STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155223	A. BUILDING 00 B. WING	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(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. Survey dates: October 2, 3, 4, 7, 8, and 9, 2024 Facility number: 000128 Provider number: 155223 AIM number: 100289650 Census Bed Type: SNF/NF: 82 Total: 82 Census Payor Type: Medicare: 10 Medicaid: 39 Other: 33 Total: 82 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on October 17, 2024.	F 0000	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections sat forth on the statement of deficiencies. This plan of Correction is prepared and submitted because of requirements under State and Federal law. The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Facility respectfully requests paper desk review.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on record review and interview, the facility failed to ensure transfer and discharge documents were completed and provided to a resident's representative for a discharge to the hospital for 1 of 2 residents reviewed for hospitalization (Resident 57). Findings include:	F 0623	F623 Notice Before Transfer/Discharge It is the policy of this facility to ensure transfer and discharge documents are completed and provided to the resident representative for a discharge to the hospital. **1 What corrective action(s) will be accomplished for those**	11/19/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Foreman	Administrator	11/01/2024

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	Resident 57's record was reviewed on 10/8/24 at 12:17 p.m. The profile indicated the resident's diagnoses included, but were not limited to, vascular dementia (a chronic condition that occurs when blood flow to the brain is disrupted, damaging brain tissue and affecting memory, thinking, and behavior). A quarterly Minimum Data Set (MDS) assessment, dated 8/27/24, indicated the resident had severe cognitive deficit with no documented behaviors. A care plan, with a revised date of 3/25/24, indicated the resident exhibited socially inappropriate behavior and other socially inappropriate verbal behaviors, regarding staff of color. A progress note, dated 3/24/24 at 7:35 a.m., indicated a Certified Nursing Assistant (CNA) had reported that the resident had put her hands between a male resident's legs while sitting next to each other in the dining room. The resident's had been separated from one another, assessed by a nurse, and placed on 15 minute checks. A Social Service progress note, dated 3/24/24 at 2:16 p.m., indicated Resident 57 had been referred to a Behavioral Health Care (BHC) hospital following the incident with the male resident earlier in the day. A historical review of the resident's physician's orders lacked documentation of an order to send the resident to the BHC hospital. The record lacked documentation that transfer and discharge forms had been completed and provided to the resident's representative.		**residents found to have been affected by the deficient practice?** The Social Service Director/Designee sent written notification of the Transfer/Discharge policy on for resident 57 for 3/24/2024 hospitalization on 11/1/2024. The DON/Designee notified the MD of the lack of order to send to hospital on 3/24/2024 on 11/1/2024. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents who reside in the facility have the potential to be affected by the alleged deficient practice. Therefore, this plan of correction applies to all residents of the facility. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** An in-service will be completed by the DON/Designee on 11/14/2024 for all nursing staff on the transfer/discharge policy and entering orders to send to hospital in the EMR. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as	

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	During an interview, on 10/8/24 at 3:16 p.m., Regional Clinical Consultant 18 indicated the facility had been unable to locate the transfer and discharge documents for the resident's BHC hospital transfer. The documents were required to be completed and provided to the resident or responsible party and a copy should have been placed into the resident's medical record. On 10/9/24 at 9:30 a.m., Regional Clinical Consultant 18 provided an undated document titled, "Transfer and Discharge Policy and Procedure," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure...2...Notice will be given the resident/responsible party...7. Before a facility transfers a resident to a hospital...the nursing facility will provide information to the resident/responsible party...." 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii)		indicated. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The DON/Designee will audit residents transferred to the hospital to verify notification of transfer form and transfer/discharge was given to the resident or resident representative and order to send to hospital is entered in the EMR 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on record review and interview, the facility failed to ensure bed hold documents were completed and provided to a resident's representative for a discharge to the hospital for 1	F 0625	F625 Notice of bed hold policy before/upon transfer It is the policy of this facility to ensure bed hold documents are completed and provided to a	11/19/2024

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	of 2 residents reviewed for hospitalization (Resident 57). Findings include: Resident 57's record was reviewed on 10/8/24 at 12:17 p.m. The profile indicated the resident's diagnoses included, but were not limited to, vascular dementia (a chronic condition that occurs when blood flow to the brain is disrupted, damaging brain tissue and affecting memory, thinking, and behavior). A quarterly Minimum Data Set (MDS) assessment, dated 8/27/24, indicated the resident had severe cognitive deficit with no documented behaviors. A care plan, with a revised date of 3/25/24, indicated the resident exhibited socially inappropriate behavior and other socially inappropriate verbal behaviors, regarding staff of color. A progress note, dated 3/24/24 at 7:35 a.m., indicated a Certified Nursing Assistant (CNA) had reported that the resident had put her hands between a male resident's legs while sitting next to each other in the dining room. The resident's had been separated from one another, assessed by a nurse, and placed on 15-minute checks. A Social Service progress note, dated 3/24/24 at 2:16 p.m., indicated Resident 57 had been referred to a Behavioral Health Care (BHC) hospital following the incident with the male resident earlier in the day. A historical review of the resident's physician's orders lacked documentation of an order to send		resident's representative for a discharge to the hospital. **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The SSD/Designee provided the notification bed hold policy to resident 57 on 11/1/2024. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents who reside in the facility have the potential to be affected by the alleged deficient practice. Therefore, this plan of correction applies to all residents of the facility. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** An in-service has been completed by the DON/Designee on 11/14/24 for all nursing staff on the bed hold policy. Additionally, any staff that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated.	

