STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00431677, IN00431905, and IN00432779. Complaint IN00431677 - No deficiencies related to the allegation are cited. Complaint IN00431905 - Federal/State deficiencies related to the allegations are cited at F584, F677, and F686. Complaint IN00432779 - No deficiencies related to the allegations are cited. Survey dates: May 13, 14, 15, 16, 17, and 20, 2024 Facility number: 000120 Provider number: 155214 AIM number: 100274780 Census Bed Type: SNF/NF: 143 SNF: 35 NCC: 3 Total: 181 Census Payor Type: Medicare: 27 Medicaid: 108 Other: 46 Total: 181 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/24/24.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jami Moore	HFA	06/18/2024

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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F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had physician's orders for self-administration of medications for 1 of 1 resident reviewed for self-administration of medication. (Resident 111) Finding includes: On 5/14/24 at 9:21 a.m., Resident 111 was observed in her room in bed. There was a medication cup noted with multiple pills in it on the table next to her. The resident indicated the nurses always had left her morning medications for her to take after she had eaten her breakfast. Resident 111's record was reviewed on 5/15/24 at 1:22 p.m. Diagnoses included, but were not limited to, dementia, heart disease, and anxiety disorder. A Significant Change Minimum Data Set (MDS) assessment, dated 4/5/24, indicated the resident was cognitively intact for daily decision making. She had taken antidepressants, anticoagulants, diuretics, and opioid medications in the last 7 day look back period. An Interdisciplinary Team (IDT) note, dated 5/14/2024 at 9:18 a.m., indicated the IDT met to review the resident and determined the resident was able to self-administer prescribed medications prepared by the nurse or QMA. The medications to be self-administered were furosemide 40 milligrams (mg) everyday, l-methylfolate 15 mg daily, levothyroxine 75 micrograms daily, macrobid	F 0554	**F 554 Resident Self-Admin Meds-Clinically Appropriate** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** Self-administration orders were completed for resident 111 observed in this deficiency. Family and physicians were notified. Physicians gave new orders for residents to keep medications at bedside/self-administer medications. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** Whole house audit of self-administration orders to ensure orders are in place. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nursing staff educated on self-administration policy for residents and completing self-administration resident assessments and orders if	06/12/2024

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	100 mg twice daily until complete, memantine 5 mg daily, norco 5-325 mg every four hours as needed (PRN), potassium 10 milliequivalents daily, pregabalin 200 mg twice daily, rivastingmine 1.5 mg twice daily, senna docusate 8.6 mg every 12 hours PRN, sumatriptan 100 mg every 2 hours PRN, tobramycin 1 drop in both eyes until complete. There were no physician orders for self-administration of the medications. During an interview on 5/16/24 at 11:09 a.m., the Administrator indicated there should have been an order to self administer the medications. 3.1-11(a)		appropriate. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/Designee will audit (3) residents per day for (5) days a week for (6) months to ensure no medications are kept at bedside prior to self-administration assessments/orders being completed. Director of Nursing/Designee will report audit findings to the QAPI committee monthly for (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing			

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	form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review and interview, the facility failed to notify the family/representative of a significant weight loss, a weight loss, and a new order for a nutritional supplement for 2 of 7 residents reviewed for nutrition. (Residents 59 and 143)	F 0580	**F 580 Notification of Changes** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** Resident 59 and 143	06/12/2024

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	Findings include: 1. Resident 59's record was reviewed on 5/14/24 at 2:42 p.m. Diagnoses included, but were not limited to, Lewy body dementia, psychotic disorder, depressive disorder and diabetes mellitus. The resident resided on the locked dementia unit. The Quarterly Minimum Data Set (MDS) assessment, dated 3/29/24, indicated the resident had severe cognitive impairment and required limited staff assistance for bed mobility and transfers, and could eat independently after set up. The Current Physician Orders indicated the resident was on a regular diet. There were no nutritional supplements or fortified food ordered. The resident's weights were as follows: 2/5/24: 232 pounds (lbs) 2/11/24: 230 lbs 2/18/24: 218 lbs 2/25/24: 217 lbs 3/6/24: 217 lbs This was a weight loss of 15 lbs, 5%, in one month. There was no documentation the family had been notified. A Quarterly Nutrition Review, dated 3/29/24, indicated the resident had a significant weight loss of 5% in 30 days. The resident did not receive snacks, supplements or fortified food. The resident's weight had been stable since 2/18. The resident's intake of food and fluid was estimated to meet needs at the time. There were no new nutritional recommendations at the time. The resident's continued weights were as follows:		families/RP/person of interest were notified of weight loss and weight loss interventions. Family and physicians were notified. Physicians gave no new orders for residents. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** Whole house audit of all residents with significant weight loss to ensure families/RP/person of interest are notified of weight loss, interventions, and any changes to interventions. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** DON, clinical CDM, and unit managers were educated to ensure that resident families/RP/person of interest are notified when resident is noted to have a significant weight loss/interventions put in place/any new orders related to weight loss are received. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/Designee will audit residents noted in the weekly meeting “nutrition at risk review” for (6)	

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	4/2/24: 220 lbs (+3 lbs) 5/3/24: 203 lbs 5/7/24: 203 lbs (reweigh) This was an additional weight loss of 14 pounds, for a total weight loss of 29 pounds, 12.5%, since her admission on 2/5/24. There was no documentation the family had been notified. During an interview on 5/17/24 at 12:52 p.m., a family member indicated she had been notified yesterday, 5/16/24, of the current 17 pound weight loss. She had not been notified of additional weight losses. She was unaware of the significant weight loss that occurred from 2/5/24-3/6/24. During an interview on 5/17/24, the Director of Nursing indicated there was no documentation the family had been notified of the initial significant weight loss. 2. Resident 143's record was reviewed on 5/17/24 at 1:55 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia, iron deficiency, and chronic lymphocytic leukemia. The Quarterly MDS assessment, dated 3/11/24, indicated the resident had significant cognitive impairment, required limited assistance with bed mobility and transfers, and could eat independently after set up. The resident's weights were as follows: 11/1/23: 124 lbs 3/6/24: 116 lbs This was an eight pound, 6.45% loss, in four months. There was no documentation the family had been notified. A Physician's Order, dated 3/23/24, indicated to give a health shake with breakfast daily for weight		months to ensure resident families/RP/person of interest are notified when resident has a significant weight loss/interventions put in place/any new orders related to weight loss are received. Director of Nursing/Designee will report audit findings to the QAPI committee monthly for (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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	loss. There was no documentation the family had been notified of the new order. During an interview with a family member on 5/20/24 at 1:03 p.m., she indicated her mother was not on a special diet and had not lost any weight that she was aware of. She indicated she was not aware of the eight pound weight loss or new order for health shake daily. During an interview with the Administrator on 5/20/24 at 3:00 p.m., she indicated there was no documentation the family had been notified. The policy, "Resident Weight Monitoring", indicated, "...The resident's physician and family/guardian will notified of any verified significant weight change..." 3.1-5(a)(3)			
F 0584 SS=D Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.			

