STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155607	A. BUILDING 00 B. WING	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BETHEL MANOR	6015 KRATZVILLE RD EVANSVILLE, IN 47710

(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 Investigation of Complaint IN00437143. Complaint IN00437143 - No deficiencies related to the allegation are cited Survey dates: July 21, 22, 23, 24, 25, & 26, 2024 Facility number: 000436 Provider number: 155607 AIM number: 100275120 Census Bed Type: SNF/NF: 55 SNF: 8 Total: 63 Census Payor Type: Medicare: 8 Medicaid: 35 Other: 20 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 8, 2024.	F 0000	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective August 25, 2024 to the annual survey conducted July 21, 2024 through July 26, 2024. **The facility respectfully requests from the department a desk review for substantial compliance.**	
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	F 0554	***The corrective action taken for those residents found to be***	08/25/2024

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

Joshua Bowman | CEO & Administrator | 08/21/2024

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	that were self administering medications were assessed for capability to self administer medications for 2 of 2 residents observed with medications at bedside (Resident 49, Resident 23) Finding include: 1. On 7/21/24 at 10:16 A.M., Desitin was observed be to be on Resident 49's bedside table with Resident's name and physician noted on the label. On 7/21/24 11:10 A.M., Resident 49's clinical record reviewed. Diagnosis included, but not limited to, Alzheimer's disease with late onset. The MDS (Minimum Data Set) Assessment dated 7/6/24 indicated that Resident 49 is severely cognitively impaired, required substantial/maximal assistance with toileting, substantial or maximal assistance with bathing, and substantial or maximal assistance with bed mobility. The clinical record lacked any self-administration of medication assessment or care plans. Physician orders included but were not limited to Desitin External Paste 40 % Zinc Oxide Topical, as needed, dated 6/28/24. QMA 8 indicated during interview on 7/25/24 at 11:20 A.M., that if medication was found at bedside it would be put away immediately and the nurse would have been notified. Also that Desitin in not a medication allowed to be kept at bedside. 2. On 7/24/24 at 12:02 P.M., a medicine cup with one pill in it was observed sitting on Resident 23's bedside table. On 7/25/24 at 10:57 A.M., Resident 23's clinical record was reviewed. Diagnosis included, but was not limited to, cerebral infarction with some residual weakness on the right side.		***affected by the deficient practice include:*** Destin was removed from Resident 49's room and placed in treatment cart. Medicine cup with pill was removed from Resident 23's room. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. Observational rounds were completed to ensure no other residents had medications or treatment products in resident rooms. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All nurses and qualified medication aides have received in-service education regarding self-administration of medication and storage of prescribed medications and treatment products. Visual reminder to return treatment products to treatment cart following administration placed on all treatment carts. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that medications and treatment products are kept in appropriate locations and that the above corrective actions and changes	

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	The most current Annual Minimum Data Set (MDS) Assessment, dated 7/9/24, indicated Resident 23 was cognitively intact and required setup assistance for eating. The clinical record lacked an order, care plans, and assessment for self administration of medications. On 7/25/24 at 1:53 P.M., the Administrative Support indicated medications were not to be left at beside. On 7/26/24 at 8:00 A.M., the Administrative Support indicated Resident 23 did not have a self administration of medication assessment. On 7/26/24 at 8:00 A.M., the Administrative Support provided a "Resident Self-Administration of Medication" policy, undated, that indicated "The results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record". 3.1-11(a)		are being followed. This tool will be completed by the Director of Nursing or designee weekly for 4 weeks, monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each			

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	resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, interview, and record review, the facility failed to ensure resident privacy for 2 of 2 random observations. Resident information was left visible on a computer screen during medication administration. (Resident 13, Resident 16) Finding includes: 1. On 7/24/24 at 10:00 A.M., Licensed Practical Nurse (LPN) 5 was observed gathering medications at a medication cart. When LPN 5 walked away from the medication cart and down the hall, the computer screen was left up with Resident 13's information visible (picture, name,	F 0583	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No adverse effect/outcome was noted for Resident 13 or Resident 16. LPN 5 received education related to incident and privacy of resident records. ***Other residents that have the potential to be affected have been identified by:*** All residents have an electronic medical record and have the potential to be affected during the	08/25/2024

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	date of birth, and medication list). LPN 5 came back to the cart at 10:04 A.M., and promptly left the cart again to enter a resident's room. At 10:06 A.M., Resident 3 was observed walking by the medication cart. LPN 5 returned to the cart at 10:06 A.M. 2. On 7/24/24 at 11:17 A.M., the medication cart was observed sitting between the nurses station and elevator with the computer screen open and Resident 16's information visible. LPN 5 was observed at that time in the Dining Room with a resident. At 11:19 A.M., Certified Nurse Aide (CNA) 3 was observed pushing a resident past the medication cart on the way to the Dining Room, then LPN 5 was observed to come back to the medication cart. On 7/24/24 at 3:04 P.M., LPN 7 indicated when leaving the medication cart, staff should hide and/or lock the computer screen to ensure resident privacy. On 7/26/24 at 8:00 A.M., a current non-dated Confidentiality of Personal and Medical Records policy was provided that indicated "This facility honors the resident's right to secure and confidential personal and medical records" 3.1-3(o)		medication pass. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All nurses and QMAs received in-service education regarding privacy and confidentiality of resident records and utilization of the screen locking feature. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that resident records are kept confidential and not viewable to unauthorized individuals and that the above corrective actions and changes are being followed. This tool will be completed by the Medical Records Coordinator or designee weekly for 4 weeks, monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation			

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	The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observations, interview, and record review the facility failed to protect the resident's rights to be free from physical abuse for 1 of 1 residents reviewed. Resident 36 was hit by CNA(Certified Nurse Aide) while receiving care resulting in laceration above the left eye. (Resident 36) Findings include: On 7/22/24 at 10:28 A.M., Resident 36 was observed in a chair smiling. On 7/22/24 at 1:21 P.M., Resident 36's clinical record was reviewed. Diagnoses included, but were not limited to, ALZHEIMER'S DISEASE and Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance. The current Annual MDS (Minimum Data Set) Assessment dated 6/12/24 indicated Resident 36 was severely cognitively impaired. The resident was dependent on transfer, toileting, and dressing.	F 0600	***The corrective action taken for those residents found to be affected by the deficient practice include:*** QMA 4 immediately intervened to ensure the safety of Resident 36. Resident 36 was assessed and treated following event with follow-up psycho-social assessments performed with no signs/symptoms of fear, sadness, or anxiety noted. Resident 36 has received follow-up visits with behavioral health provider to address behaviors. CNA 6 was terminated from employment and IDOH was notified of the event. All staff received in-service education regarding abuse prevention. ***Other residents that have the potential to be affected have been identified by:*** All residents on units CNA 6 had worked were interviewed by Social Services Director with no other residents identified as having been	08/25/2024

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	Current physician orders included, but were not limited to: Lexapro Tablet 10 MG (Milligrams) (Escitalopram Oxalate)(Antidepressant medication). Give 1 tablet by mouth one time a day for depression/anxiety related to adjustment disorder with mixed anxiety and depressed mood dated 9/9/22. Seroquel oral tablet 50 MG (Quetiapine Fumarate) (Antipsychotic medication) Give 1 tablet by mouth two times a day related to ALZHEIMER'S DISEASE and Dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance dated 8/8/23. The current care plan indicated the resident may exhibit verbal/physical behaviors with care r/t (Related to) the inability to comprehend the need for care r/t cognitive status. Interventions included, but were not related to: Allow resident time to respond to directions or requests d/t (due to) dementia more time is required to absorb instructions. Be cognizant of invading resident's personal space. Approach the resident slowly and from the front. Be sure to have the resident's attention before speaking or touching. Those interventions were dated 7/11/22. A nursing progress note dated 7/5/24 at 9:30 P.M., indicated " QMA (Qualified Medicine Aide) 4 working unit heard resident yelling from hallway. Upon entering room QMA 4 observed a resident with a skin tear above left eyebrow. QMA 4 assisted resident to safe position. CNA (Certified Nurse Aid) 6 reported to QMA 4 on unit resident was being combative, hitting and scratching him. CNA 6 also reported he was defending himself when the resident obtained a skin tear 3 cm x 0.5		affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All staff received in-service education regarding abuse prevention and caregiver burnout following event. All staff already receive abuse education upon hire and at least annually. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure the above corrective actions and changes are being followed. This tool will be completed by the Social Services Director or designee monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	cm above left eyebrow. QMA called on call management. Head to toe assessment completed. Cleaned left eye with normal saline and applied steri strips. Resident denies pain. No change in ROM. No change in LOC. Neurological assessments x 72 hours initiated. Administrator notified, DON, POA (Power of Attorney) , PCP (Primary Care Physician) ." The progress note was recorded by an RN in the facility at the time. A Social Service Progress note done on 7/8/24 at 9:20 A.M., indicated there was a Psychosocial Assessment completed and the resident was not having s/s (signs or symptoms) of sadness, anxiety, or fear. The resident voiced no concerns, and none noted in body language or overall mood. A Psychiatric Nurse Practitioner dated 7/8/24 at 12:22 P.M., indicated there was a new order to discontinue Melatonin (sleep aid) and to notify Nurse Practitioner of issues with insomnia. On 7/10/24 at 4:45 P.M., the Social Service Progress Note indicated there was another Psychosocial Assessment completed and the resident was not exhibiting s/s of sadness, fear, or anxiety. The resident was up doing normal routine and was not voicing concerns or observed via body language On 7/11/24 at 12:28 P.M., the Social Service Progress Note indicated there was another Psychosocial Assessment completed and the resident was not exhibiting s/s of sadness, fear, or anxiety. The resident was up doing normal routine and was not voicing concerns or observed via body language. Reviewed at the time of the medical record review,			

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	an Indiana Department of Health Form was dated 7/5/24 at 1:33 P.M. The form indicated on 7/5/24, the resident was involved in an altercation with CNA (Certified Nurse Aide) 6 while receiving care. QMA (Qualified Medicine Aide) 4 heard the resident yelling and being combative with CNA 6. CNA 6 indicated in the report the resident was combative and scratching CNA 6. The on-call nurse manager, DON (Director of Nursing), Administrator, physician, and family made aware. Follow up dated 7/8/24 indicated the scratch was 0.3 cm (Centimeters) x (By)) 0.5 cm was cleaned with saline and stertripes. Resident Assessment completed there was no loss of consciousness or range of motion. A Psychological Assessment was completed with no s/s of fear, anxiety, or sadness. The nurse practitioner saw the resident on 7/8/24 and was to continue present orders, clean wound, keep dry and clean and monitor for signs and symptoms of infection, were to continue present orders and monitor for behaviors. CNA 6 indicated in a written statement dated 7/5/24 he is changing urine-soaked socks. The resident was kicking in response to the care and protesting not wanting clothes changed. CNA 6 calmly spoke with the resident, but resident got more aggressive and tried to scratch CNA 6 while turning and fastening the brief. CNA 6, again, tried to calmly talk to the resident while the resident was physically assaulting him and yelling. CNA 6 indicated he has had post-traumatic stress from childhood abuse of a parent and allowed his anger to take over. During an interview on 7/22/24 at 3:05 P.M., the wife indicated that she was told the resident was hit by CNA that was apparently witnessed. During an interview on 7/23/24 at 2:31 P.M., the			