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	the resident to the BHC hospital. The record lacked documentation that a bed hold policy had been completed and provided to the resident's representative. During an interview, on 10/8/24 at 3:16 p.m., Regional Clinical Consultant 18 indicated the facility had been unable to locate the completed bed hold policy documents for the resident's BHC hospital transfer. The documents were required to be completed and provided to the resident or responsible party and a copy should have been placed into the resident's medical record. On 10/9/24 at 9:30 a.m., Regional Clinical Consultant 18 provided an undated document, titled, "Bed Hold," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: It is the policy of the facility to provide the Resident, Resident's family member and/or the Resident's legal representative...prior to transfer to a hospital...information regarding the Resident's facility bed status and how the bed will be "held." Note: A copy of the Bed Hold policy given to the Resident, Resident's family member and/or Resident's legal representative will be placed in the resident's record...." 3.1-12(a)(25)(A) 3.1-12(a)(25)(B) 3.1-12(a)(26)		**4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place**: The DON/Designee will audit residents transferred to the hospital to verify letter of bed hold policy was given to the resident or resident representative 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then weekly x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review, the facility failed to ensure care plan meetings had been conducted in a timely manner for 2 of 24 residents	F 0657	F657 Care plan timing/revision It is the policy of this facility to ensure care plan meetings have been conducted in a timely	11/19/2024

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	reviewed for care plan meetings (Residents 44 and 76). Findings include: 1. During an interview, on 10/2/24 at 2:31 p.m., Resident 44 indicated she could not remember the last time she had a care plan meeting. Resident 44's record was reviewed on 10/7/24 at 10:44 a.m. The profile indicated the resident's diagnoses included, but were not limited to, multiple sclerosis (a chronic autoimmune disease [a condition where the body's immune system attacks healthy cells, tissues, or organs by mistake] that damages the areas of the body which protects nerve cells in the brain and spinal cord) and adult failure to thrive (when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal). A quarterly Minimum Data Set (MDS) assessment, dated 7/29/24, indicated the resident had moderate cognitive deficit. A care plan meeting progress note, dated 2/9/24 at 3:00 p.m., indicated a care plan meeting had been held. The resident and her representative had been invited to attend the meeting and the resident had attended the meeting. The record lacked documentation that a care plan meeting had been held since 2/9/24. During an interview, on 10/7/24 at 12:10 p.m., the Social Services Director (SSD) indicated she had not been in her position very long. She was not aware that the resident had not had a meeting since 2/9/24. When she became aware, she		manner. **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** A care plan meeting was completed for Resident 44 on 10/14/2024 and resident 76 on 10/15/24. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** The SSD/Designee completed a care plan meeting for residents 44 on 10/14/2024 and 76 on 10/15/2024.. The SSD/Designee completed an audit of care plan meetings. Those residents identified during the audit will have a care plan meeting scheduled by the SSD/Designee and will be completed by 11/19/2024. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The ADM/Designee in-serviced the IDT on the care plan meeting process for resident's quarterly ad as needed on 11/14/2024. Additionally, any staff member that fails to comply with the points of this in-service will be further education and/or disciplined as indicated.	

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	planned a meeting for 8/7/24 and sent invitations to the family and resident. Neither indicated they were going to attend the meeting. Because the resident and family did not plan to attend, the meeting had not been held. She was not aware that she should have documented that the meeting was not held and the explanation of why the resident had not attended, nor that a meeting could have been held without the resident and/or her representative present. 2. During an interview, on 10/3/24 at 10:07 a.m., Resident 76 indicated she could not recall when she had a care plan meeting. Her daughter may have attended one, but she had not told her about it. Resident 76's record was reviewed on 10/7/24 at 12:16 p.m. The profile indicated the resident's diagnoses included, but were not limited to, history of cerebral infarction (a serious condition that occurs when blood flow to the brain is blocked, causing brain tissue to die), Bell's palsy (a neurological disorder that causes temporary weakness or paralysis of the muscles on one side of the face), and cognitive communication deficit (a difficulty with communication caused by a disruption in cognitive processes). A quarterly Minimum Data Set (MDS) assessment, dated 8/27/24, indicated the resident had no cognitive deficit. A care plan meeting progress note, dated 6/26/24 at 1:33 p.m., indicated a care plan meeting had been held. The resident and her daughter had been invited to the meeting. The resident declined to attend, but her daughter was present for the meeting.		**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place**? The SSD/Designee will audit 10 residents weekly for care plan meetings weekly x 4 weeks, then 5 random residents weekly x 4 weeks, then 3 random residents monthly x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	

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	The record lacked documentation that a care plan meeting had been held since 6/26/24. During an interview, on 10/7/24 at 12:10 p.m., the Social Services Director (SSD) indicated she had not been in her position very long. She was not aware that the resident had not had a meeting since 6/26/24. When she became aware, she planned a meeting for 9/13/24 and sent invitations to the family and resident. She had not yet heard back from the resident or the resident's family about their plans to attend. She was not aware that she should document the reason why a resident declined to attend the meetings. She was also unaware that a meeting could take place, even if, a resident and/or their representative declined to attend. On 10/7/24 at 12:49 p.m., the Director of Nursing (DON) provided a document, with a revised date of 9/18/18, titled, "Baseline Care Plan Assessment/Comprehensive Care Plans, " and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...5. The facility Social Service Director or designee will notify the resident's responsible party...of the scheduled care plan conference...These notifications will be documented for reference...8...A...note will be made in reference to the meeting to include all who attended...." 3.1-35(c)(2)(C) 3.1-35(e)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and	F 0690	F690 Bowel/Bladder Incontinence, Catheter, UTI	11/19/2024