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	(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation and interview, the facility failed to ensure a clean and homelike environment related to stained and dirty bed linens for 1 of 35 residents reviewed for a homelike environment. (Resident B) Finding includes: On 5/14/24 at 10:03 a.m., Resident B was observed lying in bed with his eyes closed. There was a dark reddish-brown stain on the bottom sheet next to where his left forearm was resting. His pillowcase also had a large brown stain along the end of it.	F 0584	**F 584 Home like Environment** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** Bed sheets were changed for resident B. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:**	06/12/2024

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	On 5/15/24 at 10:42 a.m., Resident B was observed lying in bed with his eyes closed. The stains remained to the bottom sheet and the pillowcase. On 5/15/24 at 10:58 a.m., a CNA exited the room after providing care to Resident B. Resident B was now sitting up in his wheelchair in his room. His bed had been made, however, the stains remained to the bottom sheet and the pillowcase. During an interview with the Administrator on 5/15/24 at 11:11 a.m., she indicated the linens were probably already stained when they were put on the bed. She then changed the linens. This citation relates to Complaint IN00431905. 3.1-19(f)(5) 3.1-19(g)(4)		All residents have the potential to be affected by this deficiency. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Facility staff educated to change bed sheets/notify staff if noted debris, stains, or holes are noted. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** Administrator/Designee will audit (10) resident's beds per day for (5) days for (6) months to ensure sheets are clean. Administrator/Designee will report audit findings to the QAPI committee monthly for (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	
F 0622 SS=A Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved			

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	sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving			

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	health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on record review and interview, the facility failed to ensure a resident had a transfer/discharge summary completed and was given a written notice of the bed hold policy and the appeal of rights information after the facility	F 0622	**F 622 Transfer and Discharge Requirements** **The corrective actions that were accomplished for those residents to have been affected**	06/12/2024

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	initiated transfer of the resident to the hospital, for 1 of 2 residents reviewed for hospitalization. (Resident 89) Finding includes: The record review for Resident 89 was completed on 5/16/24 at 1:37 p.m. Diagnoses included, but were not limited to, obstructive uropathy, diabetes mellitus, and end stage renal disease. The Quarterly Minimum Data Set (MDS) assessment, dated 4/1/24, indicated the resident was cognitively intact. The resident was dependent for toileting and required substantial assistance with bed mobility. The resident had an indwelling urinary catheter. A Progress Note, dated 4/12/24 at 11:00 p.m., indicated the resident had returned to the facility at that time via emergency medical services from the emergency room at the hospital. The resident's urinary catheter was draining clear yellow urine. New orders were received to start an antibiotic medication. The record lacked any documentation of when the resident was sent out to the emergency room from the facility. There was a lack of documentation that a transfer/discharge summary for the resident was completed, or the resident received the notice of the bed hold policy and the appeal of rights information after the facility initiated the transfer of the resident to the hospital. During an interview on 5/17/24 at 1:38 p.m., the Director of Nursing indicated the resident had gone to the emergency room for penile pain. Nursing staff should have completed a transfer/discharge assessment.		**by from the practice are:** Resident 89 has returned from the hospital. Family and physicians were notified. Physicians gave new orders for resident. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents who are discharged to the hospital have a potential to be affected by this deficiency. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nursing staff were educated discharge assessments. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/Designee will audit hospital discharges the following day in IDT clinical meeting for (6) months to ensure compliance with discharge assessments. Director of Nursing/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-12(a)(6)(A) 3.1-12(a)(9)(A)			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure dependent residents received the activities of daily living (ADL) care needed related to showers not given as scheduled, facial hair unshaven, and soiled sheets on a resident's bed for 5 of 8 residents reviewed for ADL care. (Residents 76, 121, 52, C, and 45) Findings include: 1. On 5/13/24 at 2:53 p.m., Resident 76 was observed lying in his bed. His hair appeared greasy and there was visible white debris observed. His beard had visible food debris. On 5/14/24 at 9:11 a.m., the resident was observed lying in bed. His hair was greasy with white debris observed. The resident's record was reviewed on 5/15/24 at 12:50 a.m. Diagnoses included, but were not limited to, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) following a cerebral vascular accident, diabetes mellitus and vascular dementia. The Annual Minimum Data Set assessment, dated 2/8/24, indicated the resident had moderate	F 0677	**F 677 ADL Care Provided for Dependent Residents** **The corrective actions that were accomplished for those residents to have been affected by the practice are:** Residents 52,76,C,45,and 121 identified in this deficiency were provided with the deficient ADL care noted in observation. Family and physicians were notified. Physicians gave no new orders. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Facility clinical staff were educated on providing showers, shaving assistance, and to ensure	06/12/2024

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	cognitive impairment and required extensive assistance for bed mobility and toileting. The current ADL Care Plan indicated the resident needed total assistance for bathing/showering due to activity intolerance, hemiplegia, and physical debility. The shower book indicated he was to receive a shower twice weekly on Wednesday and Saturday. Shower sheets for the past 30 days were reviewed as follows: 4/20/24: bed bath 5/1/24: bed bath 5/4/24: bed bath 5/11/24: bed bath 5/15/24: bed bath There were no documented showers, bed baths, or refusals for 4/24, 4/27 or 5/8/24. During an interview on 5/15/24 at 2:26 p.m., CNA 8 indicated if a resident refused a shower, then a bed bath was offered. If they refused the bed bath, a refusal form should be completed and the nurse was to be notified. During an interview on 5/16/24 at 11:15 a.m., the Director of Nursing indicated there were no additional shower sheets available. 2. During an interview on 5/13/24 at 11:17 a.m., Resident 121 indicated he was not getting showers twice weekly as scheduled. The residents record was reviewed on 5/16/24 at 11:45 a.m. Diagnoses included, but were not limited to, congestive heart failure, unspecified dementia, and diabetes mellitus.		solid sheets are changed. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/designee will observe (5) residents per (5) days per week for (6) months to ensure showers are provided per scheduled, shaved per preference, and nails are clean. DON/designee will report audit findings to the QAPI committee monthly for (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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	The Annual MDS assessment, dated 3/15/24, indicated he was cognitively intact and required extensive assistance for bed mobility and limited assistance for toileting and transfers. The current ADL Care Plan indicated he needed total assistance with bathing/showering related to activity intolerance and dementia. The shower book indicated he was to receive a shower twice weekly on Monday and Thursday. Shower sheets for the past 30 days were reviewed as follows: 4/24/24: shower 4/29/24: shower 5/2/24: shower 5/9/24: shower There were no documented showers, bed baths, or refusals for 4/18, 4/22, 5/6 or 5/13. During an interview on 5/16/24 at 11:15 a.m., the Director of Nursing indicated there were no additional shower sheets available. 3. On 5/14/24 at 10:17 a.m., Resident 52 was observed lying in bed. The resident had long facial hair observed to her chin. The resident indicated the staff would sometimes shave her and was unsure the last time she was shaved. On 5/15/24 at 11:09 a.m., Resident 52 was observed lying in bed. The resident was still observed with long facial hair to her chin. The record review for Resident 52 was completed on 5/15/24 at 11:10 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, heart failure, hypertension, diabetes mellitus, dementia, and stroke.			