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	Human Resources Director indicated she was told that CNA 6 reacted to the situation with the resident that swung at him. There were no complaints against the CNA and was popular with staff and residents liked him. She indicated there were no indications that CNA 6 was angry. During an interview on 7/23/24 at 7:10 PM., QMA 4 indicated she did not really witness the incident but was in the hallway outside the resident's door. QMA 4 heard the resident say, "don't hit me". QMA 4 then went into the room and CNA 6 was trying to tell QMA 4 what happened, and the resident was saying "you're lying." QMA 4 also noted CNA 6 was trying to clean the gash above the resident's left eye not knowing how big it was. QMA 4 indicated CNA 6 had asked if QMA 4 was going to report this and she said she had to because she was not going to lose her license. She stated CNA 6 was angry with himself about the situation and was apologizing to her and the resident. She immediately came to the nurse on call and (Director of Nursing) who came to assess the resident. They in turn called the family, who did not come to the facility. During an interview on 7/24/2 at 8:41 A.M., the Nurse Manager on Call indicated QMA 4 had called her and indicated there was an incident with Resident 36 and CNA 6. CNA 6 was doing care and QMA 4 had walked into the room and the resident had blood above his left eyebrow. QMA 4 indicated she had asked what had happened and CNA 6 had admitted that he had struck the resident 1 time, but the resident had been resistive to care with the resident had been scratching and hitting him. There was a skin tear. QMA 4 had CNA 6 leave the room and she immediately called her. She called the Administrator and the DON, she then called said that they had made a 3-way			

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	call with QMA 4 where she indicated that the resident had been scratching CNA 6 chest and reaching for face while the resident was also trying to hit CNA 6. They then spoke with CNA 6, and he was crying about the incident . CNA 6 was remorseful. He never indicated anything about PTSD (Post Traumatic Stress Disorder) or having flash back. The conversation was only a few minutes. The nurse on call indicated the resident and CNA 6 had never had a problem. The DON said that the wife and family actually preferred CNA 6 to take care of the resident. They feel that this incident was an isolated incident and he had never had a problem like this before. On 7/26/24 at 8:00 A.M., the Administrator Support Person provided a current policy "Abuse, Neglect, and Exploitation Policy" dated 3/31/23. The policy indicated "...it is the policy of the facility to provide protections for the health, welfare, and rights of each resident by developing written policies and procedures that prohibit abuse...the facility will have written procedures to assist staff in identifying the different types of abuse mental/verbal abuse, sexual abuse, physical abuse...This include staff to resident abuse and certain resident to resident altercations... Possible indicators of abuse include, but are not limited to: resident, staff, or family report of abuse and physical marks...on a resident's body..." 3.1-27(a)(1)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with			

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	the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or			

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	arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on record review and interview, the facility failed to ensure person-centered care plans were developed and implemented for 2 of 5 residents reviewed for unnecessary medications and behaviors. (Resident 37, Resident 49) Finding includes: 1. On 7/23/24 at 1:59 P.M., Resident 37's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and anxiety. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/4/24, indicated Resident 37 was severely cognitively impaired, required substantial assistance from staff for toileting and bathing, and was receiving antianxiety, antidepressant, diuretic, antiplatelet, and hypoglycemic medications. Current physician orders included, but were not limited to: Lexapro (antidepressant medication) 10 mg (milligram) Give 1 tablet by mouth at bedtime, start date 12/8/23. Ativan (antianxiety medication) 0.5 mg (Lorazepam) Give 1 tablet by mouth one time a day, start date 4/12/24. Lasix (diuretic medication) 20 mg Give 1 tablet by mouth one time a day, start date 1/27/23. Aspirin (antiplatelet medication) 81 mg Give by mouth one time a day, start date 2/9/22. Metformin (hypoglycemic medication) 1000 mg Give by mouth two times a day, start date 2/24/23. Invokana (hypoglycemic medication) 100 mg Give 1 tablet by mouth one time a day, start date	F 0656	***The corrective action taken for those residents found to be affected by the deficient practice include:*** Resident 37's plan of care was reviewed and updated to address monitoring of antianxiety, antidepressant, diuretic, and antiplatelet medications. CNA 84 no longer works at facility. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected. Interdisciplinary Team has reviewed all plans of care to ensure accuracy and completeness. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All direct care staff have received in-service education regarding accessing and following plan of care. Tool including list of medication types that need to be included in plan of care has been created for utilization by Interdisciplinary Team. IDT also performed in-service education on developing a comprehensive care plan. ***The corrective action taken to monitor performance to assure***	08/25/2024

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	1/24/24. Januvia (hypoglycemic medication) 100 mg Give by mouth one time a day, start date 1/24/24. Current care plans included, but were not limited to: Resident is at risk for altered blood sugars and resulting physical complications related to diabetes, Observe for hypo-/hyperglycemic reactions. Date Initiated: 4/26/21. The clinical record lacked care plans related to monitoring of antianxiety, antidepressant, diuretic, and antiplatelet medications. 2. On 7/21/24 at 11:10 A.M., Resident 49's clinical record was reviewed. Diagnosis included, but was not limited to, Alzheimer's Disease with late onset. The MDS (Minimum Data Set) Assessment dated 7/6/24 indicated resident was not cognitively intact, required use of wheelchair, required partial/moderate assistance with eating, substantial/maximal assistance with toileting, substantial or maximal assistance with bathing, and substantial or maximal assistance with bed mobility. Care plan initiated on 6/28/24 had the following interventions: get resident's attention before beginning to speak to resident, provide reassurance and patience when communicating with resident. Care plan initiated on 7/8/24 included the following: allow resident time to respond to directions or requests (due to dementia more time is required to absorb instructions), approach the resident slowly and from the front, be cognizant of not invading resident's personal space, be sure you have the residents attention before speaking or touching, if strategies are not working, leave resident and		***compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that plans of care are complete and interventions being implemented and that the above corrective actions and changes are being followed. This tool will be completed by the Director of Nursing or designee weekly for 4 weeks, monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	reapproach at later time and/or different staff. On 7/21/24 at 12:46 P.M. CNA 84 performed incontinence care on Resident 49. Care plan was not implemented at that time. Resident 49 resisted this care, cried out for CNA to stop and attempted to push CNA 84 away repeatedly. CNA continued providing incontinence care. Resident 49 told CNA 84 she did not want to get out of bed. After CNA 84 performed incontinence care, transferred Resident to wheelchair while resident continued to yell out and push CNA away. On 7/25/24 at 1:02 P.M. QMA 8 indicated that if Resident 49 exhibited behaviors/resisted care, staff would have stopped what they were doing to prioritize safety. Staff would have been expected to give resident space, time, and reapproach at another time. QMA 8 indicated there would have been 2 staff members caring for Resident 49. One staff member to have kept Resident calm while the other performed care. During an interview on 7/25/24 at 1:51 P.M. the DON (Director of Nursing) indicated care plans should be updated any time there are new orders or new issues with the resident. On 7/26/24 at 8:00 A.M. Administrative Support provided a undated policy titled Comprehensive Care Plans that indicated "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." 3.1-35(a)			

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F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on interview and record review the facility failed to ensure residents were free of any significant medication errors for 1 of 5 residents reviewed for unnecessary medications. A resident was given the wrong medication resulting in rebound congestion when the medication was discontinued. (Resident 56) Finding includes: On 7/23/24 at 9:23 A.M., Resident 56's clinical record was reviewed. Diagnosis included, but were not limited to, anxiety, depression, and psychotic disorder. The most recent Admission MDS (Minimum Data Set) Assessment, dated 5/6/24, indicated no cognitive impairment and no behaviors. Resident 56 required supervision with bed mobility, eating, transfers, and toileting. Physician orders included, but were not limited to: Nasal spray nasal solution 0.05% (Oxymetazoline HCl) 2 sprays in both nostrils two times a day for allergies, dated 6/3/24 through 7/1/24. (medication if used more than 3 days may cause rebound congestion) Saline nasal solution 0.65% (Saline) 2 sprays in both nostrils four times a day for nasal congestion for 5 days, dated 7/3/24. A Nurse Practitioner (NP) visit note, dated 6/3/24, indicated the resident complained of nasal	F 0658	***The corrective action taken for those residents found to be affected by the deficient practice include:*** Medication error for Resident 56 had been identified and corrected by facility prior to survey. Oxymetazoline HCl nasal spray was stopped and saline nasal solution was started and patient was monitored. ***Other residents that have the potential to be affected have been identified by:*** All residents have had medication orders reviewed to ensure accuracy. All nurses have received in-service education on ensuring accuracy when inputting new orders. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All nurses have received in-service education on ensuring accuracy when inputting new orders. Agenda item added to morning clinical meeting to review new physician orders. ***The corrective action taken to***	08/25/2024