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	interview, the facility failed to ensure a resident's indwelling urinary catheter bag (a bag that collects urine from a catheter inserted into the bladder) was kept from coming in contact with the floor for a resident with a UTI (urinary tract infection) for 1 of 4 residents reviewed for catheters (Resident 4), and failed to ensure measured urine output amounts from indwelling urinary catheter bags were accurate for 2 of 4 residents reviewed for catheter/UTI (Residents 4 and 1). Findings include: 1. Resident 4's record was reviewed on 10/4/24 at 11:18 a.m. The profile indicated the resident's diagnoses included, but were not limited to, obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional) and benign prostatic hyperplasia (a non-cancerous condition that causes the prostate gland to enlarge, which can lead to urinary issues). A quarterly Minimum Data Set (MDS) assessment, dated 8/24/24, indicated the resident had an indwelling catheter. A care plan, dated 8/26/24, indicated the resident had a diagnosis of obstructive uropathy and had an indwelling urinary catheter and had a goal that he would not experience any signs or symptoms of infection. Interventions included, but were not limited to, document urine output every shift. The record indicated the resident had a current active UTI and had a physician's order for an antibiotic to treat the infection.		It is the policy of this facility to ensure a residents indwelling urinary catheter bag is kept from coming in contact with the floor and accurately documenting urinary output. **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 4 catheter was immediately removed from the floor on 10/4/2024, by the DON/Designee. Resident 4 and resident 1 were assessed by Nurse on 10/10/2024 with no adverse effects noted. 2 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** The DON/Designee completed an audit of catheters on 10/7/2024. Those residents identified during the audit will have orders reviewed for the need to have measured output and catheters maintained off the floor. 3 **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?**	

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	A physician's order, dated 10/1/24, indicated to administer an 800-160 milligram (mg) tablet of Bactrim DS (antibiotic medication), by mouth two times a day for 10 days (stop date of 10/11/24) for UTI. During a random observation, on 10/4/24 at 3:01 p.m., Resident 4 was laying in his bed sleeping. His catheter drainage bag was lying flat on the floor. Both sides of the dignity bag (a bag that conceals a catheter drainage bag so it's not visible) were spread open exposing the sides of the catheter drainage bag. The catheter drainage bag was directly in contact with the floor. During an interview, on 10/8/24 at 3:01 p.m., the Regional Clinical Consultant 17 indicated it was the expectation of the facility that catheter tubing and/or catheter drainage bags should never be in contact with the floor. It would be an infection control risk. On 10/8/24 at 2:47 p.m., Regional Clinical Consultant 18 provided an undated document, titled, "Catheters," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...4....ongoing care...protocols that adhere to professional standards of practice and facility policy and procedure with adherence to infection prevention and control techniques...." 2. Resident 4's record was reviewed on 10/4/24 at 11:18 a.m. The profile indicated the resident's diagnoses included, but were not limited to, obstructive and reflux uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional) and benign prostatic hyperplasia (a non-cancerous condition that causes the prostate		The DON/Designee in-serviced staff on the Catheter policy on 11/14/2024 to include monitoring output accurately and maintaining bag off floor and providing privacy. Additionally, any staff member that fails to comply with the points of this in-service will further education and/or disciplined as indicated. 4 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place**? The DON/designee will audit residents with catheters for positioning and measured output 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then weekly x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	

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	gland to enlarge, which can lead to urinary issues). A quarterly Minimum Data Set (MDS) assessment, dated 8/24/24, indicated the resident had an indwelling catheter. A care plan, dated 8/26/24, indicated the resident had a diagnosis of obstructive uropathy and had an indwelling urinary catheter and had a goal that he would not experience any signs or symptoms of infection. Interventions included, but were not limited to, document urine output every shift. A physician's order, dated 8/19/24, indicated to provide catheter care every shift, ensure catheter is anchored to the upper thigh and ensure catheter drainage bag is below the waist and covered. A physician's order, dated 8/21/24, indicated to anchor a 14 French (size of a catheter using the French size scale) Coude (a catheter with a curved tip that helps it pass through tight spots in the urethra, prostate, or bladder neck) catheter with a 10 cubic centimeter (cc) bulb (portion of the catheter which is inflated to hold the catheter in place) due to obstructive uropathy. Review of the September and October 2024 Treatment Administration Records (TARs) catheter output documentation and the resident's 30-day Point of Care (POC) task document, dated 9/5/24 through 10/4/24, completed by the Certified Nursing Assistants (CNAs), indicated significant discrepancies in the output amounts that had been documented. The discrepancies were as followed: a. 9/5/24, the POC form indicated an output value			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF COVINGTON, THE	1600 E LIBERTY ST COVINGTON, IN 47932

(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
	of 750 ml (milliliters), and the TAR indicated 700 ml with a discrepancy of 50 ml. b. 9/6/24, the POC form indicated an output value of 2300 ml, and the TAR indicated 1800 ml with a discrepancy of 500 ml. c. 9/7/24, the POC form indicated an output value of 1250 ml, and the TAR indicated 850 ml with a discrepancy of 400 ml. c. 9/8/24, the POC form indicated an output value of 1100 ml, and the TAR indicated 1200 ml with a discrepancy of 100 ml. d. 9/9/24, the POC form indicated an output value of 1100 ml, and the TAR indicated 1250 ml with a discrepancy of 150 ml. e. 9/10/24: the POC form indicated an output value of 900 ml, and the TAR indicated 450 ml with a discrepancy of 450 ml. f. 9/11/24: the POC form indicated an output value of 1200 ml, and the TAR indicated 1000 ml with a discrepancy of 200 ml. g. 9/12/24: the POC form indicated an output value of 950 ml, and the TAR indicated 1000 ml with a discrepancy of 50 ml. h. 9/13/24: the POC form indicated an output value of 2050 ml, and the TAR indicated 750 ml with a discrepancy of 1300 ml. i. 9/14/24: the POC form indicated an output value of 1550 ml, and the TAR indicated 1200 ml with a discrepancy of 350 ml. j. 9/15/24: the POC form indicated an output value			