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	The Quarterly Minimum Data Set (MDS) assessment, dated 4/29/24, indicated the resident was cognitively intact. The resident was dependent for bathing, transfers and mobility. The resident required substantial/maximal assistance for personal hygiene. A Care Plan, dated 1/27/24 and revised 1/30/24, indicated the resident needed assistance with activities of daily living. An intervention included the resident needed an extensive assistance x 1 person for personal hygiene. During an interview on 5/15/24 at 2:04 p.m., CNA 2 indicated the resident was given 1 shower a week and 1 bed bath a week. She was to be shaved weekly with her bathing or when her facial hair was observed. CNA 2 had given the resident a bed bath the day before and did not shave the resident, but she should have shaved her.4. On 5/14/24 at 9:39 a.m., Resident C was observed in bed wearing only a t-shirt and appeared disheveled. He had no brief on and the linens under him were soiled. On 5/14/24 at 10:16 a.m., Resident C was observed in bed wearing only a t-shirt. He had no brief on and the linens under him were soiled. Resident C's record was reviewed on 5/14/24 at 2:16 p.m. Diagnoses included, but were not limited to peripheral vascular disease and type 2 diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 4/5/24, indicated the resident was severely cognitively impaired. He was dependent on staff for toileting hygiene and required substantial/maximal assistance for personal hygiene and shower/bathing.			

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	A Care Plan, dated 4/1/24, indicated the resident needed assistance with activities of daily living. Interventions included, but not limited to, the resident required extensive assistance for toilet use. The Shower Sheets from April and May 2024 indicated the resident had refused on 4/13/24, received a shower on 4/15/24, refused on 4/27/24, and received a shower on 4/28/24. There was nothing further documented. During an interview on 5/16/24 at 10:02 a.m., the Administrator had no further information to provide. 5. During an interview on 5/13/24 at 11:34 a.m., Resident 45 indicated she was not receiving showers twice a week. Resident 45's record was reviewed on 5/16/24 at 1:13 p.m. Diagnoses included, but were not limited to, schizoaffective disorder, anxiety disorder, and bipolar disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 2/21/24, indicated the resident was moderately cognitively impaired for daily decision making. She required substantial/maximal assistance for showering. A Care Plan, dated 9/22/23, indicated the resident needed assistance with activities of daily living. Interventions included, but were not limited to, the resident required extensive assistance with showering and had fluctuations in needs and provide additional staff assistance as needed. The Shower Sheets were reviewed for April and			

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	May 2024 and indicated the resident received a shower on 4/5/24, 4/9/24, 4/16/24, 4/19/24, 4/23/24, 5/7/24, and 5/14/24. During an interview on 5/20/24 at 2:37 p.m., the Director of Nursing had no further information to provide. This citation relates to Complaint IN00431905. 3.1-38(a)(3)(D) 3.1-38(b)(2)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to the monitoring and assessment of skin discolorations for 3 of 7 residents reviewed for non-pressure related skin conditions. (Residents B, 66, and 10) Findings include: 1. On 5/14/24 at 10:03 a.m., Resident B was observed lying in bed with his eyes closed. He had 2 scabbed areas to his right forearm and multiple purple discolorations to his left forearm.	F 0684	**F 684 Quality of Care** **The corrective actions that were accomplished for those residents to have been affected by the practice are:** Residents were assessed and monitoring put in place for bruising. MD orders updated for treatment placed on residents 66,10. Family and physicians were notified. Residents are in stable condition and experienced no negative outcomes as a result of this observation.	06/12/2024

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	On 5/15/24 at 10:42 a.m., Resident B was observed lying in bed with his eyes closed. The scabbed areas and discolorations remained to his arms. Record review for Resident B was completed on 5/15/24 at 3:50 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, dementia with behavioral disturbance, and chronic kidney disease. The Significant Change Minimum Data Set (MDS) assessment, dated 3/5/24, indicated the resident was cognitively impaired and required substantial/maximal assist with upper body dressing. A current Care Plan, updated 3/11/24, indicated the resident was at risk for skin breakdown. An intervention included, "skin inspection weekly and as needed, document and notify md of abnormal findings..." The most recent Weekly Nursing Summary, dated 4/25/24, indicated there were no current skin issues. During an interview on 5/15/24 at 3:10 p.m., the Director of Nursing (DON) indicated the Wound Nurse would assess the resident's skin. No further information was provided. 2. On 5/13/24 at 10:49 a.m., Resident 66 was observed seated in her Broda chair in her room. There were dark purple discolorations to the tops of both hands. On 5/15/24 at 10:04 a.m., Resident 66 was observed seated in her Broda chair in her room. The dark purple discolorations remained to the tops of both hands.		**How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nursing staff educated on obtaining orders for any treatment placed on residents and to ensure assessments and monitoring of noted bruises are in place. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/designee will observe (3) residents (5) days a week for (6) months to identify any new non-pressure skin concerns are monitored and addressed. DON/designee will report audit findings to the QAPI committee monthly for (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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Record review for Resident 66 was completed on 5/16/24 at 1:41 p.m. Diagnoses included, but were not limited to, hypertension, dementia with psychotic disturbance, and hyperlipidemia.

The Quarterly Minimum Data Set (MDS) assessment, dated 4/5/24, indicated the resident was cognitively impaired. She was dependent on staff for upper body dressing and received antiplatelet medications.

A current Care Plan, updated 4/8/24, indicated the resident was at risk for increased bruising or bleeding due to aspirin therapy. An intervention included, "observe for signs of abnormal bleeding such as increased frequency of bruising, increased size of bruises...document abnormal findings and notify MD..."

The Medication Administration Record (MAR), dated 5/2024, indicated the resident had received aspirin daily.

The most recent Weekly Nursing Summary, dated 5/4/24, indicated there were no current skin issues.

During an interview on 5/16/24 at 11:13 a.m., the Administrator was made aware of the skin discolorations. No further information was provided.

3. On 5/13/24 at 2:32 p.m., Resident 10 was sitting in a wheelchair in his room. He had scattered discolorations noted to bilateral lower legs, a splotchy reddened area on his neck, and his right arm was red and swollen. He indicated he had lotion to put on his lower legs, but could not reach it himself. He was unsure what happened with his neck and his right arm was swollen.

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	Resident 10's record was reviewed on 5/14/24 at 3:01 p.m. Diagnoses included, but were not limited to, congestive heart failure, respiratory failure, and cellulitis of the right upper limb. The Quarterly Minimum Data Set (MDS) assessment, dated 5/8/24, indicated the resident was severely cognitively impaired for daily decision making. There was no documentation related to the discolorations noted to the bilateral shins or reddened area on the neck in the record. During an interview on 5/16/24 at 3:15 p.m., the Wound Nurse indicated the resident had never had a rash on his neck that she was aware of, but he occasionally had heat rashes. She was not aware of the discolorations to the lower extremities. 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on observation, record review, and	F 0685	**F 685 Treatment/Devices to**	06/12/2024

