STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155086	A. BUILDING 00 B. WING	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN 46514

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaints IN00434221 and IN00434242. This visit resulted in an Immediate Jeopardy. Complaint IN0434221 - Federal/state deficiencies related to the allegation are cited at F812 and F925. Complaint IN00434242 - Federal/state deficiencies related to the allegations are cited at F812 and F925. Survey dates: May 13, 14, 15, 16, & 17, 2024 Facility number: 000034 Provider number: 155086 AIM number: 100274880 Census Bed Type: SNF/NF: 67 Total: 67 Census Payor Type: Medicare: 1 Medicaid: 58 Other: 8 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review completed on 5/29/2024	F 0000	By submitting the enclosed materials, 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 July 5, 2024, for annual survey completed May 17, 2024.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katherine Wright	Administrator	06/14/2024

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

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	The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			

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	Based on observation, record review, and interview, the facility failed to ensure staff spoke to residents respectfully for 1 of 20 residents reviewed for resident rights, and failed to ensure personal dignity was provided 1 of 2 residents reviewed for Foley (urinary) catheter use. (Residents 5 & 33) Findings include: 1. During an interview, on 5/14/2024 at 10:04 A.M., Resident 5 indicated that when ordering coffee, a dietary worker yelled at her about telling the surveyors the food was cold. On 5/14/2024 at 12:23 P.M., Resident 5 indicated that she had not informed the staff of this incident, and agreed to allow the surveyor to inform the administrator, and at 12:27 P.M. the administrator was informed of Resident 5's allegation. On 5/14/2024 at 1:50 P.M., the Director of Nursing (DON) and the Administrator indicated that they reported the allegation to the Indiana Department of Health. A record review of Resident 5 was completed on 5/15/2024 at 2:21 P.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, and bipolar disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 4/18/2024, indicated Resident 5 was cognitively intact. A Nurse"s Note, dated 5/14/2024 at 12:30 P.M., indicated Resident 5 alleged to a state surveyor that dietary assistant was not kind to her by "throwing her under the bus" for speaking to the	F 0550	It is the practice of this facility that we ensure that staff treat all residents with dignity and respect while speaking and providing care. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* The dietary manager and Social Services followed up with resident 5 about her concerns. The dietary staff member was removed from the schedule pending investigation and educated on resident rights including speaking to residents respectfully. The police were notified, but no report was filed. The residents care plan was reviewed and updated. A dignity bag was obtained to cover the catheter bag of resident 33. *How other resident 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 deficient practice(s). All residents or their representative will be contacted for interviews on staff speaking to residents respectfully. Any issues presented will be addressed. All residents with catheters were reviewed to ensure dignity covers were in place over the catheter bags.	07/05/2024

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	surveyors about the food. Resident 5 felt this invaded her privacy. The physician and the police were notified. This incident was reported to the Indiana Department of Health by the Administrator on 5/14/2024 at 12:30 P.M. The report indicated the dietary assistant was taken off the schedule pending an investigation, and the staff member denied the allegation. A Nurse's Note, dated 5/14/2024 at 3:53 P.M., indicated the police came to the facility, and no report was filed. A handwritten statement from Cook 12 indicated, " ...As I'm making everyone their drikes [sic] Resident 5 says oh the coffee is hot today and I reply [Resident 5] I don't know why that is a surprise the coffee is always hot it comes out of a machine we don't make it so I don't know why she got cold coffee yesterday and she kept say [sic] well it was cold yesterday and I told her we made it the same way we made it today. So she wanted to keep going so as I was walking away to finish passing drinks I did say well I don't know Resident 5 I'm not going to win with you ...." During an interview on 5/17/2024 at 1:55 P.M., the Administrator indicated that the dietary staff should have approached her with any concern, and she didn't feel the dietary staff member spoke to Resident 5 in a degrading tone. A current policy was provided by the Director of Nursing on 5/17/2024 at 2:43 P.M. The policy titled, "Resident Rights", indicated, " ...Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:..b. be treated with respect		*What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* The policies “Quality of Life – Dignity” will be reviewed by the IDT. An in-service will be held with all staff on the policy, including speaking respectfully to residents and providing urinary catheter bag covers. A performance improvement tool has been developed to audit that residents/representatives feel that staff speak respectfully to residents and all catheter bag covers are in place for dignity. *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits (5) residents/representatives at random to ensure staff speak respectfully to residents. An audit of catheter bags will also be included to ensure bag covered. This performance improvement tool will be completed by the Administrator/ Designee weekly for four weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly.	