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	of 1900 ml, and the TAR indicated 1300 ml with a discrepancy of 600 ml. k. 9/16/24: the POC form indicated an output value of 1000 ml, and the TAR indicated 750 ml with a discrepancy of 250 ml. l. 9/17/24: the POC form indicated an output value of 800 ml, and the TAR indicated 1725 ml with a discrepancy of 925 ml. m. 9/18/24: the POC form indicated an output value of 1800 ml, and the TAR indicated 1000 ml with a discrepancy of 800 ml. n. 9/19/24: the POC form indicated an output value of 1475 ml, and the TAR indicated 600 ml with a discrepancy of 875 ml. o. 9/20/24: the POC form indicated an output value of 700 ml, and the TAR indicated 1100 ml with a discrepancy of 400 ml. p. 9/21/24: the POC form indicated an output value of 1800 ml, and the TAR indicated 1450 ml with a discrepancy of 350 ml. q. 9/22/24: the POC form indicated an output value of 850 ml, and the TAR indicated 850 ml with no discrepancy noted. r. 9/23/24: the POC form indicated an output value of 1050 ml, and the TAR indicated 650 ml with a discrepancy of 400 ml. s. 9/24/24: the POC form indicated an output value of 850 ml, and the TAR indicated 1000 ml with a discrepancy of 150 ml. t. 9/25/24: the POC form indicated an output value			

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	of 1450 ml, and the TAR indicated 800 ml with a discrepancy of 650 ml. u. 9/26/24: the POC form indicated an output value of 500 ml, and the TAR indicated 1000 ml with a discrepancy of 500 ml. v. 9/27/24: the POC form indicated an output value of 600 ml, and the TAR indicated 650 ml with a discrepancy of 50 ml. w. 9/28/24: the POC form indicated an output value of 1000 ml, and the TAR indicated 1000 ml with no discrepancy noted. x. 9/29/24: the POC form indicated an output value of 950 ml, and the TAR indicated 450 ml with a discrepancy of 500 ml. y. 9/30/24: the POC form indicated an output value of 400 ml, and the TAR indicated 450 ml with a discrepancy of 50 ml. z. 10/1/24: the POC form indicated an output value of 1450 ml, and the TAR indicated 1450 ml with no discrepancy noted. aa. 10/2/24: the POC form indicated an output value of 900 ml, and the TAR indicated 1000 ml with a discrepancy of 100 ml. bb. 10/3/24: the POC form indicated an output value of 1950 ml, and the TAR indicated 600 ml with a discrepancy of 1350 ml. cc. 10/4/24: the POC form indicated an output value of 900 ml, and the TAR lacked documentation of any output measurement, resulting in a discrepancy of 900 ml. 3. Resident 1's record was reviewed on 10/4/24 at 10:19 a.m.			

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	The profile indicated the resident's diagnoses included, but were not limited to, personal history of urinary tract infections (UTI- an infection in any part of the urinary system), obstructive and reflux uropathy (conditions that damage the kidneys and urinary tract due to impaired urine flow), and neuromuscular dysfunction of bladder (condition that occurs when the nerves and muscles of the bladder don't communicate properly with the brain resulting in bladder control issues). A quarterly Minimum Data Set (MDS) assessment, dated 7/15/24, indicated the resident had severe cognitive impairment and had an indwelling catheter (a thin hollow tube that is inserted into the bladder to drain urine) and ostomy (a surgical procedure that creates an opening in the abdominal wall to allow waste to leave the body). A care plan, dated 6/10/23, indicated the resident had frequent urinary tract infections. Interventions included, but were not limited to, staff would monitor residents' vitals and report abnormal findings to the doctor. A care plan, dated 6/26/20, indicated the resident had a left side nephrotomy tube (a thin flexible tube that drains urine directly from the kidney into a bag outside of the body) and a catheter due to obstructive reflux uropathy. Interventions included, but were not limited to, monitor intake and output every shift, notify medical doctor of any changes, and provide catheter care every shift and as needed. A physician order, dated 1/6/24, indicated urinary catheter 16 Fr (French) (diameter of catheter tubing) 10cc (cubic centimeter) balloon, change as			

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	needed for occlusion and every night shift starting on the 14th and ending the 14th every month. A physician order, dated 9/21/24, indicated catheter care every shift, ensure catheter is anchored to the upper thigh and ensure catheter drainage bag was below the waist and covered every shift for Foley catheter. Review of September 2024 Treatment Administration Record (TAR) indicated Resident 1 had several holes where catheter care and outputs had not been documented. There was other documentation noted on a Point of Care (POC) task form that was completed by the Certified Nurse's Assistants (CNA) that catheter care and output were completed. During review of a September 2024 POC task form and the September 2024 TAR, the following indicated discrepancies in urinary output values for Resident 1: a. 9/5/24 the POC form indicated an output value of 1500ml (milliliters), and the TAR indicated 1350ml with a discrepancy of 150ml. b. 9/6/24 the POC form indicated an output value of 1450ml, and the TAR indicated 1400ml with a discrepancy of 50ml. c. 9/7/24 the POC form indicated an output value of 1250ml, and the TAR indicated 1900ml with a discrepancy of 650ml. d. 9/8/24 the POC form indicated an output value of 1750ml, and the TAR indicated 1900ml with a discrepancy of 150ml.			

