locking medications carts and narcotic boxes when not in use on	10/25/2024

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			10-10-2024. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The DON/Designee will audit medication carts 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week for 4 weeks, then once a month's x 3 months to verify medication cart and narcotic box is locked when not in use. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. by what date the systemic changes for each deficiency will be completed.	
F 0812 SS=D	483.60(i)(1)(2) Food			

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Bldg. 00	Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to serve food in accordance with professional standards for food service safety for 1 of 1 observations of the kitchen. The food temperature log lacked food temperatures for food served 12 of 19 days reviewed. Finding includes: On 9/24/24 at 9:38 A.M., the food temperature logs from 9/5/24 through 9/23/24 were reviewed. The following dates had no temperatures documented for the food served at dinner: 9/6/24 9/8/24 9/10/24--no temperatures for breakfast, lunch, or dinner 9/13/24--no temperatures for breakfast, lunch, or dinner 9/15/24 9/16/24 9/17/24 9/18/24 9/20/24 9/21/24 9/22/24 9/23/24 On 9/24/24 at 9:40 A.M., the Dietary Manager indicated if there was nothing written for food served at dinner on those days, staff probably didn't do them. If they were taken, they should be documented there. At that time, he indicated they do have some newer staff at that time and they may need to re-educate them about getting food temperatures before serving it. On 9/30/24 at 12:30 P.M., a current non dated	F 0812	F 812 It is the intent of this facility to ensure food temperature or completed and logged for food being served. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were identified to be affected by this alleged deficient practice. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that reside in the facility have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents in the facility. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Administrator in-serviced the dietary staff on monitoring food temperature and logging	10/25/2024

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	Monitoring Food Temperatures Policy was provided by the DON (Director of Nursing) and indicated, " ...food temperatures will be monitored daily to prevent food borne illness. Food temperatures will be taken and recorded for all hot and cold foods prior to placing them on the serving line. The temperature for each food item shall be recorded on the Food Temperature Log ... If hot foods are not 135 degrees Fahrenheit or higher when checked, they will be reheated to at least 135 degrees Fahrenheit. Cold foods and beverages which are not 41 degrees Fahrenheit or below will be chilled on ice or in the freezer ... " 3.1-21(i)(2) 3.1-21(i)(3)		temperatures daily on 10-10-2024. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The Dietary Manager/Designee will monitor food temperature logs for completion of food temperatures daily for meal services 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week for 4 weeks, then once a month's x 3 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. - by what date the systemic changes for each deficiency will be completed.	

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F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection during 1 of 4 observations of care. The facility failed to track all infections for 3 of 5 residents reviewed for infections. Staff lathered hands for 6 seconds, touched items with gloved hands before care was performed, wiped the residents buttock's first, failed to perform hand hygiene when gloves were changed, and touched multiple items with soiled gloves after care. (Resident G, Resident J, Resident K, Resident M) Findings include: 1. On 10/1/24 at 9:15 A.M., the facility tracking binder was reviewed for July 2024, August 2024, and September 2024. The facility tracking lacked the following UTI's (urinary tract infections): Resident K had a UTI in July 2024. The facility tracking map lacked documentation of the UTI. Resident J had a UTI in August 2024. The facility tracking map lacked documentation of the UTI. Resident G had a UTI in August and September 2024. The facility tracking map lacked documentation of the UTI. During an interview on 10/1/24 at 9:23 A.M., the IP (Infection Preventionist) indicated the UTI's were not tracked due to her not being able to complete them. The facility tracking should have had their name, date, infection, and be labeled on the facility tracking map.	F 0880	F 880 It is the intent of this facility to track all infections, for staff to perform hand hygiene when changing gloves and to not touch items with soiled gloves. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The DON/Designee add Resident K to July 2024 Infection Tracking Log and mapping, Resident J to the August 2024 Infection Tracking log and mapping and Resident G to the August and September 2024 Infection Tracking Log and mapping for Urinary Tract Infections on DATE. The DON/Designee assessed Resident M and no negative outcome related to the cited practice on 10-10-2024. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that reside in the facility have the potential to be affected by the cited practice,	10/25/2024