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	kindness, and dignity ...." 2. During observations of Resident 33 on 5/13/2024 at 7:43 A.M. and 8:48 A.M., a Foley catheter bag could be seen with urine in the bag from the hallway hanging on the frame of the bed. A record review was completed on 5/15/2024 at 10:29 A.M. Diagnoses included, but were not limited to: obstructive and reflux uropathy, hydronephrosis, BPH, and hemiplegia affecting dominant side. A Significant Change Minimum Data Set (MDS) assessment, dated 2/20/2024, indicated Resident 33 had an indwelling urinary catheter. A Physician's Order, dated 2/21/2024, indicated Resident 33 to receive catheter care every shift. A Care Plan, dated 2/16/2023, indicated Resident 33 had an indwelling catheter related to obstructive uropathy and hydronephrosis. An intervention was to position the catheter bag and tubing below the level of the bladder and away from the entrance room door. During an interview on 5/17/2024 at 8:08 A.M., the Director of Nursing (DON) indicated a catheter should be covered with a dignity bag. A current policy was provided by the Director of Nursing on 5/17/2024 at 8:00 A.M. The policy titled, "Catheter Care, Urinary", did not address the use of a dignity bag over the Foley catheter drainage bag. 3.1-3(a)(2)(D) 3.1-3(t)		*By what date the systemic changes will be made;* 7/5/24	

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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 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			

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	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 arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review and interview, the facility failed to develop person centered care plans for behaviors for 2 of 22 residents whose care plans were reviewed. (Residents 63 & 64) Findings include: 1. A record review was completed on 5/15/2924 at 1:48 P.M. for Resident 63. Diagnoses included but were not limited to Vascular dementia, falls, hypertension, and insomnia. An Admission MDS (Minimum Data Set) assessment, dated 4/24/2024, indicated the resident had no behaviors during the assessment period and required supervision for eating needs, and substantial to maximum assist for bathing and transfer needs. The resident had a fall prior to admission and fell after admission and received antipsychotic and antidepressant medications. Resident 63's current medications included: Trazodone 150 mg (milligram) (antidepressant) give 1.5 tablet by mouth at bedtime for sleep. Mirtazapine 7.5 mg (antidepressant) give 0.5 tablet by mouth at bedtime for insomnia. Olanzapine Oral Disintegrating (an antipsychotic) 5 mg give 1 tablet by mouth three times a day for psychosis.	F 0656	/p> *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* /p> *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* /p> *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* The policy “Care Plan, Comprehensive Person-Centered” will be reviewed by the IDT. An in-service will be held with the IDT on the policy, specifically the development of interventions that are targeted and meaningful. A performance improvement tool has been developed to audit care plans of those residents with psychiatric disorders being treated with psychotropic meds to ensure residents have care plans to address behaviors with	07/05/2024

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	A discharge summary, dated 4/24/2024, indicated the resident was discharged from the facility and admitted to a psychiatric hospital due to increased behaviors and confusion. The psychiatric hospital's discharge recommendations were for ongoing psychiatric follow up with close monitoring of psychiatric medications. A current Care Plan, dated 5/1/2024, indicated the resident was on antipsychotic medications related to behavior management. Interventions included, but were not limited to; "...Administer medications as ordered. Observe/document for side effects and effectiveness per facility policy. Consult with pharmacy. MD to consider dosage reduction when clinically appropriate. Observe the resident every shift for effectiveness of medications. Refer to psych as indicated. The resident will be followed by a behavior management program...." There was no person centered care plan to address the resident's exhibited behaviors. During an interview, on 5/17/2024 at 10:24 A.M., Social Service staff indicated she was unaware of Resident 63's behaviors. She said if there were behaviors, they should be documented in the progress notes. She indicated the care plan was not person centered. 2. A record review was completed on 5/16/2024 at 9:12 A.M. for Resident 64. Diagnoses included but were not limited to dementia, psychotic disorder, anxiety, and post traumatic stress disorder. Resident 64's current Physician Orders included: Quetiapine (antipsychotic) 150 mg every day for psychotic disorder.		interventions that are person-centered. *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits (5) residents at random to ensure care plans are present to address behaviors with person-centered interventions. This performance improvement tool will be completed by the Social Service Director/ Designee weekly for four weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made;* 7/5/24	