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	e. 9/9/24 the POC form indicated an output value of 1350ml, and the TAR indicated 1400 with a discrepancy of 50ml. f. 9/10/24 the POC form indicated an output value of 2350ml, and the TAR indicated 900ml with a discrepancy of 1450ml. g. 9/11/24 the POC form indicated an output value of 1850ml, and the TAR indicated 1300 with a discrepancy of 550ml. h. 9/12/24 the POC form indicated an output value of 900ml, and the TAR indicated 1600ml with a discrepancy of 700ml. i. 9/13/24 the POC form indicated an output value of 1500ml, and the TAR indicated 1940ml with a discrepancy of 440ml. j. 9/14/24 the POC form indicated an output value of 2250ml, and the TAR indicated 1100ml with a discrepancy of 1150ml. k. 9/15/24 the POC form indicated an output value of 1250ml, and the TAR indicated 800ml with a discrepancy of 450ml. l. 9/16/24 the POC form indicated an output value of 2100ml, and the TAR indicated 1550ml with a discrepancy of 550ml. m. 9/17/24 the POC form indicated an output value of 1550ml, and the TAR indicated 1400ml with a discrepancy of 150ml. n. 9/18/24 the POC form indicated an output value of 1650ml, and the TAR indicated 820ml with a discrepancy of 830ml.			

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	o. 9/19/24 the POC form indicated an output value of 1200ml, and the TAR indicated 450ml with a discrepancy of 750ml. p. 9/20/24 the POC form indicated an output value of 0ml, and the TAR indicated 2600ml with a discrepancy of 2600ml. q. 9/21/24 the POC form indicated an output value of 2050ml, and the TAR indicated 2500 with a discrepancy of 450ml. r. 9/22/24 the POC form indicated an output value of 2400ml, and the TAR indicated 1650ml with a discrepancy of 750ml. s. 9/23/24 the POC form indicated an output value of 1700ml, and the TAR indicated 800ml with a discrepancy of 900ml. t. 9/24/24 the POC form indicated an output value of 620ml, and the TAR indicated 1250ml with a discrepancy of 630ml. u. 9/25/24 the POC form indicated an output value of 1650ml, and the TAR indicated 950ml with a discrepancy of 700ml. v. 9/26/24 the POC form indicated an output value of 1750ml, and the TAR indicated 1700ml with a discrepancy of 50ml. w. 9/27/24 the POC form indicated an output value of 1600ml, and the TAR indicated 2200ml with a discrepancy of 600ml. x. 9/28/24 the POC form indicated an output value of 1400ml, and the TAR indicated 3150ml with a discrepancy of 1750ml.			

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	y. 9/29/24 the POC form indicated an output value of 2400ml, and the TAR indicated 800ml with a discrepancy of 1600ml. z. 9/30/24 the POC form indicated an output value of 2200ml, and the TAR indicated 2200ml, with output totals that matched. During an interview, on 10/4/24 at 3:00 p.m., the Regional Nurse Consultant indicated the CNA's empty the urinary catheter drainage bags and then should be relaying that information to the nurses. There should not be two separate staff members documenting output because it could cause discrepancies and could impact residents' care. During an interview, on 10/4/24 at 3:38 p.m., Licensed Practical Nurse (LPN) 8 indicated she was not sure sometimes where to document the urine outputs because it was placed in different spots in the computer system. She indicated the CNA's do not always report to her when they empty the catheter bags. She understood how there could be discrepancies in the urine output documentation. On 10/7/24 at 9:39 a.m., the Director of Nursing (DON) provided a document and indicated it was a CNA's skills checklist and it was the expectation that they would measure urinary output on the residents who had catheters. On 10/4/24 at 2:20 p.m., the Regional Nurse Consultant, provided an undated document, titled, "Catheters," and indicated it was the policy currently being used by the facility. The policy indicated, " ...b) need for accurate measurement of urinary output ...6. The resident will have ongoing monitoring of the catheter related to the potential of UTI's and recognizing, reporting, and			

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	addressing significant changes ...." 3.1-4(a)(1)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, interview, and record review, the facility failed to ensure an opened bottle of tube feeding formula (a liquid mixture that contained all the necessary nutrients, delivered directly into a person's stomach or intestines through a tube when they were unable to eat normally by mouth) was labeled and dated for 1 of 1 resident reviewed for tube feeding (Resident 74). Findings include: On 10/04/24 at 10:43 a.m., observed 2 bottles of tube feeding formula on Resident 74's bedside table. One full bottle, and one bottle that had more than half of the contents missing. Both bottles indicated they were Glucerna with Carbsteady 1.2 CAL (a calorie dense formula with a specialized blend of slowly digestible carbohydrates [sugar]). Neither bottle was labeled or dated. During an interview on 10/04/24 at 10:43 a.m., Licensed Practical Nurse (LPN) 8 indicated she had given Resident 74 his bolus (syringe) feeding at about 8:30 a.m. that morning and had given him the bolus out of the mostly empty bottle of Glucerna that was located on the resident's bedside table. She indicated she was not the one who opened the bottle and was not sure who opened it or when. When tube feeding formulas were opened, they were required to label it with an opened date, expiration date, and initials. Once the container was opened, it was only good for 24	F 0693	F693 Tube Feeding Mgmt/Restore Eating Skills It is the policy of this facility to ensure tube feeding is dated and labeled. **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Tube feeding formula was immediately removed from resident 74's room on 10/4/2024 by the DON/Designee. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents receiving tube feedings have the potential to be affected, therefore, this plan of correction applies to those residents. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient**	11/19/2024