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	2. On 9/27/24 at 10:47 A.M., CNA (Certified Nurse Aide) 7 and RN (Registered Nurse) 5 were observed performing incontinence care on Resident M. CNA 7 washed her hands with a 13 second lather of soap and RN 5 with a 6 second lather. Both put on gloves and RN 5 hooked the strap of the lift pad on to the lift. CNA 7 removed the resident's blanket, hooked the other straps of the lift pad on to the lift, used the controller to raise the resident from her wheelchair, and lower her into the bed. CNA 7 opened the closet door, grabbed a clean incontinence pad, and closed the closet. CNA 7 opened the dresser, grabbed wipes, and closed the drawers. CNA 7 did not remove gloves or perform hand hygiene prior to beginning incontinence care. They rolled Resident M onto her right side and RN 5 tucked the soiled incontinence pad under the resident. CNA 7 grabbed a wipe from the package laying on the blanket, and reached across the resident to wipe Resident M's left hip, grabbed another wipe and wiped left hip area again, while RN 5 tucked a new incontinence pad under the resident using her gloved hands on the inside and center of the clean incontinence pad. Resident M was rolled on to her left side. CNA 7 pulled out the soiled incontinence pad. CNA 7 grabbed a wipe and wiped the resident's backside from front to back with bowel movement visible on her gloves. She grabbed another wipe, and wiped bowel movement off her gloves with the wipe. CNA 7 propped herself by leaning on her left hand glove in a fist on the clean sheet. After grabbing 3 more wipes and wiping the resident, CNA 7 removed her gloves, discarded them, and put on new gloves without using hand hygiene. At that time, the resident indicated she was urinating. Someone knocked on the door, proceeded to open door with the resident exposed, then closed the door. Then opened the door again and threw a clean		therefore, this plan of correction applies to all residents in the facility. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The DON/Designee in-serviced the Infection Preventionist on tracking and mapping infections on 10-10-2024. The DON/Designee in-serviced nursing staff on incontinence care and hand hygiene on 10-10-2024. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The DON/Designee will monitor the Infection Tracking and mapping weekly x 4 weeks, then every other week x 4 weeks then once a month x 4 months for tracking and mapping of all infections. The DON/Designee will monitor 10 random staff members providing incontinence care, hand hygiene	

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	dress on a hanger on to residents feet and closed the door again. CNA 7 indicated the resident's urine did not get on the clean incontinence pad so they continued care. Resident M was rolled to the left side again while CNA pulled the new incontinence pad out and then rolled the resident to her back. CNA 7 wiped the resident's perineal (peri) area crease on the left, got a new wipe, and folded and wiped 3 times from front to back. CNA 7 lifted the resident's dress out of the way wearing the same gloves and both CNA 7 and RN 5 fastened the incontinence pad with their gloves on. CNA 7 opened the dresser drawer, put the wipes in a drawer, then closed it. CNA 7 grabbed the clean dress off the bed, opened the closet, hung the clean dress in the closet, and closed the closet. CNA 7 then used the controller to lower the bed to floor, and took off her gloves. She held on to her soiled gloves and touched those gloves to her left side scrub pocket to get a trash can liner from her pocket. RN 5 washed her hands with a 9 second lather with soap and then CNA 7 washed her hands with an 8 second lather. During an interview on 10/1/24 at 9:00 A.M., the Infection Preventionist (IP) indicated she would expect staff to clean the resident's front side, take off gloves, wash hands, put new gloves on, clean the resident's back side, and then remove gloves and wash hands. While washing their hands, staff should lather with soap for at least 20 seconds, should change gloves and wash hands if they touch items, they definitely should sanitize hands and change gloves between clean and dirty tasks, and should change gloves and sanitize hands after care was completed before they touch any other items. On 9/30/24 at 3:14 P.M., a current Perineal Care Policy, dated 4/12/23, was provided by the		and not touching items with soiled gloves on random shifts for weekly x 4 weeks, then 5 random staff members weekly x 4 weeks, then 3 random staff members weekly x 4 weeks, then 3 random staff members monthly x 3 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. by what date the systemic changes for each deficiency will be completed. 10/25/2024	

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	Director of Nursing (DON) and indicated " ... separate the labia and clean downward from front to back ... turn the resident to the side ... clean the rectal area ... " On 9/30/24 at 3:14 P.M., a current Guidelines for Gloves Policy, dated 4/12/23, was provided by the DON and indicated " ... Procedure: perform hand hygiene apply latex free non-sterile gloves one at a time ... remove gloves ... perform hand hygiene ... if for any reason there is a need to remove the gloves and reapply new gloves, hand hygiene must occur between the removal of the used pair of gloves and the application of the new pair of gloves ... " On 9/30/24 at 3:14 P.M., a current non dated Hand Hygiene Policy was provided by the DON, and indicated " ... hands should be washed with a non-microbial or anti-microbial soap ... apply generous amount of soap to hands and run hands together vigorously for at least 20 seconds ... On 10/1/24 at 9:32 A.M., the IP provided a current Guidelines for infection Prevention and Control policy, dated 8/17/23 that indicated, " ...A surveillance system designed to do the following will be maintained: Identify possible communicable diseases or infections before they can spread to other persons in the facility ...A recording system for incidents under the facility's INFECTION AND PREVENTION and CONTROL PROGRAM to do the following will be maintained: Identify any incident(s) considered as an infection "risk" within the facility ..." This Federal tag relates to Complaint IN00443360. 3.1-18(b)(1) 3.1-18(l)			