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	interview, the facility failed to ensure a resident received the assistive device needed to maintain vision related to broken glasses not addressed in a timely manner, for 1 of 2 residents reviewed for vision/hearing. (Resident 76) Finding includes: On 5/13/24 at 2:53 p.m., 5/14/24 at 9:11 a.m., and 5/15/24 at 1:20 p.m., Resident 76 was observed lying in his bed. There was a pair of glasses with one of the arms broken off sitting on the overbed table. The resident indicated he used them for reading. The resident's record was reviewed on 5/15/24 at 12:50 a.m. Diagnoses included, but were not limited to, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) following a cerebral vascular accident, diabetes mellitus, and vascular dementia. The Annual Minimum Data Set assessment, dated 2/8/24, indicated the resident had moderate cognitive impairment and required extensive assistance for bed mobility and toileting. There was no documentation in the record related to the broken glasses or optometry appointments. During an interview on 5/16/24 at 9:47 a.m., CNA 1 indicated the glasses had been broken for several days. She did not know if the nurse or Unit Manager had been notified of the broken glasses because she had been off work for a couple days. The glasses had been broken before and the Social Service Director (SSD) took care of it. During an interview on 5/16/24 at 9:55 a.m., the SSD indicated she had not been notified the		**Maintain Hearing and Vision** **The corrective actions that were accomplished for those residents to have been affected by the practice are:** Facility attempted to have ophthalmologist complete visit for resident 76 to receive new glasses. however, resident refused. Family and physicians were notified. Physician gave no new orders. Resident is in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** Whole house audit of residents with glasses to ensure glasses are in functional order. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** All staff educated on ensuring it is communicated when a resident has broken glasses. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** SSD/designee will conduct audit (3) residents (5) times a week for (6) months to identify any concerns with resident glasses. Any trends will be reported to	

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	glasses were broken but would look into it. 3.1-39(a)(b)		Executive Director and Administrator. SSD/designee will report audit findings to the QAPI committee monthly for (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure each resident received the necessary treatment and services to promote healing for pressure ulcers, related to ensuring a wound treatment and offloading boots were in place for 2 of 8 residents reviewed for pressure ulcers. (Residents D and E) Findings include: 1. The closed record for Resident D was reviewed	F 0686	**F 686 Treatment/Prevention Pressure Ulcers** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** Resident was discharged prior to the noted deficiency during survey. **How other residents of the facility were identified to potentially be affected by the**	06/12/2024

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	on 5/16/24 at 2:52 p.m. Diagnoses included, but were not limited to, anemia, dementia with mood disturbance, and atrial fibrillation. The resident was admitted to the facility on 2/7/24 and discharged on 4/1/24. The Admission Minimum Data Set (MDS) assessment, dated 2/13/24, indicated the resident was cognitively impaired, had no unhealed pressure ulcers, and was at risk for pressure ulcers. A Care Plan, dated 3/19/24, indicated the resident had a pressure ulcer to the left hip. An intervention included, "wound treatments as ordered." The Skilled Care Nursing Documentation form, dated 3/18/24, indicated there were no current skin issues. A Pressure Ulcer Note, dated 3/19/24 at 3:03 p.m., indicated the resident had a newly acquired stage 3 pressure ulcer to her left trochanter (hip). This was the first observation of the area, and it measured 0.7 cm (centimeters) x (by) 0.9 cm x 0.1 cm. A Skin and Wound Note by the Wound Nurse Practitioner (NP), dated 3/19/24 at 3:14 p.m., indicated the resident had MASD (moisture associated skin damage) to the left buttock that was healed and had a new pressure injury to the left hip. The left hip area measured 0.7 cm x 0.9 cm x 0.1 cm and was a stage 3. The treatment recommendation for the left hip was, "...1. Cleanse with wound cleanser. 2. apply medical grade honey to base of the wound. 3. secure with Bordered gauze. 4. change Daily, and PRN [as needed] ..."		**practice are:** Whole house audit of residents who have current orders for treatments and/or preventive boots to ensure accuracy and implementation of orders. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nursing staff educated on ensuring residents wear preventive boots; and if resident is non-compliant, the noncompliance is documented. Nursing staff educated to immediately inform DON if treatment order for pressure is resolved or treatment is inaccurate for location of wound. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** Wound nurse/Designee will observe (5) residents (5) days a week for (6) months to ensure preventive boots are worn, or noncompliance documentation is complete. Wound nurse/Designee will audit (5) residents per week to ensure accuracy of wound location is listed in treatment order. Wound nurse/Designee will report audit findings to the QAPI committee monthly for (6) months. The QAPI committee will monitor the data presented for any trends	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Pressure Ulcer Weekly Observation, dated 3/26/24, indicated the left trochanter pressure area measured 0.6 cm x 0.9 cm x 0.1 cm and was a stage 3. The area was improving, and treatment orders were in place. A Skin and Wound Note by the Wound NP, dated 3/26/24 at 12:48 p.m., indicated the left hip stage 3 area measured 0.6 cm x 0.9 cm x 0.1 cm and was healing. The treatment recommendation for the left hip was, "...1. Cleanse with wound cleanser. 2. apply medical grade honey to base of the wound. 3. secure with Bordered gauze. 4. change Daily, and PRN [as needed] ..." The Physician's Orders Summary, dated 3/2024, lacked any treatment orders for the left hip area. There was an order, dated 2/20/24, for silver sulfadiazine/miconazole/triamcinolone cream mixture to the left buttock every shift. This order was discontinued on 3/20/24 and a new order for the same treatment was put in as a preventative treatment to the left buttock starting 3/20/24. The Medication Administration Record (MAR), dated 3/2024, lacked documentation of any treatment to the left hip area at any time. During an interview with the Wound Nurse and the Director of Nursing (DON) on 5/17/24 at 9:45 a.m., the Wound Nurse indicated she had made a data entry error and had written left buttock instead of left hip in the treatment order on 3/20/24. She had disagreed with the Wound NP's recommendation for the medical honey treatment to the left hip and continued with the same treatment they had used to the left buttock area previously. She had not documented this. The Wound NP had seen the resident the following		& determine if further monitoring/action is necessary for continued compliance.	

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	155214	A. BUILDING 00 B. WING	05/20/2024

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	week and indicated the wound was healing. 2. On 5/13/24 at 10:47 a.m., Resident E was observed sitting in his Broda chair in his room. The pressure offloading boots were not observed in place to his feet. Two pressure offloading boots were observed on the floor behind his recliner. On 5/13/24 at 10:03 a.m., Resident E was observed sitting in his Broda chair in his room. The pressure offloading boots were not observed in place to his feet. Two pressure offloading boots were observed on the floor behind his recliner. Record review for Resident E was completed on 5/15/24 at 10:34 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, type 2 diabetes mellitus, and anemia. The Significant Change Minimum Data Set (MDS) assessment, dated 2/29/24, indicated the resident had 2 unstageable pressure ulcers and one suspected deep tissue injury. A current Care Plan indicated the resident was at risk for skin breakdown. The interventions included, preventative skin care as ordered. A Wound Nurse Practitioner Note, dated 3/5/24, indicated the deep tissue injury (DTI) to the right heel had resolved. A Physician's Order, dated 3/6/24, indicated bilateral heel offloading boots/float heels as tolerated every shift for preventative. A Physician's Order, dated 2/8/24, indicated to assist resident to elevate heels off the bed with boots every shift for preventative.			