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	A Behavior Note, dated 4/25/2024 at 10:50 A.M., indicated the resident was standing at the doorway to unit 4 and blocking the door yelling, "PAIN MED" over and over. The nurse asked the resident to back up from door, and the resident backed up but continued yelling "pain med." The nurse explained she was there to hook up his intravenous medication and would find out what medication she could give him. The resident told the nurse to "get the h--- out of here" A Nurses' Note, dated 4/26/2024, indicated: the following: "alert with confusion. Excessive call light use, gets agitated and loud if not answered immediately. Stated he is speaking with staff in morning to leave." A Social Service Note, dated 4/29/2024 at 2:28 P.M., indicated: "[Name of Resident] admitted for short term rehab to home- currently living in a hotel and states he likes it very well and wants to return there. [Name of Resident] has diagnoses of depression, PTSD (Post Traumatic Stress Disorder), and unspecified dementia. Currently taking Quetiapine and Duloxetine." A current Care Plan, dated 4/29/2024, indicated the resident had a diagnosis of depression and exhibited behaviors such as tearfulness and verbal expression of sadness. The interventions included, but were not limited to; "Offer a calm and quiet space for the resident to have some alone time. Offer to go outside and get fresh air. Offer to turn on Southern Rock music." The record lacked a person centered Care Plan for the use of the Antipsychotic medications and for the yelling behavior.			

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	During an interview on 5/17/2024 at 10:24 A.M., Social Service staff indicated the Care Plan was not person centered. On 5/17/2024 at 1:55 P.M., the Director of Nursing provided the policy titled, "Care Plan, Comprehensive Person-Centered", dated 9/2022, and indicated the policy was the one currently used by the facility. The policy indicated: "...1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, developes and implements a comprehensive person-centered care plan for each resident. 2. The care plan interventions are derived from a through analysis of the information gathered as part of the comprehensive assessment. 7. The care planning process will:...b. Include an assessment of the resident's strengths and needs; and c. Incorporate the resident's personal and cultural preferences....8...h. Incorporate identified problem areas; i. Incorporate risk factors associated with identified problems...10. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint f an interdisciplinary process...." 3.1-35(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for			

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	the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to provide care plan meeting for 1 of 4 residents reviewed for care planning. (Resident 32) Finding includes: During an interview, on 5/14/2024 at 9:28 A.M., Resident 32 indicated he did not have routine care plan meetings. A record review of Resident 32 was completed on 5/15/2024 at 12:05 P.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, obesity, and gastroesophageal reflux disorder (GERD). A Care Plan Note, dated 3/2/2023, indicated a care plan meeting had occurred	F 0657	It is the practice of this facility to hold care plan meetings with residents/representatives after each MDS assessment, including both the comprehensive and quarterly reviews. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* A care plan reviewed was scheduled with resident 32 and conducted with the IDT on 6/5/24. *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* All residents have the potential to be affected by the alleged deficient	07/05/2024