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	hours. Since she was not sure when it was opened, the safest thing would have been for her to discard it and get a new one. On 10/04/24 at 1:11 p.m., observed another bottle of Glucerna tube feed to be on Resident 74's bedside table. The container had a handwritten opened date of 10/4/24 and initials for LPN 8. The bottle lacked documentation of the time it had been opened. During an interview on 10/04/24 at 2:30 p.m., observed the bottle of Glucerna located in Resident 74's room on the bedside table with the Director of Nursing (DON). She indicated that the bottle had been opened, and along with the date and initials, the bottle should have a time opened written on the bottle. Once opened, the formula was only good for 72 hours. On 10/04/24 at 2:35 p.m., Resident 74's record was reviewed. The diagnoses included, but were not limited to, nontraumatic intracranial hemorrhage in cortical hemisphere (bleeding in the brain that occurs without trauma or surgery), dysphagia (difficulty swallowing), obstructive hydrocephalus (fluid built up in the brain due to a blockage in the brain's fluid passages, and aphasia (difficulty reading, writing, understanding, and expressing oneself). A physician's order, with a start date of 9/25/24, indicated to administer an enteral feed (a way to provide nutrition and fluids to someone unable to eat or drink) of Glucerna 1.2 at 285 milliliters (mL) per g-tube (a small, flexible tube that was surgically inserted through the abdomen and into the stomach to deliver food, liquids, and medication) every 4 hours.		**practice does not recur?** The DON/Designee in-serviced staff on Enteral Tube Feeding to include dating, add time opened and labeling a bottle when opened via syringe on 11/14/2024. Additionally, any staff member that fails to comply with the points of this in-service will further education and/or disciplined as indicated. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place**? The DON/designee will audit Tube feeding formula for proper labeling for date and time opened 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then weekly x 4 months. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	

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	A quarterly Minimum Data Set (MDS), dated 10/01/23, indicated Resident 74 had a feeding tube and had severe cognitive impairment. On 10/2/24 at 11:48 a.m., the DON provided an undated document titled, "Enteral Tube Feeding via Syringe (Bolus)," and indicated it was the policy currently being used by the facility. The policy indicated, " ...The purpose of this procedure is to provide nutritional support to residents unable to obtain nourishment orally ...3. Check the nutrition label against the order before administration. Check the following information: a. Resident name, ID and room number; b. Type of formula; c. Date formula was prepared; d. Route of delivery; e. Access site; f. Method (pump, gravity, syringe); and g. Rate of administration (ml/hr) ...." On 10/4/24 at 3:28 p.m., the DON provided a document with an updated date of 7/4/24 titled, "Abbott Glucerna 1.2 Cal", and indicated it was the policy currently being used by the facility. The policy indicated, " ...NOTE: Failure to follow the INSTRUCTIOS FOR USE increases the potential for microbial contamination ...unless a shorter hand time is specified by the set manufacturer, hand product for up to 48 hours after initial connection when clean technique and only one new set are used. Otherwise hang for no more than 24 hours ...." 3.1-44(a)(2)			
F 0732 SS=A Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information Based on observation, interview, and record review, the facility failed to ensure accurate staffing sheets were posted daily for 1 of 6 days during the recertification survey.	F 0732	**F732 (D)** **Posted Nurse Staffing Information**	11/19/2024

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	Findings include: During an observation, on 10/2/24 at 9:45 a.m., the staffing sheet posted on the inside wall by the front door was dated 9/30/24. During an observation, on 10/2/24 at 11:12 a.m., the staffing sheet posted on the inside wall by the front door was dated 9/30/24. During an interview, on 10/3/24 at 9:36 a.m., the Director of Nursing (DON) indicated the expectation was that the Assistant Director of Nursing (ADON) would post the staffing sheet daily. She indicated the staffing sheet should be accurate with the correct date and staffing information. During an interview, on 10/9/24 at 1:18 p.m., the Administrator indicated it was the responsibility of the ADON to post the staffing sheet daily. She indicated the ADON had worked the night before and her back up person had forgotten to post the staffing sheet for 10/1/24 as well. On 10/3/24 at 9:38 a.m., the DON provided an undated document titled, " ...Staffing Posting Requirement," and indicated it was the policy currently being used by the facility. The policy indicated, " ...It is the policy of the facility, in cooperation with Medicare/Medicaid Services, ... to comply with the requirement of daily posting of nursing staff in the facility ...1) SNFs (skilled nursing facilities) and NFs (nursing facilities) must post daily, at the beginning of each shift, the facility specific shift schedule for the 24 hour period ...3) Other required posted data includes: a) Facility Name b) Current Date c) Current Census ...."		It is the policy of the facility to post the nurse staffing data daily at the beginning of each shift. Data must be posted in a clear and readable format in a prominent place readily accessible to residents and visitors. 1 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were found to be affected by the deficient practice. 2 **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Residents who reside in the facility have the potential to be affected by this deficient practice. 3 **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The Administrator /Designee in-serviced the Director of Nursing and scheduler on the policy “Guidelines for BIPA Staffing Posting Requirement” on 11/14/2024. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined	

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			as indicated. 5 **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The Administrator/Director of Nursing/Designee will audit the BIPA staffing posting and location 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on record review and interview, the facility failed to address a pharmacy recommendation for 1 of 5 residents reviewed for unnecessary medications (Resident 36). Findings include: On 10/04/24 Resident 36's record was reviewed. His diagnoses included, but were not limited to, depressive episodes (a period of time when	F 0758	F758 Free from Unnec Psychotropic meds/PRN use It is the policy of this facility to addressed pharmacy recommendations for unnecessary medications. **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	11/19/2024

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	155223	A. BUILDING 00 B. WING	10/09/2024