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	The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 5/2024, indicated the offloading boots had been signed off every shift. During an interview with the DON on 5/15/24 at 3:10 p.m., she was made aware the resident's offloading boots had not been in place. She indicated the order was written to wear the boots "as tolerated" and the resident may not like to wear them or kick them off. She was unable to provide any documentation the resident had refused to wear the boots or was not tolerating them. This citation relates to Complaint IN00431905. 3.1-40(a)(2)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence			

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	unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure a resident's positioning was maintained related to hand splints not applied as ordered, for 3 of 4 residents reviewed for positioning/mobility. (Residents 76, 10 and 125) Findings include: 1. On 5/13/24 at 2:53 p.m., Resident 76 was observed lying in his bed. His left hand was contracted and there was no splint in place. On 5/15/24 at 1:20 p.m., the resident was observed lying in bed. His left hand was contracted and there was no splint in place. The resident indicated he used to wear a splint, but was told he didn't need to wear it anymore. He was unable to open his left hand. The resident's record was reviewed on 5/15/24 at 12:50 a.m. Diagnoses included, but were not limited to, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) following a cerebral vascular accident, diabetes mellitus and vascular dementia. The Annual Minimum Data Set assessment, dated 2/8/24, indicated the resident had moderate cognitive impairment and required extensive assistance for bed mobility and toileting. A Physician's Order, dated 2/6/24, indicated the resident was to wear a left resting hand splint 6-8 hours daily as tolerated to promote anatomical alignment and prevent contracture. The April and May 2024 Treatment	F 0688	**F688 Increase/Prevent Decrease in ROM/Mobility** **The corrective actions that were accomplished for those residents to have been affected by the practice are:** Resident 125,75,10 MD orders were updated to reflect on MAR. Resident 125 care plan updated to include refusals of splint placement. Family and physicians were notified. Physician gave no new orders. Resident is in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** Whole house audit of residents with splint orders was complete. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nursing staff educated on ensuring splints are worn by residents per MD order. Nursing staff was educated on verifying splint orders to ensure they are reflected on MAR. Therapy department was educated on splint orders and communication to nursing department with all new splint orders.	06/12/2024

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	Administration Record (TAR) did not have the splint order, so there was no documentation if it was applied or refused. During an interview on 5/15/24 at 2:17 p.m., LPN 1 indicated she did not know if the resident was supposed to wear a splint or not. During an interview on 5/15/24 at 3:05 p.m., the Director of Nursing provided a copy of the physician's order for the splint and a care card that indicated the resident was to wear a left hand splint as tolerated. She was unaware the treatment was not showing up on the TAR. No additional information was provided. 2. On 5/13/24 at 2:32 p.m., Resident 10 was sitting in a wheelchair in his room. His right forearm was resting on the armrest of the wheelchair and noted to be red and swollen. He was not wearing any splinting device. On 5/15/24 at 10:21 a.m., Resident 10 was noted in a wheelchair in his room. His right forearm was resting in his lap with no splinting device. On 5/16/24 at 9:32 a.m., Resident 10 was noted in a wheelchair in his room with his right forearm resting in his lap with no splinting device. Resident 10's record was reviewed on 5/14/24 at 3:01 p.m. Diagnoses included, but were not limited to, congestive heart failure, respiratory failure, and cellulitis of the right upper limb. The Quarterly Minimum Data Set (MDS) assessment, dated 5/8/24, indicated the resident was severely cognitively impaired for daily decision making. A Care Plan, dated 3/7/24, indicated the resident needed assistance with activities of daily living.		**Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/designee will observe (2) residents (5) days a week for (6) months to ensure splits are in place per MD order and therapy orders are inputted. Any trends will be reported to Executive Director and Administrator. DON/designee will report audit findings to the QAPI committee monthly for (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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	Interventions included, but were not limited to, right hand brace per Physician's Orders. A Physician's Order, dated 5/1/24, indicated right hand splint, circulation checks every shift. During an interview on 5/20/24 at 2:37 p.m., the Director of Nursing had no further information to provide. 3. During an interview on 5/13/24 at 2:55 p.m., Resident 125 indicated his left hand was contracted. He wore a splint at one time, but staff had not assisted with putting it on "in a long time. They never look at my hand any more, not even for nail care." On 5/15/24 at 11:12 a.m., Resident 125 was observed in his bed with no splinting device to his left hand. Resident 125's record was reviewed on 5/16/24 at 9:43 a.m. Diagnoses included, but were not limited to type 2 diabetes mellitus and heart failure. The Admission Minimum Data Set (MDS) assessment, dated 3/19/24, indicated the resident was cognitively intact for daily decision making. He had no impairment to both lower extremities for range of motion. There was no care plan related to a contracture or splinting device. The May 2024 Physician's Order Summary indicated the resident was to wear a left hand splint for up to 8 hours during the day as tolerated to promote skin integrity and prevent further contracture.			

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	During an interview on 5/16/24 at 11:09 a.m., the Administrator indicated the resident had a contracture to the left hand. The staff put the splinting device on and he would take it off. He did not have any care plans related to the contracture or splinting device or documentation of refusals. 3.1-42(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure fall interventions were in place for 2 of 3 residents reviewed for accidents. (Residents B and 91) Findings include: 1. On 5/14/24 at 10:03 a.m., Resident B was observed lying in bed with his eyes closed. There were no floor mats in place at the bedside. Both mats were leaning up against the wall by the window. On 5/15/24 at 10:42 a.m., Resident B was observed lying in bed with his eyes closed. There were no floor mats in place at the bedside. Both mats were leaning up against the wall by the window.	F 0689	**F 689 Free of Accidents Hazards/Supervision/Devices** **The corrective actions that were accomplished for those residents to have been affected by the practice are:** Resident 91 fall interventions were put into place. Family and physicians were notified. Physician gave no new orders. Resident is in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the**	06/12/2024

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	Record review for Resident B was completed on 5/15/24 at 3:50 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, dementia with behavioral disturbance, and chronic kidney disease. The Significant Change Minimum Data Set (MDS) assessment, dated 3/5/24, indicated the resident was cognitively impaired and required substantial/maximal assist with bed mobility and transfers. A current Care Plan, updated 3/11/24, indicated the resident was at risk for falls An intervention included, "mat beside bed." During an interview with the Director of Nursing (DON) on 5/15/24 at 3:10 p.m., she was made aware the floor mats had not been in place. No further information was provided. 2. On 5/14/24 at 9:47 a.m., Resident 91 was observed seated in her Broda chair near the Nurse's Station. She was not wearing any socks and had bare feet. On 5/15/24 at 10:03 a.m., Resident 91 was observed seated in her Broda chair near the Nurse's Station. She was not wearing any socks and had bare feet. The record for Resident 91 was reviewed on 5/16/24 at 9:35 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, osteoarthritis, and hypothyroidism. The Significant Change Minimum Data Set (MDS) assessment, dated 3/20/24, indicated the resident was cognitively impaired and one fall since the		**practice are:** Whole house audit of resident fall interventions complete. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nursing staff educated on ensuring fall interventions are in place. Nurse leadership educated to ensure care cards are updated with fall interventions. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/designee will conduct random observation of fall interventions for (3) residents per unit (5) times a week for (6) months. DON/designee will report audit findings to the QAPI committee monthly for (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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	prior assessment. A current Care Plan, updated 3/27/24, indicated the resident was at risk for falls. An intervention included, "encourage and assist to wear appropriate non-skid footwear." During an interview with the Director of Nursing (DON) on 5/15/24 at 3:10 p.m., she indicated she was unsure why the resident had not been wearing socks. She would find out and if she liked to keep them off or kick them off, she would update the care plan to reflect that. 3.1-45(a)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that			