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	congestion. The NP sent an order through triage to begin nasal saline 2 sprays in each nostril at bedtime for nasal congestion. Nursing progress notes included, but were not limited to, the following: 7/1/24 at 5:56 A.M. Triage called to discontinue the nasal spray (Oxymetazoline HCl) and to report if the resident had any rebound nasal congestion in the following 3-5 days. 7/3/24 at 2:26 A.M. The resident was very upset the nasal spray had been discontinued due to "a lot" of rebound symptoms. 7/3/24 at 4:28 P.M. A new order for saline nasal spray 2 sprays each nostril four times a day for 5 days was received from the NP. On 7/24/24 at 9:37 A.M., the DON indicated when the NP was in the facility, she would put any new orders through triage to be entered into the resident's record. She indicated she could not remember the conversation, but would look in the communication history to see what was communicated about the resident taking the Oxymetazoline HCl nasal spray for over 3 days. At that time, a triage communication form was reviewed for Resident 56 from 6/3/24 that indicated the NP ordered nasal saline two sprays each nostril at bedtime for nasal congestion. On 7/24/24 at 10:30 A.M., the NP indicated she did not order the Oxymetazoline HCl nasal spray for Resident 56 and instead wanted the resident to have nasal saline spray. She indicated she was unaware how the order was put in for Oxymetazoline HCl, but when it was noticed, it was discontinued.		***monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that new physician orders are input correctly and that the above corrective actions and changes are being followed. This tool will be completed by the Director of Nursing or designee weekly for 4 weeks, monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	On 7/26/24 at 8:00 A.M., a current non-dated Medication Orders policy was provided that indicated "When recording orders for medication, specify the type, route, dosage, frequency and strength of the medication ordered" 3.1-48(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 interview and record review, the facility failed to ensure residents requiring assistance with Activities of Daily Living (ADLs) received adequate assistance with showering/bathing for 4 of 4 residents reviewed for dependent ADL care. (Resident 28, Resident 37, Resident 57, Resident 6) Findings include: On 7/23/24 at 3:10 P.M., multiple Resident's attending the Resident Council meeting voiced concern of not receiving routine showers and/or complete bed baths as scheduled. 1. On 7/23/24 at 10:12 A.M. Resident 28's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and polyosteoarthritis. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/8/24, indicated Resident 28 was severely cognitively impaired and required substantial assistance from staff for toileting, bathing, and transfers. A self-care deficit care plan, dated 3/26/18,	F 0677	***The corrective action taken for those residents found to be affected by the deficient practice include:*** Residents 28, 37, 57 and 6 were reviewed to ensure recent showers had been received per shower schedule. Following review, we are confident that residents are receiving their scheduled showers as part of their routine care. However, we found instances where documentation was incomplete or missing, leaving it unclear whether a shower was or was not given. This lack of documentation makes it difficult to verify whether the showers were provided as scheduled or simply not recorded. ***Other residents that have the potential to be affected have been identified by:*** All residents that require staff assistance with bathing have	08/25/2024

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	indicated Resident 28 had need for assistance with personal care and should receive a shower twice weekly and partial bath all other days. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated the Resident received showers on Tuesdays and Fridays. A record review from 5/1/24 through 7/26/24 indicated Resident 28 had only received 3 of 25 scheduled showers, with no documented refusals. 2. On 7/23/24 at 1:59 P.M., Resident 37's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and anxiety. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/4/24, indicated Resident 37 was severely cognitively impaired and required substantial assistance from staff for toileting and bathing. A self-care deficit care plan, dated 4/26/21, indicated Resident 37 had need for assistance with personal care and should receive a shower twice weekly and partial bath all other days. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated the Resident received showers on Mondays and Thursdays. A record review from 5/1/24 through 7/26/24 indicated Resident 37 had only received 8 of 25 scheduled showers, with one documented refusal on 5/2/24. 3. On 7/24/24 at 8:53 A.M. Resident 57's clinical record was reviewed. Diagnoses included, but were not limited to, dysphagia and muscle weakness.		potential to be affected. Plans of care, point of care documentation, and shower schedule reviewed by IDT. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All CNAs provided education regarding shower/bathing and importance of documenting showers/baths they assist with. IDT collaborated with resident council to include standing agenda item regarding showers/bathing. Identified concerns will be addressed and followed up by IDT. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that showers/baths are being performed per the resident's preference, being documented by staff and that the above corrective actions and changes are being followed. This tool will be completed by the Director of Nursing or designee weekly for 4 weeks, monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance	

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	The most recent Admission MDS (Minimum Data Set) Assessment, dated 6/17/24, indicated Resident 57 was moderately cognitively and was completely dependent on staff for toileting and showers. A self-care deficit care plan, dated 6/11/24, indicated Resident 57 required assistance with personal care and should receive a shower twice weekly and partial bath all other days. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated the Resident received showers twice a week starting 6/10/24. A record review from 6/10/24 through 7/26/24 indicated Resident 57 had only received 3 showers in the past 7 weeks, with no documented refusals. 4. On 7/25/24 at 11:18 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes and chronic kidney disease. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/23/24, indicated Resident 6 was severely cognitively impaired and required substantial assistance from staff for toileting and bathing. A self-care deficit care plan, dated 1/16/24, indicated Resident 6 required assistance with personal care and should receive a shower twice weekly and partial bath all other days. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for showering indicated the Resident should receive showers twice a week. A record review from 5/1/24 through 7/26/24		meeting to determine if any additional interventions are needed.	

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	indicated the Resident 6 had only received twice weekly showers for 5 weeks during the 12 week period. During an interview on 7/25/24 at 1:51 P.M., the DON (Director of Nursing) indicated Resident's should receive at least two (2) showers each week, or a complete bed bath only if it is their personal preference, and should receive a partial bed bath each day, and staff should document showers given or refused in the POC tasks each day. On 7/25/24 at 1:30 P.M., a shower policy was request but was not provided. 3.1-38(a)(3)			
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, interview, and record review, the facility failed to ensure prevention of pressure ulcers for 2 of 3 residents reviewed for pressure injury. Interventions were not followed, and wound assessments were not completed as	F 0686	***The corrective action taken for those residents found to be affected by the deficient practice include:*** Resident 54's pressure ulcer has	08/25/2024

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	ordered. (Resident 54, Resident 55) Findings include: 1. On 7/21/24 at 12:42 P.M., Resident 54 was observed lying in bed on her back. When the resident was rolled to the left side, there was no dressing observed covering the pressure area on her sacrum. At that time, the area was observed slightly open in the middle revealing subcutaneous tissue, and the area surrounding the pressure injury was observed a dark pink color indicative of a deeper wound under the skin. No drainage was observed. Granulation tissue (healing connective tissue in the wound bed) was observed in the middle of the wound. At that time, Licensed Practical Nurse (LPN) 21 did not indicate anything about a missing dressing. On 7/22/24 at 1:24 P.M., Resident 54 was observed lying on her back with the head of the bed raised and knees elevated. On 7/2/24 at 8:14 A.M., Resident 54 was observed lying on her back with the head of the bed raised. On 7/22/24 at 1:00 P.M., Resident 54's clinical record was reviewed. Resident 54 was admitted 10/4/23. Diagnosis included, but were not limited to, Alzheimer's disease, anxiety, and Stage 3 pressure ulcer. The most recent Significant Change MDS (Minimum Data Set) Assessment, dated 5/5/24, indicated total dependence for bed mobility and toileting, and one Stage 3 pressure ulcer. Cognition level could not be assessed. Current physician orders included, but were not limited to:		already been healed while at the facility. Resident 55's skin impairment has decreased in size since ***Other residents that have the potential to be affected have been identified by:*** All residents that have interventions to treat pressure injuries or require weekly skin injury assessments have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** In-service education has been provided to all nursing staff regarding the implementation of care plan interventions. Additional nurses have been trained to utilize EHR wound assessment application so that coverage is available when designated wound nurse is unavailable. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that interventions are being followed and scheduled assessments are being performed and that the above corrective actions and changes are being followed. This tool will be completed by the Director of Nursing or designee weekly for 4 weeks, monthly for	

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	Cleanse pressure injury to sacrum with normal saline, apply Medihoney to wound bed, and cover with bordered foam dressing every night shift for wound care, dated 7/17/24. A current care care plan for impaired skin integrity indicated as of 4/5/24, the area on the sacrum was a Stage 3. Interventions included, but were not limited to: treatments per order, dated 3/11/24 and weekly assessment of site to include full measurements, drainage, odor, wound bed assessment, surrounding tissue assessment, and pain/discomfort at site, dated 3/11/24. A current potential for further impaired skin integrity, dated 10/4/23, included but was not limited to, an intervention for weekly skin assessments by a licensed nurse, also dated 10/4/23. Progress notes included, but were not limited to: 3/4/24 at 9:43 P.M. Weekly assessment revealed an abrasion to coccyx measuring 1 cm (centimeter) x 0.1 cm with barrier cream applied. A fax was sent to the doctor regarding treatment for the area. 3/11/24 at 6:12 P.M., a Physician's Order note indicated to cleanse pressure injury to sacrum with normal saline, apply Hydrogel to wound bed and cover with bordered foam dressing. The order was received from triage. 4/8/24 at 2:54 P.M., a Dietary note from the Registered Dietician (RD) indicated they were notified of the resident having a Stage 3 pressure injury to the sacrum. 4/9/24 at 10:44 A.M., an MDS Quarterly Assessment Note indicated resident had a Stage 3 pressure injury to the medial sacrum related to		three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	impaired mobility and incontinence, and treatment to the area was completed daily per licensed nursing staff. 4/9/24 at 1:31 P.M. a Social Services note indicated resident was severely impaired with decision making and that resident would be at risk for skin breakdown and poor nutrition without staff intervention as the resident would not request routine care and did not make decisions related to care needs. A Braden Scale for predicting pressure sore risk was completed on the following dates: 10/4/23 1/5/24 4/5/24 4/30/24 All assessments indicated a high risk for pressure. Weekly skin assessments prior to the development on the sacrum were completed with the exception of the following dates: No assessment between 11/7/23 and 11/21/23 No assessment between 12/12/23 and 12/26/23 A skin assessment on 3/4/24 indicated the coccyx had an abrasion measuring 1 cm x 0.1 cm. A skin assessment on 3/11/24 indicated a pressure area was present to the sacrum. Wound assessments were started on 3/11/24, and included the following information: 3/11/24 unstageable pressure to sacrum, measuring 1.4 cm x 0.8 cm. 3/19/24 unstageable pressure to sacrum, measuring 1.2 cm x 0.6 cm. (completed 8 days after the previous assessment)			

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	3/28/24 Stage 3 pressure to sacrum, measuring 1.0 cm x 0.5 cm. (completed 9 days after the previous assessment) 4/5/24 Stage 3 pressure to sacrum, measuring 0.9 cm x 0.5 cm. (completed 8 days after the previous assessment) 4/16/24 Stage 3 pressure to sacrum, measuring 0.8 cm x 0.3 cm. (completed 11 days after the previous assessment) 4/30/24 Stage 3 pressure to sacrum, measuring 0.6 cm x 0.2 cm. (resident was in the hospital from 4/18/24 through 4/30/24) 5/10/24 Stage 2 pressure to sacrum, measuring 0.6 cm x 0.3 cm. (completed 10 days after the previous assessment) 5/17/24 Unstageable pressure to sacrum, measuring 3.2 cm x 1.3 cm. 5/23/24 Unstageable pressure to sacrum, measuring 3.2 cm x 1.1 cm. 5/31/24 Unstageable pressure to sacrum, measuring 2.3 cm x 0.8 cm. (completed 8 days after the previous assessment) 6/7/24 Unstageable pressure to sacrum, measuring 1.6 cm x 0.8 cm. 6/11/24 Unstageable pressure to sacrum, measuring 1.4 cm x 0.7 cm. 6/20/24 Unstageable pressure to sacrum, measuring 1.7 cm x 0.8 cm. (completed 9 days after the previous assessment)			