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	someone experiences a depressed mood, along with other symptoms, that lasts for at least two weeks), insomnia (a sleep disorder that makes it hard to fall asleep, stay asleep, or get good quality sleep), cognitive communication deficit (struggle with social language skills, paying attention when conversing or being spoken to, reasoning and judgment abilities, and short and long-term memory), disorientation (a mental state where someone was confused about their time, place, or identity), auditory hallucinations (the experience of hearing sounds or voices that were not actually there), and visual hallucinations (a perceptual experience where a person sees things that were not there). A historical physician's order, dated 6/29/23, indicated to administer Zoloft (sertraline) 50 milligrams (mg) daily for depression. A quarterly Minimum Data Set (MDS) assessment, dated 10/01/23, indicated the resident was cognitively intact. On 10/08/24 at 1:08 p.m., pharmacy recommendations for Resident 36 were reviewed. A pharmacy review from Pharmacy Management Solutions, dated 12/23/23, indicated the order for Zoloft (sertraline) 50 mg daily was due for a review and dose reduction attempt. The recommendation requested to decrease Zoloft (sertraline) to 25 mg daily, and for the provider to document current mental and behavior status, review the new dose recommendation, or provide detailed reasons that a dose reduction was not indicated. The recommendation lacked documentation of a response from the provider. During an interview on 10/08/24 at 3:02 p.m., the Director of Nursing (DON) indicated the pharmacy		**practice?** DON/Designee assessed resident 36 on 10/10/2024 and no negative outcomes. Resident to continue on medication. The Physician/Designee assessed and documented reason dose reduction not indicated on 11/7/2024. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** The DON/Designee completed a 90 day look back of pharmacy recommendations and any documentation follow up was addressed by 11/14/2024 . **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The ADM/Designee in-serviced the DON and SSD on pharmacy recommendations to include physician documentation for reason dose reduction was not indicated on 11/14/2024. **4 How the corrective action(s) will be monitored to**	

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	review had not been addressed. She was not an employee at the facility during the time the pharmacy review should have been addressed and was not sure why it had not been completed. During an interview on 10/08/24 at 3:16 p.m., the Regional Nurse Consultant (RNC) 18 indicated she did not know what happened or why the pharmacy recommendation was not addressed and was not able to find any additional documentation in the electronic record to indicate that it was addressed by the provider. On 10/08/24 at 3:20 p.m., the RNC 18 provided an undated document, titled, "Distribution of Medication Regimen Review Report" and indicated it was the policy currently being used by the facility. The policy indicated, " ...The consultant pharmacist will report any recommendations of apparent irregularities resulting from the medication regimen review of each resident to the attending physician, the director of nursing and medical director on a medication regimen review report form or in electronic record keeping system. Each recommendation must be acted upon ...1. The report form will be used by the consultant pharmacist to communicate findings of monthly pharmaceutical care consultation. 2. The consultant pharmacist will retain the information. 3. The report will be forwarded to the director of nursing. 4. The attending physician and/or medical director will document their review and response to the recommendations made by the consultant pharmacist directly on the medication regimen review report form or in the resident's medical record. If physician disagrees with recommendation or no change is being made, the physician must document rationale in the resident's medical record. 5. The director of		**ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place** The DON/Designee will audit pharmacy recommendations monthly x 6 months for recommendations being reviewed by physician, documentation for reason dose reduction not indicated and follow up completed. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	

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	nursing will follow up with any nursing actions needed relative to the physician's response. 6. Physician response to recommendations resulting in changes in medication therapy for individual resident will be forwarded to the POS or documented in electronic record keeping system and the nurse will order the medication from the pharmacy ...." 3.1-48(b)(2)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to ensure expired foods were disposed of, failed to ensure facial hair was covered with hair restraints, and failed to ensure potentially hazardous food (uncooked meats) were stored separately from other foods (cooked meat) during 2 of 2 kitchen observations. Findings include: During the initial kitchen tour with the Dietary Manager (DM) on 10/02/24 on 9:50 a.m., observed Cook 12 preparing food with a mustache that was not covered by a hair restraint. On 10/02/24 at 10:22 a.m., on the bottom shelf of the walk-in refrigerator, observed thawing beef in a pan with red liquid surrounding it. Sitting on top of the thawing beef was a package that the DM identified as thawing pork. On the same shelf, resting on top edge and side of the pan with thawing meats, was a container that the DM identified as cooked beef. During an interview on 10/02/24 at 10:25 a.m., the DM indicated that cooked and raw meat should	F 0812	F812 Food Procurement It is the policy of this facility to ensure expired foods are disposed of facial hair is covered and uncooked meats are stored separately from other foods. **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The DON/Designee assessed all residents on 10/10/2024 and no residents were affected by the cited practice. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** The Dietary Manager/Designee audited all pantries for expired food items and disposed as	11/19/2024