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	catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure urinary output was recorded as per the plan of care for 1 of 1 residents reviewed for urinary catheters. (Resident 89) Finding includes: On 5/13/24 at 1:57 p.m., Resident 89 was observed lying in bed. The resident had a urinary catheter attached to the side of his bed. The bag was observed with a small amount of urine in the bag. The resident indicated staff did not empty his catheter bag and he would have to tell them multiple times a day to make sure they emptied it. Record review for Resident 89 was completed on 5/16/24 at 1:37 p.m. Diagnoses included, but were not limited to, obstructive uropathy, diabetes mellitus, and end stage renal disease. The Quarterly Minimum Data Set (MDS) assessment, dated 4/1/24, indicated the resident was cognitively intact. The resident was dependent for toileting and required substantial assistance with bed mobility. The resident had an indwelling urinary catheter.	F 0690	**F 690 Bowel/Bladder Incontinence Catheter, UTI** **The corrective actions that were accomplished for those residents to have been affected by the practice are:** Resident 89 was assessed. Urine output noted. Family and physicians were notified. Resident is in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** Whole house audit of residents with orders to document urine output was complete. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nursing staff educated on ensuring urine output is documented per orders.	06/12/2024

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	A Care Plan, dated 5/8/23 and revised 6/28/23, indicated the resident was at risk for infection or complications related to an indwelling catheter. An intervention included to document the catheter output every shift. The Bowel and Bladder Care in the Tasks section, dated 4/16/24-5/15/24, indicated the catheter output was not documented on the following dates and shifts: - Evening shifts on 4/18, 4/19, 4/24, and 4/27/24 - Midnight shifts on: 4/16, 4/17, 4/19, 4/21, 4/22, 4/23, 4/27/24, 4/28, 4/29, 4/30, 5/1, 5/2, 5/3, 5/5, 5/10, 5/12, 5/13, 5/14, and 5/15/24 During an interview on 5/17/24 at 1:38 p.m., the Director of Nursing indicated the staff should have documented the urinary output on the Tasks documentation every shift. 3.1-41(a)(2)		**Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/designee will review (2) residents (5) days per week for (6) months to ensure urine output was properly documented. DON/designee will report audit findings to the QAPI committee monthly for (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;			

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	§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure interventions were implemented for a resident with a significant weight loss, failed to ensure food consumption logs were completed and weekly weights were completed as ordered for 3 of 7 residents reviewed for nutrition. (Residents 59, 91 and 158) Findings include: 1. Resident 59's record was reviewed on 5/14/24 at 2:42 p.m. Diagnoses included, but were not limited to, Lewy body dementia, psychotic disorder, depressive disorder, and diabetes mellitus. The resident resided on the locked dementia unit and was admitted on 2/5/24. The Quarterly Minimum Data Set (MDS) assessment, dated 3/29/24, indicated the resident had severe cognitive impairment and required limited staff assistance for bed mobility and transfers, and could eat independently after set up. The current May 2024 Physician Order Summary indicated the resident was on a regular diet. There were no nutritional supplements or fortified food ordered. The resident's weights were as follows: 2/5/24: 232 pounds (lbs) 2/11/24: 230 lbs 2/18/24: 218 lbs	F 0692	**F 692 Nutrition/Hydration** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** Resident 59 was assessed, interventions put in place, and is being monitored by the IDT during nutrition at risk meetings. Resident 91 was assessed, interventions put in place, and is being monitored by the IDT during nutrition at risk meetings. Resident 158 discharged to assisted living. Family and physicians were notified. Physicians gave new orders for resident. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** Whole house audit of residents with a significant weight loss to ensure interventions are in place, weekly weights are complete, and food consumption logs are completed. **The facility has taken the following measures to ensure**	06/12/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2/25/24: 217 lbs 3/6/24: 217 lbs This indicated a weight loss of 15 lbs in one month. A Quarterly Nutrition Review, dated 3/29/24, indicated the resident had a significant weight loss of 5% in 30 days. The resident did not receive snacks, supplements or fortified food. The resident's weight had been stable since 2/18. The resident's intake of food and fluid was estimated to meet needs at this time. There were no new nutritional recommendations at this time. The resident's continued weights were as follows: 4/2/24: 220 lbs (+3 lbs) 5/3/24: 203 lbs 5/7/24: 203 lbs (reweigh) This was an additional weight loss of 14 pounds, for a total weight loss of 29 pounds, 12.5%, since her admission on 2/5/24. There was no documentation in the record the weight loss between 4/2 and 5/7/24 had been identified. There were no progress notes, Nutrition at Risk (NAR) notes, or Nutrition Reviews completed. The food consumption task documentation, dated 4/18/24 through 5/15/24, indicated there were no meal consumptions documented on the following days and meals: 4/18/24 - breakfast, lunch 4/19/24 - dinner 4/20/24 - breakfast, lunch & dinner 4/21/24 - breakfast, lunch 4/22/24 - breakfast, lunch & dinner 4/23/24 - breakfast, lunch 4/24/24 - breakfast, lunch 4/27/24 - dinner		**that the problem has been corrected and will not recur by:** IDT was educated on nutrition at risk meeting, the requirements of F692 regulation, and the nutrition management policy and weight monitoring policy. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/Designee will conduct daily audits (5) days per week on all new admissions, residents who trigger weight loss, and residents with weekly weights for (6) months to ensure substantial compliance. Director of Nursing/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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	4/29/24 - breakfast, lunch 5/1/24 - lunch 5/2/24 - breakfast, lunch & dinner 5/3/24 - breakfast, lunch & dinner 5/4/24 - dinner 5/6/24 - breakfast, lunch & dinner 5/9/24 - breakfast, lunch 5/10/24 - breakfast, lunch & dinner 5/11/24 - breakfast, lunch & dinner 5/14/24 - dinner 5/15/24 - breakfast, lunch & dinner The Nutrition Care Plan, initiated on 2/7/24, indicated the resident had potential nutritional risk related to above BMI (body mass index) for height. A care plan revision, on 3/20/24, indicated the resident had a significant weight loss since admission with more mobility which was currently stabilizing. The goal was for the resident not to exhibit a significant weight change. Interventions included, but were not limited to, Registered Dietician to evaluate and make diet change recommendations as needed and document food and fluid intakes. During an interview on 5/16/24, the Director of Nursing Services (DNS) indicated she was just made aware of the significant weight loss and she would look into it. During a follow up interview on 5/16/24 at 1:40 p.m., she indicated the resident would be reviewed in the NAR meeting today and they would complete a Significant Change MDS. During an interview on 5/17/24 at 10:15 a.m., the Dietary Technician (DT) indicated she completed the Nutrition Reviews. If a resident had a significant weight loss, the Registered Dieticians (RD) were consulted and they would make recommendations. The DT indicated the first significant weight loss may have been attributed			

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	to an incorrect admission weight, but no interventions were put into place and that was an oversight on her part. The current significant weight loss had also been overlooked by her. She was not made aware of it until yesterday, 5/16/24, when surveyors identified it. The policy, "Resident Weight Monitoring", indicated, "...A weight report will be generated monthly and reviewed by the DM (Dietary Manager), RD, DNS, and MDS for significant changes. A significant weight change is defined as 5% in 30 days, 7.5% in 90 days and 10% in 180 days..." and, "...Residents with verified significant weight change will be followed by IDT (interdisciplinary team) in the Risk Nutrition meeting..." 2. The record for Resident 91 was reviewed on 5/16/24 at 9:35 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, osteoarthritis, and hypothyroidism. The Significant Change Minimum Data Set (MDS) assessment, dated 3/20/24, indicated the resident was cognitively impaired, required substantial/maximal assist with eating, and had a significant weight loss. A Care Plan, updated 3/27/24, indicated the resident had shown significant weight loss. An intervention included to serve the diet and supplements as ordered and record the amount of consumption. The resident weighed 137 pounds on 1/3/24 and 119 pounds on 3/26/24. A Registered Dietitian (RD) Review, dated 3/27/24, indicated the resident had lost 6% of her body weight in one month.			