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	6/28/24 Stage 3 pressure to sacrum, measuring 2.9 cm x 0.6 cm. (completed 8 days after the previous assessment) 7/9/24 Stage 3 pressure to sacrum, measuring 1.7 cm x 1.0 cm. (completed 11 days after the previous assessment) 7/17/24 Stage 3 pressure to sacrum, measuring 3.7 cm x 0.4 cm. (completed 8 days after the previous assessment) On 7/23/24 at 10:45 A.M., LPN 5 indicated wound assessments were completed weekly, but had not been completed when she was on vacation from 6/28/24 through 7/6/24. She indicated she followed the National Pressure Ulcer Advisory Panel for staging pressure ulcers and that Resident 54's sacral pressure was a Stage 3 that began with yellow and slough granulation. She indicated once a pressure was staged a 3, it was always a 3, and could not be labeled anything lower. She indicated Resident 54's pressure had gotten worse at the hospital, but was currently getting better. She indicated the area should be kept covered at all times, and if staff needed assistance with the dressing, they could ask her for help. (The National Pressure Ulcer Advisory Panel indicates that full thickness loss of skin, in which adipose tissue is visible in the ulcer, meets the definition of a Stage 3 pressure injury. Granulation tissue and epibole (rolled wound edges] are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If			

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	slough or eschar obscures the extent of tissue loss, this becomes an Unstageable Pressure Injury) On 7/23/24 at 1:32 P.M., LPN 5 was observed to change Resident 54's sacral dressing. The old dressing was removed, and the wound was observed with two open areas. No drainage was observed, and the surrounding area was a dark pink. LPN 5 indicated areas were measuring 0.4 cm x 0.3 cm each. LPN 5 emptied a vial of normal saline onto gauze, then indicated she was unsure if the order was for normal saline or wound cleanser, then sprayed wound cleanser on a gauze and used that to wipe the area. Medihoney was applied to a bordered dressing, and placed on the wound. 2. On 7/25/24 at 2:17 P.M., Resident 55's clinical record was reviewed. Diagnoses included but were not limited to, Type 2 diabetes mellitus with diabetic neuropathy, unspecified and peripheral vascular disease, unspecified, and pressure ulcer of left heel, unstageable The current Quarterly MDS (Minimum Data Set) Assessment dated 7/16 indicated the resident was cognitively intact. The resident needed substantial help toileting and transferring. During the 7 day look back period the resident had an unstageable pressure ulcer. Current physician orders included, but were not limited to: Heel lift boots on when in bed every shift for pressure relief to pressure ulcer of left heel, unstageable dated 1/9/24. Betadine swab to the left heel every shift for wound care related to pressure ulcer of left heel			

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	unstageable dated 1/22/24. Weekly vital signs, nursing summary, and skin assessment per schedule dated 3/22/24. Current care plan indicated the resident has an actual impairment to skin integrity related to as evidenced by deep tissue injury to left medial heel related to type 2 diabetes and peripheral vascular disease area turned to unstageable 3/8/24. Interventions included but were not to: Weekly assessment of site to include full measurements, drainage, odor, wound bed assessment, surrounding tissue assessment, pain/discomfort at site dated 1/23/2024. The record lacked weekly regular skin and wound assessments. During an interview on 7/25/24 at 10:09 A.M., the Administrative Support Person indicated there should be weekly skin assessments done and the wound person had not been doing them. On 7/25/24 at 8:00 A.M., the Administrative Support Person provided a current, nondated policy "Pressure Injury Prevention and Management" The policy indicated "...the facility is committed to the prevention of avoidable pressure injuries and the promotion of healing or existing pressure injuries ...licensed nurses will conduct, ...weekly skin assessment...findings will be documented in the medical records..." On 7/26/24 at 8:00 A.M., a current non-dated Pressure Injury Surveillance policy was provided and indicated "A system of surveillance is utilized for preventing, identifying, reporting, and investigating any new or worsened pressure			

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	injuries in the facility" On 7/26/24 at 8:00 A.M., a current non-dated Wound Dressing policy was provided and indicated to change dressings as directed by the physician or wound nurse. 3.1-40(a) 3.1-40(a)(2)			
F 0688 SS=E 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 unless a reduction in mobility is demonstrably unavoidable. Based on interview and record review, the facility failed to ensure residents with limited range of motion or mobility received services to maintain or improve mobility for 4 of 4 residents reviewed for restorative therapy. (Resident 6, Resident 28, Resident 52, Resident 55) Findings include:	F 0688	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No negative outcome or decline in mobility noted for identified residents. Plans of care for identified residents have been	08/25/2024

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	1. On 7/23/24 at 10:12 A.M. Resident 28's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and polyosteoarthritis. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/8/24, indicated Resident 28 was severely cognitively impaired and required substantial assistance from staff for toileting, bathing, and transfers. Current care plans included, but were not limited to: Resident requires RNP (Restorative Nursing Program) of ROM (Range of Motion), Date initiated 11/2/22. Resident to perform BLE (bilateral lower extremities) exercises throughout all planes x 20 reps or on cubii pedaler on Level 1 for 15 minutes 3-4x/week, Date initiated: 11/9/23. Resident to perform BUE (bilateral upper extremities) strengthening exercises at 1-2 sets of 15 reps utilized light resistance thera-band (red) 3-4x/week, Date initiated: 11/9/23. Resident will perform BUE (bilateral upper extremities) strengthening exercises on arm bike x6-8 min with rest breaks as needed (2 sets) 3-4x/week, Date initiated 7/21/23. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for restorative nursing therapy was reviewed from 5/1/24 through 7/26/24 and indicated Resident 28 had only received 5 days of restorative nursing therapy during the 12 week period.		reviewed to ensure appropriateness for restorative nursing program. ***Other residents that have the potential to be affected have been identified by:*** All residents on restorative nursing program have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** New position of Restorative Nursing Assistant created. All residents currently on a restorative program reviewed by IDT. All nursing assistants provided in-service education related to ensuring completeness and accuracy of point of care documentation. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that residents on restorative program receive services indicated in plan of care and that the above corrective actions and changes are being followed. This tool will be completed by the Director of Nursing or designee weekly for 4 weeks, monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be	

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	2. On 7/25/24 at 11:18 A.M., Resident 6's clinical record was reviewed. Diagnoses included, but were not limited to, diabetes and chronic kidney disease. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 4/23/24, indicated Resident 6 was severely cognitively impaired and required substantial assistance from staff for toileting and bathing. Current care plans included, but were not limited to: Resident requires RNP (Restorative Nursing Program) of ROM (Range of Motion) due to diabetes insipidus, impaired mobility, and to help resident remain at his highest level of physical functioning, Date initiated: 3/13/24. Resident will perform BUE strengthening exercises x 10 reps; BLE exercises x 10 reps (2 sets) seated 3-4x/week x 90 days. Resident will walk > (greater/more than) 200ft 3-4x/week Date initiated, 3/13/24. The Point of Care (POC) (a Certified Nurse Aide documentation system) Tasks for restorative nursing therapy was reviewed from 5/1/24 through 7/26/24 and indicated Resident 6 had only received 5 days of restorative nursing therapy during the 12 week period.3. On 7/23/24 at 11:42 A.M., Resident 52's clinical record was reviewed. Diagnosis included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting unspecified side. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/18/24, indicated no cognitive impairment, no behaviors, and no days of restorative. Resident 52 required supervision		immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	assistance of one staff with transfers. A current restorative nursing program care plan, dated 7/6/23, indicated an intervention but was not limited to, resident to walk up to 150-200 feet with staff 3-4 times per week, dated 5/17/24. In the last 30 days, Resident 52 had received restorative nursing that entailed resident walking up to 150-200 feet with staff on 7/21/24 for 10 minutes. On 6/27/24, Resident 52 refused. All other dates were not completed. On 7/24/24 at 9:50 A.M., the Director of Nursing (DON) indicated they had been trying to get a dedicated Certified Nurse Aide (CNA) for restorative nursing, but currently did not have one. She indicated whatever CNA was working was responsible for doing restorative nursing tasks with the residents. On 7/24/24 at 9:59 A.M., CNA 3 indicated restorative nursing range of motion exercises were performed with Resident 52 in the room with transfers. She indicated there was nothing in particular that needed to be done with the resident as far as which extremities and whatever was done was supposed to be documented in the clinical record. 4. On 7/22/24 at 12:22 P.M., Resident 55 was observed sitting in wheelchair in dining room with wife. On 7/23/24 at 9:00 A.M., Resident 55 was observed sitting in wheelchair in room watching television. On 7/25/24 at 10:20 A.M., Resident 55 was observed sitting in wheelchair in room after morning care.			

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	On 7/25/24 at 2:17 P.M., Resident 55's clinical record was reviewed. Diagnoses included but were not limited to, Type 2 diabetes mellitus with diabetic neuropathy, unspecified and peripheral vascular disease, unspecified. The current Quarterly MDS (Minimum Data Set) Assessment dated 7/16/24 indicated the resident was cognitively intact. The resident needed substantial help toileting and transferring. MDS indicated there was a restorative program. During the 7 days look back period 0 minutes were recorded daily for restorative care. The medical record lacked current physician orders for restorative care. The current care plan indicated the resident requires RNP (Restorative Nursing Program) related to impaired mobility due to diabetic neuropathy. Interventions included but were not limited to: Resident will perform active ROM (Range of motion) to BUE(Bilateral Upper Extremities) for strengthening seated or supine x(Times) 15 minutes 3-4x /week x 90 days and resident will walk 50-100 feet with FWW(Full Weight Bearing) and GB(Gait Belt), Min A-CGA (Minimum Activity -Comprehensive Geriatric Assessment 3-4x/week dated 4/15/24. On 7/25/24 at 1:55 P.M., LPN (Licensed Practical Nurse) 2 provided the CNA(Certified Nurse Aide) Tasks for Nursing Rehabilitation that was for Active ROM BUE for strengthening seated or supine x15 minutes 3-4x/week the only days from 6/26/240-7/22/24 that included Nursing Rehabilitation times were as follows: 6/30/24 at 2:40 P.M. for 15 minutes 7/1/24 at 9:29 P.M. for 5 minutes			

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	7/8/23 at 6:29 P.M. for 15 minutes 7/9/24 at 3:15 P.M. for 15 minutes 7/21/24 at 6:29 P.M. for 4 Minutes 7/22/24 at 6:29 P.M. for 3 minutes During an interview on 7/25/24 at 1:50 P.M., LPN 2 indicated there was no restorative aide for the facility. On 7/26/24 at 8 A.M., Administrative Support provided an undated policy titled Restorative Nursing Program that indicated "It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. Restorative aides will implement the plan for a designated length of time, performing the activities, and documenting on the Restorative Aide Documentation Form. The Restorative Nurse, or designated licensed nurse, will provide oversight of the restorative aide activities, review the documentation at least weekly, and evaluate the effectiveness of the plan monthly." On 7/24/24 at 10:45 A.M., the DON provided a current Restorative Nursing Services policy, revised 7/2017, that indicated "Residents will receive restorative nursing care as needed to help promote optimal safety and independence" At that time, the Administrative Support indicated restorative nursing had not been done. On 7/26/24 at 8 A.M., Administrative Support provided an undated policy titled Restorative Nursing Program that indicated "It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. Restorative aides will implement			