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	not be on the same shelf. On 10/02/24 at 10:31 a.m., observed the front hall pantry to have a loaf of bread dated 9/16/24. The DM indicated once the bread was opened and dated, it was only good for 7 days and should have been discarded. On 10/02/24 at 10:36 a.m., observed the middle hall pantry to have a loaf of bread dated 9/11/24. She indicated that the night dietary aides were responsible for monitoring the pantry expiration dates daily. On 10/02/24 at 10:39 a.m., entered the back hall pantry with the DM, she took a loaf of opened bread from the counter and disposed of it in the trash. When asked why she threw it away, she indicated it should have been discarded and that it was dated for 9/11/24. During an interview on 10/02/24 at 11:37 a.m., the DM indicated that pork and beef should not have been thawing together on the same tray. On 10/07/24 at 12:25 p.m., observed Cook 12 in the food preparation area with a mustache that was not covered by a hair restraint. During an interview on 10/07/24 at 12:44 p.m., the DM indicated everyone who had facial hair was supposed to have it covered with a hair restraint or they would have shave. If staff had a mustache, it was also required to be covered. When asked if Cook 12's mustache was covered, she turned around and advised Cook 12 to pull the hair restraint up to cover his mustache. When she turned back around, she indicated that his mustache was not covered.		needed on 11/1/2024, staff was educated on use of hair restraints including beards on 11/14/2024 and staff educated on thawing foods on 11/14/2024. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Dietary Manager/Designee in-serviced the dietary department on disposing of expired foods, use of hair restraints including beards and thawing frozen foods on 11/14/2024. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place**? The Dietary Manager/Designee will audit pantries for expired foods and audit frozen food placement during thawing 5 times a week x 4 weeks, then 3 times a week x 4 weeks, then once a week x 4 months for foods that are properly sealed, labeled and dated. The Dietary Manager will audit 10 random staff members a week x 4	

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	On 10/2/24 at 11:48 a.m., the DM provided an undated document titled, "Date Marking," and indicated it was the policy currently being used by the facility. The policy indicated, " ...Once a package is opened, it will be re-dated with the date the item was opened and shall be used by the safe food storage guidelines ...4. Food items should be discarded when: The food item doesn't have a specific manufacturer expiration date and has been refrigerated for 7 days ...." On 10/2/24 at 11:48 a.m., the DM provided an undated document titled, "Food Storage," and indicated it was the policy currently being used by the facility. The policy indicated, " ...store raw meat, poultry, and fish separately from cooked and ready-to-eat food ..." On 10/7/24 at 2:20 p.m., the DM provided an undated document titled, " ...Code of Dress and Personal Appearance," and indicated it was the policy currently being used by the facility. The policy indicated, " ...1. The following practices and guidelines will be enforced by the Dining Services Manager. A. Hairnets, hair restraints, and beard guards shall be worn ...." 3.1-21(i)(3)		weeks, then 5 random staff members a week x 4 weeks then 3 random staff members a month x 4 months for hair coverings being worn during food preparation and serving. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing in-service education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection.	F 9999	F9999 Personal It is the policy of this facility to provide annual in-serving for staff. **1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	11/19/2024

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	(3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (l) The frequency and content of in-service education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. For nursing personnel, this shall include at least twelve (12) hours of in-service per calendar year and six (6) hours of in-service per calendar year for nonnursing personnel. (m) Inservice programs for items required under subsection (k) shall contain a means to assess learning by participants. (n) The administrator may approve attendance at outside workshops and continuing education programs related to that individual's responsibilities in the facility. Documented attendance at these workshops and programs meets the requirements for in-service training. (o) Inservice records shall be maintained and shall indicate the following: (1) The time, date, and location. (2) The name of the instructor. (3) The title of the instructor. (4) The names of the participants. (5) The program content of in-service. The employee will acknowledge attendance by written signature. This state rule is not met as evidenced by: Based on record review and interview the facility failed to ensure employees were provided annual in-service training for 5 of 10 employees' files reviewed. Findings include:		No residents were identified to be affected by the cited deficiency. **2 How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** The BOM/HR/Designee with complete an audit of employee files for completion of annual education by 11/7/2024. Education to be completed by 11/14/2024 to include LPN 20, CNA 26, CNA 27, Housekeeping aide 28 and RN 29. **3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The Regional Nurse Consultant in-serviced the DON/ADM on annual in-services required for staff on 11/14/2024. Additionally, any staff member that fails to comply with the points of this in-service will be further educated and/or disciplined as indicated. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put**	

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	During the review of state form 5440 titled, "Employee Records," on 10/9/24 at 10:30 a.m., the following was noted: a. Licensed Practical Nurse (LPN) 20 employee files were reviewed. The file indicated LPN 20 received in-service training for abuse, resident rights, and dementia in January 2023, but lacked documentation the employee had resident rights or dementia training in 2024. His hire date was 1/2/23. b. Certified Nurse's Assistant (CNA) 26 employee files were reviewed. The filed indicated CNA 26 received in-service training for abuse, resident rights, and dementia in August 2023, but lacked documentation the employee had received the training in 2024. Her hire date was 8/9/23. c. CNA 27 employee files were reviewed. The filed indicated CNA 27 received in-service training for abuse, resident rights, and dementia in July 2023, but lacked documentation the employee had received resident rights or dementia training in 2024. Her hire date was 7/31/23. d. Housekeeping aide 28 employee files were reviewed. The file indicated housekeeping aide 28 received in-service training for abuse, resident rights, and dementia in May 2022, but lacked documentation the employee had received resident rights and dementia training in 2024. His hire date was 5/10/22. e. Registered Nurse (RN) 29 employee files were reviewed. The filed indicated RN 29 received in-service training for abuse, resident rights and dementia in August 2023, but lacked documentation the employee had received		**into place**? The BOM/HR will audit 10 random employee and new employee files weekly x 4 weeks, then 5 random employee and new employee files weekly x 4 weeks then 5 random employees and new employees monthly x 4 months for completed annual in-services.. If the facility is within 95% compliance at the end of 6 months, the monitoring will be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved.	

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	resident rights and dementia training in 2024. Her hire date was 8/9/23. During an interview, on 10/9/14 at 11:55 a.m., the Regional Director of Operations indicated the facility was aware there was an issue with the annual in-services being completed and they are working on a resolution. She indicated they were unable to provide documentation that the 3-hour annual dementia training had been completed or resident rights. During an interview, on 10/9/24 at 1:15 p.m., the Regional Director of Operations indicated they do not have a policy regarding employee in-services, but they followed the state regulation.			