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	The food consumption task documentation, dated 4/17/24 through 5/15/24, indicated there were no meal consumption intakes documented for the following days and meals: 4/17/24 breakfast 4/18/24 dinner 4/19/24 breakfast and dinner 4/20/24 breakfast and lunch 4/21/24 breakfast and dinner 4/22/24 dinner 4/24/24 breakfast 4/25/24 breakfast and dinner 4/27/24 breakfast and dinner 4/28/24 dinner 4/29/24 dinner 5/1/24 dinner 5/3/24 breakfast, lunch, and dinner 5/4/24 breakfast, lunch, and dinner 5/5/24 breakfast and lunch 5/7/24 breakfast and dinner 5/8/24 dinner 5/9/24 breakfast and dinner 5/10/24 breakfast and dinner 5/11/24 dinner 5/12/24 dinner 5/13/24 breakfast and dinner 5/14/24 breakfast and dinner 5/15/24 breakfast, lunch, and dinner During an interview with the Administrator on 5/16/24 at 11:13 a.m., she was made aware of the lack of documentation of meal consumption. No further information was provided.3. Resident 158's record was reviewed on 5/15/24 at 10:26 a.m. Diagnoses included, but were not limited to, congestive heart failure and chronic kidney disease. The Admission Minimum Data Set (MDS)			

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	assessment, dated 4/23/24, indicated the resident was severely cognitively impaired for daily decision making. He required supervision for eating and received a therapeutic diet. The Weights and Vitals log indicated the resident weighed 175 pounds on 4/21/24 and 162 pounds on 5/10/24. A Physician's Order, dated 5/19/24, indicated weekly weights for four weeks. The Medication/Treatment Administration Record for May 2024 indicated there was not a weekly weight obtained on 5/5/24. The Nutrition - Amount Eaten CNA Task was blank for the following meals: - Breakfast on 4/17/24, 4/24/24, 4/29/24, 5/10/24, and 5/13/24 - Lunch on 4/17/24, 4/19/24, 4/24/24, 4/26/24, 4/29/24, and 5/13/24 - Dinner on 4/18/24, 4/19/24, 4/20/24, 4/21/24, 4/22/24, 4/23/24, 4/26/24, 4/28/24, 4/29/24, 4/30/24, 5/1/24, 5/3/24, 5/4/24, 5/5/24, 5/8/24, 5/9/24, 5/10/24, and 5/13/24 During an interview on 5/17/24 at 2:07 p.m., the Director of Nursing had no further information to provide. 3.1-46(a)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a			

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	resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure a resident with a gastronomy tube (g-tube) received appropriate treatment related to not completing water flushes before medication administration as ordered by the physician, for 1 of 7 residents reviewed during medication administration. (Resident 115 and RN 1) Finding includes: On 5/16/24 at 11:11 a.m., RN 1 was observed preparing Resident 115's medication to administer via a g-tube. The nurse crushed Tylenol 325 mg (milligrams) x 2 tablets and poured them into a medicine cup. She then proceeded to add 30 ml (milliliters) of water to the cup with the Tylenol. RN 1 checked placement of the g-tube, attached a syringe to the g-tube and poured the medicine cup into the syringe. After the diluted medication went through the tubing, she then proceeded to administer 30 ml of water into the tubing.	F 0693	**F 693 Tube Feeding Management** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** Resident 115 was assessed. Family and physicians were notified. Physicians gave new orders for resident. Residents are in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents who have tube feedings have potential to be affected by this deficiency. **The facility has taken the following measures to ensure**	06/12/2024

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	Record review for Resident 115 was completed on 5/16/24 at 11:08 a.m. The May 2024 Physician's Order Summary indicated an order to administer 30 ml of water before and 30 ml of water after medication administration via the g-tube. During an interview after the observation, RN 1 indicated she forgot to flush the g-tube with water before she administered the medication. 3.1-44(a)(2)		**that the problem has been corrected and will not recur by:** Nurse who did not administer flush prior to medication administration was provided with 1:1 education. Nursing staff were educated on following flush orders during medication administration for tube feeding management. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/Designee will observe (2) tube feeding medication administration for (6) months to ensure flushes are administered per physician orders. Director of Nursing/Designee will report audit findings to the QAPI committee monthly for (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	
F 0699 SS=D Bldg. 00	483.25(m) Trauma Informed Care §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. Based on observation, record review, and	F 0699	**F 699 Trauma informed Care**	06/12/2024

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	interview, the facility failed to ensure to deliver care and services and to address the needs of a resident with a diagnosis of post-traumatic stress disorder (PTSD) related to not following care plan interventions or updating care plans for a PTSD diagnosis for 1 of 1 residents reviewed for behaviors. (Resident 134) Finding includes: On 5/13/24 at 9:54 a.m., Resident 134 was noted to be yelling out. On 5/16/24 at 10:10 a.m., Resident 134 was observed in a broda chair in a common area with other residents. He was observed making noises under his breath. On 5/17/24 at 10:23 a.m., Resident 134 was observed in his room in a broda chair loudly yelling out. Resident 134's record was reviewed on 5/15/24 at 1:57 p.m. Diagnosis included, but were not limited to, dementia, PTSD, psychosis, major depressive disorder, and generalized anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 3/3/24, indicated the resident was severely cognitively impaired for daily decision making. He displayed inattention, disorganized thinking, and altered level of consciousness. His behaviors were present and fluctuated. He had physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others. A Care Plan, dated 11/24/23, indicated the resident required room visits or one to one activities due to		**The corrective actions that were accomplished for those residents to have been affected by from the practice are:** Family of resident 134 were interviewed. This resident's care plan was updated to reflect triggers and interventions for triggers. **How other residents of the facility were identified to potentially be affected by the practice are:** Whole house audit of residents with diagnosis of PTSD was completed. Families/RP/persons of interests were interviewed specifically on trauma, triggers, and any known interventions for the PTSD of those identified. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Social Services was educated on requirements of compliance for this deficiency related to ensuring interviews of families/RP/persons of interests are interviewed specifically on trauma, triggers, and any known interventions. Nursing and activity staff educated on using interventions to provide support during PTSD related behaviors. Activity staff educated **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved**	

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	a frequent preference to be in lower stimulating environments along with verbal expressions of comprehension and emotional experiences which may cause the resident to have difficulty participating in group settings successfully. Interventions included, but were not limited to, provide monthly activity calendar, provide room visits of choice, provide sensory stimulation in room, and discuss past interests with resident and family. A Care Plan, revised on 11/24/23, indicated the resident had behavioral symptoms including restlessness, resistive to care, combativeness, and going into other resident's rooms. Interventions included, but were not limited to, assess the resident's needs, document behaviors, identify behavior triggers and reduce exposure to triggers, and provide a diversional activity. A Care Plan, dated 9/26/23, indicated the resident had a history of trauma and diagnosis of PTSD and exhibited yelling out, anxiety, restlessness, and irritability. Interventions included, but were not limited to, the resident would learn and utilize relaxation techniques, have positive social interactions, participation in relaxation exercises, and he would share feelings. An Activities-Quarterly Review note, dated 12/8/23 at 10:45 a.m., indicated the resident was passive in most group programs, he made loud noises that could be heard by peers. One to one activities with staff were provided for more appropriate interactions. He preferred a setting of one to ones and independent. A Psychiatric Note, dated 4/10/2024, indicated during his clinical intake on 9/18/23, the resident was referred to psychiatric services for having		**and are permanent are:** SSD/Designee will audit any new admission with diagnosis of PTSD for (6) months to ensure Families/RP/persons of interests are interviewed specifically on trauma, triggers, and any known interventions for the PTSD of those identified. SSD/Designee will report audit findings to the QAPI committee monthly for (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	