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	the plan for a designated length of time, performing the activities, and documenting on the Restorative Aide Documentation Form. The Restorative Nurse, or designated licensed nurse, will provide oversight of the restorative aide activities, review the documentation at least weekly, and evaluate the effectiveness of the plan monthly." On 7/24/24 at 10:45 A.M., the DON provided a current Restorative Nursing Services policy, revised 7/2017, that indicated "Residents will receive restorative nursing care as needed to help promote optimal safety and independence" At that time, the Administrative Support indicated restorative nursing had not been done. 3.1-42(a)(1) 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, interview, and record review, the facility failed to ensure adequate supervision and assistance to prevent accidents for 3 of 3 residents reviewed for falls. Interventions were not updated following falls. (Resident 52, Resident 28, Resident 11 Findings include:	F 0689	***The corrective action taken for those residents found to be affected by the deficient practice include:*** IDT performed review of plan of care related to falls for identified residents to ensure completeness and appropriateness of focus,	08/25/2024

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	1. On 7/21/24 at 9:43 A.M., Resident 52 indicated she had fallen about a month ago when she lost her footing. At that time, Resident 52 was sitting in a recliner with her walker in front of her. On 7/23/24 at 11:42 A.M., Resident 52's clinical record was reviewed. Diagnosis included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting unspecified side. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/18/24, indicated no cognitive impairment, and no behaviors. Resident 52 required supervision assistance of one staff with transfers. Current physician orders included, but were not limited to: Up with walker and staff assist and non skid shoes, dated 1/4/24. A current risk for falls care plan, dated 6/13/23, indicated the following interventions: 1/4 side rails in bed for mobility enablers, dated 6/13/23. Call light within reach, dated 6/13/23. Ensure environment is free of clutter, dated 6/13/23. Have commonly used articles within easy reach, dated 6/13/23. Non skid footwear at all times, dated 3/20/24. Non skid strips in front of the toilet, dated 12/29/23. Reminder sign to call for assistance in room, dated		goals, and active interventions. ***Other residents that have the potential to be affected have been identified by:*** All residents that are at risk of falls have the potential to be affected. IDT has performed review of all fall care plans to ensure appropriateness of focus, goals, and active interventions. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** A fall log was developed to be used by IDT to ensure all falls are reviewed and interventions are implemented. IDT received in-service education regarding fall prevention care planning. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that falls are reviewed, plans of care are updated to reflect new interventions and that the above corrective actions and changes are being followed. This tool will be completed by the Director of Quality or designee weekly for 4 weeks, monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be	

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	7/15/24. Shoes with backs when ambulating, dated 8/24/23. Roho cushion with Dycem underneath in resident's recliner, dated 8/18/23. Independent with transfers, initiated 6/13/23 and revised 12/20/23. Resident 52 experienced the following falls since 12/18/23: Fall 1 12/18/23 at 12:05 A.M. Fall was not witnessed. Resident was found lying on the floor on her back, with a walker near her feet. A hematoma measuring 5cm (centimeters) x5cm was observed on the back of her head. An ice pack was applied to the hematoma, and neuro checks were initiated. The resident indicated she was trying to pull back the curtain and lost her balance. The immediate intervention put into place was for the resident to call for assistance. A post fall evaluation, dated 12/20/23, indicated the resident was attempting to self toilet at the time of the fall. An Interdisciplinary Team (IDT) note, dated 12/28/23, indicated Resident 52 was diagnosed with RSV (Respiratory Syncytial Virus) and pneumonia at the time of the fall, and physical therapy was to evaluate for weakness related to the diagnosis. The falls care plan intervention for mobility was updated 12/20/23 to indicate independent with transfers. Fall 2 12/29/23 at 3:44 A.M. Fall was unwitnessed. Resident was found on the bathroom floor sitting upright with feet extended out and back facing the toilet. The resident indicated she had just used the bathroom, and when she went to grab her		reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	walker it slid causing her to lose her balance. The falls care plan was updated the same day to include non skid strips in front of the toilet. Fall 3 3/19/24 at 5:10 A.M. Fall was unwitnessed. Resident was attempting to self toilet, resulting in a fall and skin tear to the right forearm. A post fall evaluation, dated 3/19/24 at 2:54 P.M., indicated the resident was wearing non-skid shoes/socks at the time of the fall. The falls care plan was updated 3/20/24 to include non skid footwear at all times. Fall 4 5/21/24 at 6:45 P.M. Fall was unwitnessed. Resident fell in her room "sneaking water". Resident was at the sink attempting to get extra water at mealtime. The falls care plan was not updated with a new intervention following fall. Fall 5 6/27/24 at 8:00 A.M. Fall was unwitnessed. Resident was found sitting on the floor to the right of the commode attempting to self toilet. The resident indicated she slid herself down to the floor. The falls care plan was not updated with a new intervention following fall. Fall 6 7/14/24 at 7:00 P.M. Fall was unwitnessed. Resident was attempting to self toilet when her legs got weak. The falls care plan was not updated with a new intervention following fall. On 7/24/24 at 9:52 A.M. the Director of Nursing (DON) indicated therapy had deemed Resident 52 not safe to be up independently and the resident and family were aware, but the resident continued to get up without asking for assistance. The DON			

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	indicated Resident 52's falls were from her wanting to be independent. She further indicated all falls were discussed the following morning during a meeting, and new interventions were added to the care plan. On 7/24/24 at 2:55 P.M., Certified Nurse Aide (CNA) 32 indicated Resident 52 should be assisted by staff to get up and with transfers by one staff. She indicated the resident required moderate assistance and supervision with mobility. 2. On 7/23/24 at 10:12 A.M. Resident 28's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and polyosteoarthritis. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 5/8/24, indicated Resident 28 was severely cognitively impaired and required substantial assistance from staff for toileting, bathing, and transfers. Current physician orders included, but were not limited to: Fall reduction measures: Non-skid strips to side of bed, personal night light, raised toilet seat. 4/17/23. Sensor alarm to wheelchair; check placement, function every shift for decreased safety awareness 12/13/22 Care plans included, but were not limited to: Resident is at high risk for falls characterized by history of falls, impaired vision, dementia, osteoarthritis, other abnormalities of gait and mobility, and medication usage. Resident frequently forgets or refuses to use call light or ask for staff assistance. Date Initiated: 03/26/2018. Substantial/maximal assist, Turner transfer aide for all transfers, Date initiated 3/29/18. Resident to wear non-skid shoes or gripper socks			

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	at all times, Date initiated: 11/20/18. Raised toilet seat, Date initiated 4/17/23. Visual aid "call before you fall" placed on bathroom door and wall in resident's room, Date initiated 12/7/23. Anti-rollbacks to wheelchair, Date initiated 1/3/24. Staff education on fall prevention, Date initiated 2/19/24. Non-skid strips to floor in front of toilet, Date initiated: 4/9/24. The clinical record indicated Resident 28 had 10 falls in the past 12 months. The following indicates the time each fall occurred, how it occurred, and the intervention put in place by the IDT (interdisciplinary team) according to the Fall Event Notes provided by the DON (Director of Nursing) on 7/26/24 at 8:00 A.M. Fall #1 9/7/23 at 1:35 P.M.; A CNA (Certified Nurse Aide) was assisting Resident 28 to the bathroom when Resident 28 began to fall, the CNA lowered resident 28 to the floor. The intervention put in place was for Two (2) staff members to assist with transfers from wheelchair to commode and transfers to bed. Fall #2 10/20/23 at 9:49 P.M.; Staff was transferring Resident 28 to bed when Resident was assisted to floor. The intervention put in place was for staff to use Turner transfer aid (device to assist with pivot transfers) and two (2) staff during transfers. Fall #3 11/14/23 at 11:45 A.M.; A CNA was transferring Resident 28 from the right side of the bed to the shower chair when the bed began to roll and Resident was lowered to the floor. The intervention put in place was for maintenance to fix the locks on the bed.			

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	Fall #4 12/6/23 at 3:58 P.M.; Resident 28 was attempting to toilet herself after activity and fell in the bathroom. The intervention put in place was a 'Call Don't Fall' sign placed in the Residents room. Fall #5 12/29/23 at 2:55 P.M.; Resident 28 was found by staff in bathroom floor. The intervention put in place was staff education on checking Resident's wheelchair alarm while up in chair. Fall #6 2/14/24 at 4:15 P.M.; Resident 28 was brought back to room by staff and instructed to reposition self in wheelchair, resulting in sliding out of wheelchair. Intervention put in place was staff education to prevent falls. Fall #7 2/21/24 at 12:41 P.M.; Resident 28 was in activities when she slid out of her wheelchair. Intervention put in place was educate staff on proper positioning in wheelchair. Fall #8 3/10/24 at 7:04 P.M.; Resident 28 Resident was found sitting in floor of bathroom. Intervention put in place was educate staff regarding toileting resident after meals. Fall #9 4/8/24 at 2:00 P.M.; Staff found Resident 28 sitting in bathroom floor. Intervention put in place was non-skid strips in front of toilet in bathroom. Fall #10 4/29/24 at 1:50 P.M.; A CNA attempted to transfer Resident 28 from the toilet to the wheelchair, resulting in Resident to slide into floor. Intervention put in place was for Resident to see physical therapy three (3) times a week for eight (8) weeks and occupational therapy three (3) times as week for four (4) weeks. During an interview on 7/25/24 at 9:24 A.M., the DON (Director of Nursing) indicated Resident 28			

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	should be transferred with assistance from two staff members. During an interview on 7/26/24 at 10:58 A.M., the DON indicated she was unable to provide the staff education as fall interventions on 12/29/23, 2/14/24, 2/21/24, 3/10/24 because the education did not exist. 3. On 7/23/24 at 11:35 A.M., Resident 11's clinical record was reviewed. Diagnoses included, but were not limited to, muscle weakness, generalized and idiopathic epilepsy and epileptic syndromes, not intractable, without status epilepticus, bilateral secondary osteoarthritis of knee. The current Quarterly MDS (Minimum Data Set) Assessment dated 6/21/24. The resident is mildly cognitively impaired and needs limited assist of 1 for transfer, toileting, and bed mobility. MDS indicated the resident had a history of falls within the last 3 months. Current physician orders included, but were not limited to: Activity level: up in wheelchair with assist from staff; turn transfer with 2 assist to be used for all transfers dated 7/2/24. Resident should not wear gripper socks with shoes. Nurses/ QMA (Qualified Medicine Aide) to check every shift for pressure relief dated 1/23/24. The current care plan indicated Resident is at risk for falls r/t (related to) seizure disorder, abnormality of gait,mild cognitive impairment, and potential to become easily frustrated and/or overstimulated and may set herself on the floor as a result. Resident has reported falls that have not been witnessed or have been questionable if they			