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F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations Based on interview and record review, the facility failed to administer or properly document the pneumococcal immunization for 3 of 5 residents reviewed for immunizations. Clinical records lacked documentation that the resident received or refused a pneumococcal vaccine when a consent was signed to receive the vaccine. (Resident 20, Resident 5, Resident 4) Findings include: 1. On 9/30/24 at 9:17 A.M., Resident 20's clinical record was reviewed. Diagnosis included, but was not limited to schizoaffective disorder, hypertension, diabetes mellitus, hyperlipidemia, aphasia, non-Alzheimer's dementia, depression, and schizophrenia. The most recent Quarterly MDS (Minimum Data Set) assessment, dated 9/13/24, indicated Resident 20 was severely cognitively impaired and his pneumococcal vaccine was not up to date. Resident 20 was 89 years old and was admitted on 12/9/22. Resident 20's immunization record was reviewed for pneumococcal vaccine. Resident 20 received Prevnar-13 on 12/20/2022. The clinical record lacked documentation that the second dose of the pneumococcal vaccine was offered, administered, or refused since that time. During an interview on 9/30/24 at 12:32 P.M., DON (Director of Nursing) indicated Resident 20 should have had a second pneumococcal vaccine. 2. On 9/30/24 at 9:17 A.M., Resident 5's clinical	F 0883	F 883 It is the intent of this facility to administer the pneumococcal vaccine and document when resident consent to receive the vaccine. what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The DON/Designee notified the MD of resident 20, 5 and 4 consented but did not receive the pneumococcal vaccine, new orders received and pneumococcal vaccines administered on 10/10/2024. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; The DON/Designee completed an audit of all residents eligible to receive the pneumococcal vaccine and residents that requested the vaccine received the vaccine on 10/10/2024. what measures will be put	10/25/2024

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	record was reviewed. Diagnosis included, but was not limited to COPD (Chronic obstructive pulmonary disease), hypertension, fracture, depression, and asthma. The most recent Quarterly MDS Assessment, dated 8/1/24, indicated Resident 5 had moderate cognitive impairment and her pneumococcal vaccine was not up to date. Resident 5 was 85 and was admitted on 8/1/22. Resident 5's immunization record was reviewed for pneumococcal vaccine. The most recent consent form for the pneumococcal vaccine was signed on 8/3/22. The clinical record lacked documentation that the pneumococcal vaccine was offered, ordered, administered, or refused since that time. 3. On 9/26/24 at 11:50 A.M., Resident 4's clinical record was reviewed. Diagnosis included, but was not limited to abscess of lung without pneumonia, asthma, diabetes mellitus with diabetic neuropathy, COPD, and dementia. The most recent Quarterly MDS assessment, dated 9/15/24, indicated Resident 4 was cognitively intact and her pneumococcal vaccine was not up to date. Resident 4 was 88 and admitted on 4/1/23. Resident 4's immunization record was reviewed for pneumococcal vaccine. The most recent consent form was signed on 5/27/23 to receive the pneumococcal vaccine. The clinical record lacked documentation that the pneumococcal vaccine was ordered, administered, or refused. During an interview on 9/30/24 at 2:42 P.M., DON (Director of Nursing) indicated if residents have a signed consent form they should receive the		into place and what systemic changes will be made to ensure that the deficient practice does not recur; The DON/Designee in-serviced the nursing staff on the policy "Pneumococcal Vaccine" and entering into the Electronic Medical Record consents, refusals and when vaccine administered on DATE. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; The DON/Designee will monitor new admissions, re-admissions and any new consent for current residents for consents for the pneumococcal vaccine, administration and documentation of the vaccine x 6 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any	

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	vaccine. On 9/24/24 at 11:15 A.M., the Administrator provided an undated Guidelines for Pneumococcal Vaccination policy which indicated "It is the intent of the facility to minimize the risk of residents acquiring, transmitting, and /or experiencing complications from Pneumococcal pneumonia. This policy will assure that each resident and/or the Representative/(POA)[Power of Attorney] is informed about the benefits and risks of immunization related to Pneumococcal pneumonia and that each resident has the opportunity to receive the vaccine unless medically contraindicated or refused- or the resident has already been immunized with the vaccine. The resident's (facility) medical record will contain documentation as to the information/education provided to the resident and/or their Representative/(POA) regarding the risks and benefits of this immunization as well as the administration or the refusal of the vaccine, or the medical contraindication to the vaccine done by the facility." 3.1-13(a)		written Action Plan will be monitored by the Administrator weekly until resolved. by what date the systemic changes for each deficiency will be completed. 10/25/24	