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	ongoing issues with yelling out, anxiety, restlessness, depression, and delusions. There were a lot of times where he would scream out in his room. When asked what is wrong he would often not be able to tell them and would continue screaming. He possibly had some PTSD related to his service as most of his delusions are focused around violence and weapons. He was calm, but very dysphoric and told the writer that everything was wrong and he felt sad. He would also often grind his teeth and squirm in his chair. He sometimes put himself on the floor. His yelling out also often disturbed other residents. An Activities-Quarterly Review note, dated 2/26/24 at 1:09 p.m., indicated the resident attended group activities with peers. He responded and interacted when prompted on a one to one basis. During an interview on 5/17/24 at 11:19 a.m., the Activity Director indicated the resident went to group activities and had never done any one to one activities with staff that she was aware of. During an interview on 5/20/24 at 3:14 p.m., the Social Services Director indicated the resident was having flashbacks and they were unable to determine what the triggers were for those. She had never reached out to the family to see what interventions were appropriate for the resident or what had triggered his yelling out. The family was invited to care plan meetings, but had never attended.			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently			

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	accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure medications were properly stored for 4 of 5 medication carts observed. (1A Medication Cart, 2C Medication Cart, 2B Medication Cart, and 3D Medication Cart) Findings include: 1. On 5/20/24 at 9:13 a.m., the 1A Medication Cart was observed with RN 2. There were approximately 20 pills of different sizes and colors that were loose and out of the packages throughout the bottoms of the drawers in the cart. The nurse indicated nursing was responsible for making sure the medication carts were cleaned.	F 0761	**F761 Label/Store Drugs and Biologicals** **The corrective actions that were accomplished for those residents to have been affected by the practice are:** Loose pills were removed from all carts. **How other residents of the facility were identified to potentially be affected by the practice are:** Whole house audit on each unit's medication cart was complete. **The facility has taken the following measures to ensure**	06/12/2024

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	2. On 5/20/24 at 9:26 a.m., the 2C Medication Cart was observed with LPN 2. There were approximately 40 pills of different sizes and colors that were loose and out of the packages throughout the bottoms of the drawers in the cart. The nurse indicated nursing was responsible for making sure the medication carts were cleaned. 3. On 5/20/24 at 9:33 a.m., the 2B Medication Cart was observed with RN 3. There were approximately 12 pills of different sizes and colors that were loose and out of the packages throughout the bottoms of the drawers in the cart. The nurse indicated nursing was responsible for making sure the medication carts were cleaned. 4. On 5/20/24 at 9:47 a.m., the 3D Medication Cart was observed with LPN 3. There were approximately 4 pills of different sizes and colors that were loose and out of the packages throughout the bottoms of the drawers in the cart. The nurse indicated nursing was responsible for making sure the medication carts were cleaned. During an interview on 5/20/24 at 10:48 a.m., the Director of Nursing indicated all of the nursing staff was responsible to making sure the medication carts were cleaned. 3.1-25(j) 3.1-25(o)		**that the problem has been corrected and will not recur by:** Nursing staff educated on ensuring medication carts are clean and free from loose pills. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/designee will conduct audit (4) carts (5) days a week for (6) months to ensure no loose pill medications are in the carts. DON/designee will report audit findings to the QAPI committee monthly for (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the			

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	agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.			

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	155214	A. BUILDING 00 B. WING	05/20/2024

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	§483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to medication administration, for 1 of 2 residents reviewed for antibiotic use. (Resident 74) Finding includes: During an interview with Resident 74 on 5/14/24 at 9:32 a.m., she indicated she had a urinary infection and was being treated with antibiotics. The record for Resident 74 was reviewed on 5/16/24 at 11:22 a.m. Diagnoses included, but were not limited to, anemia, congestive heart failure, and hypertension. The Quarterly Minimum Data Set (MDS)	F 0842	**F842 Resident Records** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** Family and physicians were notified. Physicians gave no new orders for resident. Resident is in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** Whole house audit of all residents receiving antibiotics to ensure documentation was accurate was	06/12/2024

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	assessment, dated 5/10/24, indicated the resident was cognitively intact and had septicemia and a urinary tract infection in the last 30 days. A Physician's Order, dated 5/6/24, indicated to give piperacillin-tazobactam (Zosyn, an antibiotic) 3.375 grams intravenously every 8 hours for 7 days for sepsis due to pseudomonas (bacteria). The Medication Administration Record (MAR), dated 5/2024, indicated the antibiotic medication had not been signed off as given on the following dates and times: 6 a.m. on 5/9/24 and 5/10/24 2 p.m. on 5/7/24, 5/8/24, and 5/12/24 10 p.m. on 5/7/24 During an interview with the Director of Nursing (DON) on 5/16/24 at 12:01 p.m., she had checked the medication storage room and there were no antibiotics left. She believed the medication had been administered as ordered, but had not been signed out on the MAR. 3.1-50(a)(1)		completed. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nursing staff educated on ensuring MARs documentation is complete at the end of their shift to ensure accuracy of medication administration. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/Designee will audit residents receiving antibiotics daily (5) times per week for (6) months to ensure documentation is complete. Director of Nursing/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.			

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	The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or			

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	their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure infection control guidelines were in place and implemented related to a lancet disposed of improperly for a random observation during a blood sugar check. (Resident 37 and RN 1) Finding includes: On 5/16/24 at 11:25 a.m., RN 1 was observed testing Resident 37's blood sugar level. The nurse washed her hands, donned gloves, cleaned the resident's finger, and then poked the resident's finger with a lancet to obtain the blood sample. The resident's blood sugar level was then assessed. The nurse then took off her gloves and disposed of them into the resident's garbage can along with the lancet. The nurse then proceeded to walk out of the resident's room into the hallway.	F 0880	**F 880 Infection Control** **The corrective actions that were accomplished for those residents to have been affected by from the practice are:** Resident is in stable condition and experienced no negative outcomes as a result of this observation. Nurse provided 1:1 education for this deficiency. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents who received blood sugar checks have a potential to be affected by this deficiency. **The facility has taken the following measures to ensure that the problem has been**	06/12/2024

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	During an interview after the observation, RN 1 indicated she disposed of the lancet into the resident's garbage can. She should have disposed of the lancet into the sharps container. A facility policy titled, "Sharps Disposal" and received as current from the Administrator indicated, "...2. Contaminated sharps will be discarded into containers that are: a. Closable..." "...d. Labeled or color-coded in accordance with our established labeling system..." 3.1-18(b)		**corrected and will not recur by:** Nursing staff were educated on infection control related to sharps disposal. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/Designee will observe (5) blood sugar checks per week for (6) months to ensure compliance with sharps disposal practices. Director of Nursing/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	