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	were behavioral in nature r/t anxiety and attention seeking. Interventions included, but were not limited to, resident is often resistive to any intervention or offer of extra help and Transfers: Turner transfer aide with 2 assists for all transfers. Progress notes included but were not limited to: On 7/24/24 8:55 P.M., a Nurse's note indicated a CNA was assisting Resident 11 from commode back to the wheelchair and reported resident fell forward on to knees bumping head on floor. The wheel chair was located outside of the bathroom near the sink. The fall occurred in front of the wheelchair. When asked what happened, the resident indicated "my legs gave out". Resident was assisted up from floor to bed and was reminded to call for assistance from the staff. On 7/24/2024 at 9:11 P.M., at post fall evaluation indicated that the fall was witnessed and occurred when a CNA (Certified Nurse Aide) was assisting resident from the bathroom to the w/c (Wheelchair)The resident did not require a visit to the ER (Emergency Room) or hospitalization. A contributing factor was noted to be loss of balance and weakness. On 7/24/24 at 7/24/2024 at 9:07 P.M., the Fall Rise Evaluation indicated: the resident had a history of falls in the past 3 months, there was no loss of consciousness. The resident had 1-2 predisposing factors. Fall Risk Score: 13.0 On 6/27/24 at 8:00 P.M., Resident 11's roommate reported that resident had fallen from her recliner. The resident was found sitting on her left hip leaning against recliner with wet clothing due to incontinence episode. Neurochecks began and			

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	were within normal limits. MD, family, and DON made aware. Intervention added was to have the resident transfer with 2 assists. On 7/26/24 at 8:00 A.M., a current non-dated Fall Prevention Program policy was provided and indicated "Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care [and] the plan of care will be revised as needed ... When any resident experiences a fall, the facility will ... Review the resident's care plan and update as indicated" 3.1-45(a) 3.1-45(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure oxygen equipment was properly labeled and oxygen services were provided according to physician order for 1 of 1 reviewed for respiratory care. (Resident 24) Findings include: On 7/21/21 9:14 A.M., Resident 24 was observed	F 0695	***The corrective action taken for those residents found to be affected by the deficient practice include:*** Resident 24's oxygen tubing was replaced and oxygen warning sign was placed outside of the door. ***Other residents that have the potential to be affected have been identified by:***	08/25/2024

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	sitting in recliner with nasal cannula in nostrils. The tubing was connected to an oxygen concentrator with a date of 6/30/24 written on the side of the tubing. There was also no oxygen warning sign on the outside of the door. On 7/22/24 at 9:40 A.M., Resident 24's clinical record was reviewed. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease) and Type 2 Diabetes Mellitus with Diabetic Polyneuropathy. The current Annual MDS (Minimum Data Set) Assessment dated 6/18/24 indicated the resident was mildly cognitively impaired. The resident needed partial assistance with toileting and dressing and was wearing O2 (Oxygen). Current physician orders included but were not limited to: Change oxygen tubing and supplies weekly every night shift every Sunday dated 12/3/23. The current care plan indicated the resident has a potential for an altered respiratory status related to COPD. Interventions included but were not limited to providing oxygen as ordered and changing O2 tubing, water, and clean filter weekly. During an interview on 7/23/24 at 3:41 P.M., LPN (Licensed Practical Nurse) 5 indicated the O2 tubing should be changed weekly and should be dated with tape label or written on the side. On 7/26/24 at 8:00 A.M., the Administrative Support Person provided a current nondated policy "Oxygen Concentrator." The policy indicated"... staff is responsible for the use of oxygen...is administered under the orders of the attending physician...to place an oxygen warning		All residents that utilize oxygen or respiratory supplies such as nebulizers could be affected. Observation rounds and review of medical records was performed to ensure all oxygen supplies were changed appropriately and oxygen warning signage was in place. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Staff provided in-service education about oxygen safety and infection control practices. Facility oxygen policies reviewed and updated. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that respiratory equipment is replaced per policy, oxygen signage is in place and that the above corrective actions and changes are being followed. This tool will be completed by the Director of Nursing or designee weekly for 4 weeks, monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are	

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	sign on the resident's door...change oxygen tubing and mask/cannula weekly and as needed." 3.1-47(a)(6)		needed.	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.			

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	§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to post accurate actual hours worked for licensed and unlicensed nursing staff directly responsible for resident care per shift daily for 5 of 6 days during the annual survey period. Finding includes: During an observation on 7/21/24 at 9:30 A.M. a posted nurse staffing data sheet, dated 7/18/24, was observed on the wall outside the 1st floor nurses station. During an observation on 7/22/24 at 2:48 P.M. a posted nurse staffing data sheet, dated 7/22/24, was observed on the wall outside the 1st floor nurses station. The sheet included, but was not limited to, the following information: Census, total number of staff for each shift and total hours of each shift for CNA (Certified Nurse Aide), LPN (Licensed Practical Nurse), and RN (Registered Nurse). The sheet indicated that .5 RNs worked the evening shift but did not specify which half of the shift the RN worked. The sheet indicated that 2.5 LPNs worked the evening shift but did not specify which half of the shift the LPN worked. On 7/25/24 at 11:35 A.M., the Scheduler provided a copy of posted nurse staffing sheets for dates 7/21/24, 7/22/24, 7/23/24, 7/24/24, and 7/25/24. Each of these dates did not reflect actual hours worked.	F 0732	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified as being affected. ***Other residents that have the potential to be affected have been identified by:*** No residents were identified as being affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The staffing sheet has been revised to meet preferences indicated in summary statement of deficiencies. New display method has been purchased which will allow multiple days to be posted. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that the daily staffing form is posted, accurate and that the above corrective actions and changes are being followed. This tool will be completed by the Administrator or designee weekly for 4 weeks, monthly for three months, and	08/25/2024

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	On 3/4/24 at 10:10 A.M., the MDS (Minimum Data Set) Coordinator indicated that some CNAs worked half shifts. She indicated she was unable to tell by looking at the posted nurse staffing sheet which half of the shift was worked. On 7/25/24 at 11:35 A.M., the Scheduler indicated the half shift was usually, but not always, the second part of the shift. At that time, she indicated that the staffing sheet was posted in the morning when she got to work. She pre-filled in the staffing sheets for the weekend before she left on Friday and a nurse posted them on Saturday and Sunday. She would update the weekend sheets with the correct staffing information when she returned to work on Monday. On 7/26/24 at 9:13 A.M., the Administrative Support provided a "Nurse Staffing Posting Information" policy, undated, that indicated "The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: the total number of staff scheduled and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift ... The facility will post with Nurse Staffing Sheet at the beginning of each shift".		then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on record review and interview, the facility failed to ensure proper interventions were in place for monitoring symptom, side effects, and	F 0744	***The corrective action taken for those residents found to be affected by the deficient practice***	08/25/2024

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	behaviors of medications for 2 of 2 residents reviewed for dementia. (Resident 46, Resident 37) Findings include: 1. On 7/23/24 at 4:09 P.M., Resident 46's clinical record was reviewed. Diagnoses included, but were not limited to unspecified dementia, unspecified severity, mood disturbance and anxiety disorder. The current Quarterly MDS (Minimum Data Set) Assessment dated 7/2/24 indicated Resident 46 was significantly cognitively impaired. Resident 46 was dependent for bathing, dressing, and toileting. MDS indicated the resident has a diagnosis of No Alzheimer dementia. Current physician orders included but were not limited to: Seroquel Oral Tablet 25 MG (Milligrams) (Quetiapine Fumarate).Give 1 tablet by mouth at bedtime for dementia with mood disturbance related to unspecified dementia, unspecified severity, with mood disturbance dated 4/15/24. Xanax Oral Tablet 0.25 MG (Alprazolam) Give 0.25 mg by mouth three times a day for anxiety/restlessness related to anxiety disorder dated 1/3/24. Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) Give 2 capsules by mouth two times a day for mood disorder related to unspecified dementia, unspecified severity, with mood disturbance, depression unspecified, unspecified mood [affective] disorder. Open capsule and sprinkle in food vehicle of choice dated 7/5/24.		***include:*** A dementia focused care plan was added for Resident 46. Care plans related to anxiety and wandering were added for Resident 37. ***Other residents that have the potential to be affected have been identified by:*** All residents with dementia have the potential to be affected. Residents with a diagnosis of dementia have had their plan of care reviewed to ensure care plans are in place. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** In-Service education was provided to the IDT. Tool including list of focus areas that need to be included in plan of care has been created for utilization by Interdisciplinary Team. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that residents with dementia have necessary care plans and that the above corrective actions and changes are being followed. This tool will be completed by the Director of Nursing or designee weekly for 4 weeks, monthly for three months, and then quarterly for three quarters. Any areas	

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	There is no current care plan designated for dementia care. During an interview on 7/24/24 at 10:41 A.M., the Licensed Social Worker indicated that she places a care plan related to dementia for residents. On 7/26/24 at 8:00 A.M., the Administrative Support Person provided a current, nondated policy "Dementia Care". The policy indicated ..."it is the policy of the facility to provide the appropriate treatment and services with residents diagnosed with dementia...the facile will assess, develop, and implement care plans through and interdisciplinary team... the care plan goals will be achievable...interventions will be related to each resident's individual symptomology and rate of dementia progression..."2. On 7/23/24 at 1:59 P.M., Resident 37's clinical record was reviewed. Diagnoses included, but were not limited to, Alzheimer's Disease and anxiety. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 6/4/24, indicated Resident 37 was severely cognitively impaired and required substantial assistance from staff for toileting and bathing. Current physician orders included, but were not limited to: Ativan (antiaxiety medication) oral tablet 0.5 mg (Lorazepam) Give 1 tablet by mouth one time a day, start date 4/12/24. Lexapro (antianxiety/antidepressant medication) oral tablet 10 mg (Escitalopram Oxalate) Give 1 tablet by mouth at bedtime for change in mood, Start date 11/29/23.		identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	A progress note, dated 3/30/24 at 12:22 A.M., indicated "(Resident) is up with his walker pacing up and down the hallways and in lobby. He states "he is waiting for his wife to pick him up". He has had various belongings wrapped in a shirt carrying them with him. He took all of his HS (hour of sleep bedtime)medications and is pleasant with staff just insistent that he is leaving. Sitting in the front lobby at present." A progress note, dated 6/21/24 at 6:11 A.M., indicated "At the beginning of this shift Resident was agitated and exit seeking yelled at staff asking, "who put me here" Resident is very hard of hearing and staff was trying to communicate with him by speaking loudly and slowly however he did not understand that this was his home and his family was not able to take care of him. He was incontinent of urine and bowel which may have been increasing his agitation. He was assisted back to his room and staff helped him get a dry adult brief on and clothes changed, given a snack and diet coke, communication was written out for him that he was spending the night. He huffed at staff. He had no further exit seeking however he was awake all night packing his things up on his bed as if he was getting ready to leave." A progress note, dated 7/11/24 at 1:11 A.M., indicated "(Resident) had a witnessed fall at 0015 (12:15 A.M.). (Resident) was exit seeking and became angry thrashing his walker around and yelling when he lost his balance and landed on his right side. This occurred while (resident) was trying to get in the dining room. (Resident) was able to stand backup with assist of 1 staff member. VS were obtained. Head to toe assessment performed. Res obtained an abrasion to his left knee and a small ST and bruise to left elbow. MD notified. Care ongoing."			

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	An elopement evaluation, dated 6/3/24, indicated Resident 37 had not expressed the desire to go home, packed belongings to go home or stayed near an exit door, and did not wander. The clinical record lacked care plans relating to anxiety or exit seeking behaviors. On 7/25/24 at 3:31 P.M., Administrative Support provided a policy titled Elopements and Wandering Residents Policy, dated 4/10/23, that indicated "The facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary." 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the			

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	general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on interview and record review, the facility failed to ensure routine medications were available and dispensed according to physician's orders for 1 of 6 residents reviewed for medication administration. (Resident 28) Finding includes: On 7/23/24 at 10:08 A.M., Resident 28's clinical record was reviewed. Diagnosis included, but was not limited to, hyperlipidemia. The most current Quarterly Minimum Data Set (MDS) Assessment, dated 5/8/24, indicated	F 0755	***The corrective action taken for those residents found to be affected by the deficient practice include:*** Resident 28's medication was ordered and received. ***Other residents that have the potential to be affected have been identified by:*** All residents that take medication have the potential to be affected. All resident MARs (medication administration records) were reviewed to ensure no other	08/25/2024

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	Resident 28 had severe cognitive impairment and required setup assistance of staff for eating. Current physician orders included, but was not limited to: Pravachol (a medication to treat high cholesterol) Tablet 80 MG (milligrams) - Give 1 tablet by mouth one time a day for hyperlipidemia, dated 7/17/22. The July 2024 MAR (Medication Administration Record) indicated resident did not receive the medication on 7/18, 7/19, and 7/22 because it was on order. The MAR indicated the resident received the medication on 7/20 and 7/21. On 7/23/24 at 10:18 A.M., the pharmacy indicated Resident 28's Pravachol was reordered early the morning of 7/23/24 and had not been dispensed yet. The medication had last been dispensed from the pharmacy on 6/13/24. On 7/23/24 at 1:27 P.M., the Director of Nursing (DON) provided a list of medications available in the facility's Emergency Drug Kit (EDK). Pravachol was not available in the EDK. On 7/25/24 at 9:54 A.M., the DON indicated she was not sure how Resident 28 could have received Pravachol on 7/20 and 7/21 and it may have been marked in error. On 7/25/24 at 12:12 P.M., Licensed Practical Nurse (LPN) 36 indicated medication should be reordered 7 days before the medication runs out. On 7/26/24 at 9:03 A.M., the Administrative Support provided a "Charting and Documentation" policy, revised July 2017, that indicated "Documentation in the medical record will be objective (not opinionated or speculative),		residents were currently affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** In-Service education provided to all nurses and QMAs. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that medications are ordered, received, and administered and that the above corrective actions and changes are being followed. This tool will be completed by the Director of Nursing or designee weekly for 4 weeks, monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	complete, and accurate". On 7/26/24 at 9:13 A.M., the Administrative Support provided an "Order and Receiving Medications" policy, dated 1/17/15, that indicated "Reorder medication when a four day supply remains, in advance of need, to assure an adequate supply is on hand". On 7/26/24 at 9:13 A.M., the Administrative Support provided a "Medication and Treatment Orders" policy, revised July 2016, that indicated "drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available". 3.1-25(a)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a			

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	specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview the facility failed to ensure a resident was free from unnecessary medications for 1 of 1 residents reviewed for hospice. A resident's as needed anti-anxiety medication was ordered for more than 14 days. (Resident 49) Finding includes: On 7/21/24 at 11:10 A.M., Resident 49's clinical	F 0758	***The corrective action taken for those residents found to be affected by the deficient practice include:*** Coordination with prescriber occurred with physician statement indicating rationale for continuing PRN Ativan longer than 14 days received and added to medical record for Resident 49.	08/25/2024

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	record was reviewed. Diagnosis included, but was not limited to, Alzheimer's Disease with late onset and Anxiety Disorder . The MDS (Minimum Data Set) dated 7/6/24 indicated that Resident 49's cognition was severely impaired and was currently receiving hospice services. Current physician orders included but were not limited to lorazepam oral tablet 0.5 MG, 1 tablet by mouth every 4 hours as needed for anxiety and agitation related to Anxiety Disorder. The order was dated 6/28/24 with no end date. On 07/25/24 at 10:53 A.M. the DON (Director of Nursing) indicated that PRN antianxiety medications should have been evaluated every 14 days, also that it would have been expected for the end date to be 14 days when order was put in. A Use of Psychotropic Medication Policy was provided by administration on 7/25/24 at 2:00 P.M. The policy stated PRN orders for all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. 14 days). 3.1-48(a)(6)		***Other residents that have the potential to be affected have been identified by:*** All residents with PRN psychotropic medications were reviewed to ensure orders had appropriate end dates or a clinical rational for continuing longer than 14 documented by the prescriber with no other residents found to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** IDT to include review of all psychotropic medication orders at weekly at-risk/QAPI meeting. Residents found to have PRN psychotropic orders will be ensured to have an end date entered to not exceed 14 days or a clinical rational on file from the prescriber. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that all PRN psychotropic medications are not prescribed longer than 14 days or have a clinical rationale from prescriber and that the above corrective actions and changes are being followed. This tool will be completed by the Director of Nursing or designee weekly for 4 weeks, monthly for three months,	

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			and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to ensure medications were administered according to physician's orders and professional standards for 2 of 26 opportunities, resulting in a medication administration error rate of 7.69%. (Resident 53 and Resident 23) Findings include: 1. On 7/23/24 at 11:35 A.M., Licensed Practical Nurse (LPN) 46 was observed preparing a Humalog Kwikpen for insulin administration for Resident 53. An AccuCheck (blood glucose test) indicated the resident had a blood sugar of 313. LPN 46 indicated the resident received sliding scale insulin and was to receive 3 units of insulin Lispro (a fast acting insulin) for a blood glucose reading of 313. LPN 46 set the insulin pen to 3 units. She cleaned the tip of the pen, attached the needle,	F 0759	***The corrective action taken for those residents found to be affected by the deficient practice include:*** Resident 53 was unable to be identified as there was no Resident 53 indicated on sample list provided to facility. No negative outcome or abnormal fluctuation in blood sugar levels noted for Resident 23. ***Other residents that have the potential to be affected have been identified by:*** All residents that receive medication utilizing insulin pens that need primed have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur***	08/25/2024

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	and administered 3 units of insulin to Resident 53 in her lower left abdomen. LPN 46 did not prime the insulin pen before administration of the medication. 2. On 7/24/24 at 12:02 P.M., Licensed Practical Nurse (LPN) 7 was observed preparing a Humalog Kwikpen (Lispro Insulin) for insulin administration for Resident 23. LPN 7 indicated the resident received scheduled insulin and was to receive 5 units of insulin lispro (a fast acting insulin) with her lunch meal. LPN 7 set the insulin pen to 5 units. She cleaned the tip of the pen, attached the needle, and administered 5 units of insulin to Resident 23 in her right arm. LPN 7 did not prime the insulin pen before administration of the medication. On 7/25/24 at 9:54 A.M., the Director of Nursing (DON) indicated insulin pens needed to be primed before insulin was administered to the resident but was unsure how many units with which to prime the pen. On 7/25/24 at 9:45 A.M., the Humalog Kwikpen user manual was reviewed. It indicated "Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your pen, turn the dose knob to select 2 units. Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and "0" is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat		***include:*** All staff approved to administer insulin received in-service education regarding priming insulin pens and following manufacturer guidelines. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that insulin pens are being appropriately, primed, and that the above corrective actions and changes are being followed. This tool will be completed by the Director of Nursing or designee weekly for 4 weeks, monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	priming steps 6 to 8, no more than 8 times. If you still do not see insulin, change the needle and repeat priming steps 6 to 8". On 7/25/24 at 10:35 A.M., the DON provided an "Insulin Pen" policy, undated, that indicated "Prime the insulin pen: Dial 2 units by turning the dose selector clockwise. With the needle point up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears". 3.1-48(c)(1)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			

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	155607	A. BUILDING 00 B. WING	07/26/2024

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	Based on observation, interview, and record review, the facility failed to ensure dishwasher temperatures and chemicals were within range and logs were completed for 1 of 2 kitchens observed. (Cottage kitchen) Findings include: 1. On 7/21/24 at 10:14 A.M. during an initial kitchen tour of the Cottage, Dietary Aide 40 indicated the dishwasher was a high temperature dishwasher, but she was unsure what the temperature was supposed to be when the machine was running. She indicated there was water on the floor when she came in that morning so she was not certain if the machine was functioning properly and would call maintenance to look at it. At that time, Dietary Aide 40 provided the dishwasher temperature logs for June and July. Sixty-Four of 90 opportunities for wash and rinse temperature testing were not filled out in June. Fifty-one of 61 opportunities for wash and rinse temperature testing were not filled out in July. Dietary Aide 40 indicated she was supposed to fill out the temperature logs at the end of her shift. On 7/22/24 at 9:45 A.M., Dietary Aide Cook 10 indicated the dishwash temperature should get to 120 degrees Fahrenheit (F). She indicated that sometimes she had to run the cycle several times to get the temperature up to where it needed to be. At that time, she ran a dishwasher cycle. The dishwasher thermometer read 113 F. She ran the cycle again and the thermometer read 115 F. She ran the cycle five more times with the thermometer reading 116 F each time. At that time, she indicated she wasn't sure why it wasn't reaching 120 F and would let maintenance know.	F 0812	***The corrective action taken for those residents found to be affected by the deficient practice include:*** No specific residents were identified as having been affected. ***Other residents that have the potential to be affected have been identified by:*** All residents whose meals are served from Cottage kitchen have the potential to be affected. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** New booster water heater installed for dish machine. New temperature log form developed for use for Cottage dish machine. Staff received in-service education. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that temperature and chemical readings are performed and that the above corrective actions and changes are being followed. This tool will be completed by the Administrator or designee weekly for 4 weeks, monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be	08/25/2024

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	On 7/22/24 at 12:45 P.M., the Administrative Support provided the instruction manual for the Dishwasher, undated, that indicated "Recommended temp 140 degrees F ... required minimum temp 120 degrees F ... follow the directions precisely that are on the litmus paper vial and test the water on the surface of the bottle of the glasses. Concentration should be 50 p.p.m. (parts per million) minimum to 100 p.p.m. maximum. If concentration is incorrect contact your chemical supplier ... low heat during operation likely cause low incoming water temperature (below 140 degrees F)." On 7/22/24 at 2:20 P.M., Cook 10 indicated there were chemicals hooked up to the dishwasher. The chemicals were dated 6/14. She indicated she tested the dishwasher chemicals with a test strip once a day if she remembered, but did not log the results anywhere. At that time, a dishwasher cycle was observed. Cook 10 used a test strip to test for p.p.m. of hypochlorite. The test strip read 0 p.p.m. On 7/23/24 at 7:42 A.M., a sign on the cottage dishwasher indicated "Out of Order! Use 3 compartment sinks to wash and sanitize dishes! Thank you!". On 7/23/24 at 11:05 A.M., the Dietary Manager indicated that the Cottage dishwasher was a low temperature dishwasher. Staff should be recording the wash temperature and the sanitizing solution readings twice a day. She indicated the dishwasher log used in the Cottage was not the right form. She further indicated the dishwasher worked on and off and had told staff multiple times that if the wash temperature was not at or over 120 F or the chemicals were not reading to not use the dishwasher, but staff wouldn't listen.		reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	2. On 7/21/24 at 10:14 A.M., Dietary Aide 40 provided the Cottage Equipment Temperature logs for June and July. The temperature logs indicated the following: The pantry refrigerator, pantry freezer, pantry freezer, kitchen refrigerator, and kitchen freezer temperatures were missing 13 times during the morning shift and 29 times during the evening shift in June, and 16 times during the morning shift and 20 times during the evening shift in July. At that time, Dietary Aide 40 indicated she was supposed to fill out the temperature logs at the end of her shift. On 7/26/24 at 9:13 A.M., the Administrative Support provided a "Dishwasher Temperature" policy, undated, that indicated "For low temperature dishwashers (chemical sanitization): the wash temperature shall be 120 degrees F. The sanitizing solution shall be 50 ppm (parts per million) hypochlorite (chlorine) on dish surface in final rinse ... Chemical solutions shall be maintained at the correct concentration, based on periodic testing, at least once per shift, and for the effective contact time according to manufacturer's guidelines. Results of concentration checks shall be recorded. Water temperatures shall be measured and recorded prior to each meal and/or after the dishwasher has been emptied or re-filled for cleaning purposes". On 7/26/24 at 9:13 A.M., the Administrative Support provided a "Monitoring of Cooler/Freezer Temperature" policy, undated, that indicated "Logs for recording temperatures for each refrigerator or freezer will be posted in a visible location outside the freezer or refrigerator unit. Temperatures will be checked and logged at least twice per day by designated personnel".			

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	3.1-21(i)(2) 3.1-21(i)(3)			
F 0880 SS=E 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. 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;			

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	(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 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 Enhanced Barrier Precautions (EBP) were implemented for 3 of 3 residents reviewed for transmission based precautions, and failed to position fans to	F 0880	***The corrective action taken for those residents found to be affected by the deficient practice include:*** Residents 57, 60, and 17 have had	08/25/2024

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	prevent cross contamination in the laundry processing area for 1 of 2 random observations of the laundry room. (Resident 57, Resident 60, Resident 17, and Laundry Room) Findings include: 1. On 7/23/24 at 7:57 A.M., a PPE (personal protective equipment) cart was observed outside of Resident 57's room. There was no sign observed indicating instructions for specific use of the PPE or to see the nurse before entering the room. On 7/23/24 at 8:00 A.M., Resident 57's clinical record was reviewed. The clinical record lacked orders, care plans, and progress notes related to transmission based precautions. On 7/23/24 at 8:15 A.M., Licensed Practical Nurse (LPN) 23 indicated that Resident 57 was on EBP because he had a feeding tube. 2. On 7/23/24 at 8:15 A.M., LPN 23 indicated Resident 60 was on EBP because he had an indwelling urinary catheter. At that time, she indicated they do not hang signs to indicate instructions for PPE use, but there is usually a flyer hanging in the nurse's station. She could not locate the flyer in the nurse's station. On 7/23/24 at 8:23 P.M., no PPE cart or sign was observed outside of Resident 60's room indicating transmission based precaution requirements. At that time, LPN 23 indicated Resident 60 had just gotten the catheter and the PPE cart hadn't been put out yet. On 7/23/24 at 8:34 A.M., Resident 60's clinical record was reviewed. Current physician orders		their orders and plan of care reviewed and updated. ***Other residents that have the potential to be affected have been identified by:*** Residents requiring Enhanced Barrier Precautions have the potential to be affected. These residents have been identified and have a bee sticker on their nameplate as a discrete and dignified visual indication for staff required to utilize Enhanced Barrier Precautions. All resident requiring EHB have also had their medical record reviewed to ensure physician orders and care plans in place. Door hanging PPE dispensers have also been purchased to utilize dispense required PPE. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** All staff that provide direct patient care have received in-service education on Enhanced Barrier Precautions. Laundry and housekeeping staff have received in-service education on appropriate placement of fans. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that appropriate documentation is in	

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	included, but was not limited to: Foley Catheter for retention, dated 7/20/2024. The clinical record lacked orders, care plans, and progress notes related to transmission based precautions. 3. On 7/23/24 at 9:30 A.M., a PPE cart was observed outside of Resident 17's room. There was no sign observed indicating instructions for specific use of the PPE or to see the nurse before entering the room. LPN 25 indicated that residents who were on transmission based precautions had a bumblebee sticker on their nameplate. Staff got the indication for precautions and instructions for PPE use during report or had to look through the physician orders. On 7/23/24 at 9:36 A.M., Resident 17's clinical record was reviewed. Physician orders included, but was not limited to: Observe Enhanced Barrier Precautions - every shift for indwelling Foley catheter, dated 4/23/24 On 7/24/24 at 2:36 P.M., the Infection Preventionist indicated that residents who were on EBP had a bumblebee sticker on their nameplate which would signify to anyone who went into the room that they needed some form of PPE. She indicated either she or the admitting nurse was responsible for placing the signage and PPE carts outside of the room upon order. On 7/25/24 at 10:15 A.M., the Administrative Support indicated any resident who required EBP should have a physician's order and a care plan for it. 4. On 7/21/24 at 12:47 P.M., a fan was observed sitting on top of the small washing machine		medical record, care plan interventions are in place and that the above corrective actions and changes are being followed. This tool will be completed by the Infection Preventionist or designee weekly for 4 weeks, monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	

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	blowing from side of room where soiled linen was stored to the side of the room where clean linen was stored. On 7/25/24 at 11:32 A.M., the Environmental Services Manager indicated that laundry staff had a fan in the laundry processing area, but the fan was supposed to stay on the clean side of the room and not blow from dirty to clean. On 7/26/24 at 9:13 A.M., the Administrative Support provided an "Enhanced Barrier Precautions Policy" that indicated "Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves ... An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube...) ... Make gowns and gloves available immediately outside of the resident's room.". On 7/26/24 at 9:13 A.M., the Administrative Support provided an "Infection Prevention and Control Program", revised 1/24/2024, that indicated "Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection". On 7/26/24 at 9:13 A.M., the Administrative Support provided a "Laundry" policy, undated, that indicated "Soiled laundry shall be kept separate from clean laundry at all times". 3.1-18(b)(1) 3.1-18(b)(2)			

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F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;			

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	(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. Based on interview and record review, the facility failed to obtain consent before administering influenza vaccines for 2 of 5 residents reviewed for immunizations. (Resident 37 and Resident 36) Findings include: 1. On 7/22/24 at 2:00 P.M., Resident 37's clinical record was reviewed. Resident 37 received the influenza vaccine on 10/20/23. The clinical record lacked a signed consent for the influenza vaccination received on 10/20/23. On 7/23/24 at 1:27 P.M., the Director of Nursing (DON) provided the most current influenza vaccination consent form signed by Resident 37 dated 4/26/21. 2. On 7/22/24 at 1:45 P.M., Resident 36's clinical record was reviewed. Resident 36 received the influenza vaccine on 10/11/23. The clinical record lacked a signed consent for the influenza	F 0883	***The corrective action taken for those residents found to be affected by the deficient practice include:*** Resident 37's legal representative had signed an open-ended consent for resident to receive the influenza vaccine at time of admission. Resident 36 had routinely received influenza immunization in prior years at facility and prior to admission with no negative outcomes noted following immunization. Both residents were noted to have physician orders for annual influenza immunizations. ***Other residents that have the potential to be affected have been identified by:*** All residents have the potential to be affected when receiving the	08/25/2024

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	vaccination received on 10/11/23. On 7/23/24 at 10:43 A.M., Licensed Practical Nurse (LPN) 5 indicated that it took too long to call every family for influenza vaccination consent every year so if they accepted it once, she did not call them again. At that time, she indicated the floor nurse gave the influenza vaccine to Resident 36 without a signed consent as all vaccines were declined by the resident's wife when the resident was admitted to the facility. On 7/26/24 at 9:13 A.M., the Administrative Support provided an "Infection Prevention and Control Program", revised 1/23/2023, that indicated "Education will be provided to the residents and/or representatives regarding the benefits and potential side effects of the immunizations prior to offering the vaccines. Residents will have the opportunity to refuse the immunizations. Documentation will reflect the education provided and details regarding whether or not the resident received the immunizations". 3.1-13(a)		influenza immunization in the fall. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Policy and procedure for influenza immunization updated to include that infection preventionist send out updated influenza immunization information and new consent form each year prior to administering influenza immunizations. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Quality Assurance Tool has been developed to ensure that consent form is obtained prior to administering the influenza vaccination and that the above corrective actions and changes are being followed. This tool will be completed by the Director of Nursing or designee monthly for three months, and then quarterly for three quarters. Any areas identified through this audit will be immediately corrected. The outcome of this tool will be reviewed at the quarterly Quality Assessment and Assurance meeting to determine if any additional interventions are needed.	