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	A Care Plan Note, dated 1/4/2024, indicated a care plan meeting had occurred. A Multidisciplinary Care Conference Note, dated February 2024, indicated a care plan meeting had occurred. During an interview, on 5/17/2024 at 9:12 A.M., the Social Service Director indicated care conferences were normally held quarterly, and Resident 32 should have had care conferences held quarterly between March 2023 and January 2024. A current policy was provided by the Director of Nursing (DON) on 5/17/2024 at 2:43 P.M. The policy titled, "Care Planning Policy & Procedure", indicated, " ...7. Each resident's care plan shall be reviewed at least quarterly and will include the Resident's strengths and weaknesses and incorporate personal and cultural preferences in developing care plans ...." 3.1-35(e)		practice. All residents charts were reviewed to determine the date of the last resident care plan meeting. The resident/representative will be contacted to schedule a meeting for those residents that did not have a care plan meeting held after their last MDS assessment. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* The policy “Care Planning Policy & Procedure” will be reviewed by the IDT. An in-service will be held with the IDT on the policy, specifically the timing of care plan meetings. A performance improvement tool has been developed to audit that residents/representatives have been invited to a care plan meeting after each comprehensive or quarterly assessment. *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits (5) residents to ensure care plans meeting were held after each comprehensive or quarterly assessment. This performance improvement tool will be completed by the Social Service Director/ Designee on (5) residents weekly for four weeks; then monthly for three months, then quarterly x three. In the event	

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	155086	A. BUILDING 00 B. WING	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODLAND MANOR	343 S NAPPANEE ST ELKHART, IN 46514

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			any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made;* 7/5/24	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to provide showers at least twice weekly for 3 of 5 residents reviewed for ADL's (activities of daily living). (Residents 20, 65 and 32) Findings include: 1. During an interview on 5/14/2024 at 9:02 A.M., Resident 20 indicated she had not had any showers since admission. Resident 20 was admitted on 4/30/2024. A record review was completed on 5/15/2024 at 9:04 A.M. .for Resident 20. Diagnoses included, but were not limited to depression, anxiety, hypertension, hemiplegia, seizures, and diabetes. An Admission MDS (Minimum Data Set) assessment, dated 5/6/2024, indicated the resident had impairment to her ROM(range of motion) on one side to both upper and lower extremities. She	F 0677	/p> *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* /p> *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* /p> *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* /p> *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits (5) residents to ensure bed	07/05/2024

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	required substantial to maximum assist for toileting, and used a mechanical lift for transfers. A current Care Plan, dated 5/8/2024, indicated the resident had an ADL (activities of daily living) Self Care Performance Deficit related to a history of CVA (cerebral vascular accident), recent hospital stay for pneumonia and UTI (urinary tract infection). An intervention included: "BATHING: The resident is totally dependent on staff to provide a bath/Shower weekly and as necessary." The shower schedule indicated Resident 20 was to receive showers on Wednesday and Saturday evenings. The shower documentation for Resident 20, dated May 2024, indicated the resident received a bed bath on Wednesday 5/1/2024. There was no documented shower on Saturday 5/4, 5/8, and 5/11/2024 During an interview on 5/17/2024 at 3:26 P.M., the Director of Nursing indicated the resident should have had more showers. 2. During a observation on 5/14/2024 at 9:41 A.M., Resident 65 was observed with whiskers to his face. During an observation on 5/15/2024 at 9:24 A.M., Resident 65 was observed with white facial whiskers 1/4 inch in length and his hair looked greasy. A record review was completed on 5/15/2024 at 9:26 A.M. for Resident 65. Diagnoses included, but were not limited to acute kidney failure, dementia, Type 2 diabetes mellitus, and retention of urine.		baths/showers have been offered twice weekly per their preference, so residents are clean and well-groomed. This performance improvement tool will be completed by the ADON/ Designee on (5) residents weekly for four weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made;* 7/5/24	

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	An Admission MDS (Minimum Data Set) assessment, dated 5/1/2024, indicated the resident exhibited no behavioral symptoms, required bathing and dressing lower body assistance and required maximum assistance with showering. A current Care Plan, dated 4/28/2024, indicated Resident 65 required assist with ADL's due to: dementia, musculoskeletal impairment, limited mobility, and a weakened state. Interventions included, but were not limited to: "the resident preferred to complete bathing with extensive assist as needed... " The shower schedule for Resident 65 indicated he was to receive showers on Wednesday and Saturday evenings. The shower documentation for Resident 65, dated April and May 2024, indicated the resident received a shower on 4/26, and a bed bath on 4/28/24 and 5/8/2024. There were no documented showers for 5/1, 5/4, and 5/11/2024. During an interview, on 5/17/2024 at 3:27 P.M., the Director of Nursing indicated the resident should have had more showers.3. During an interview on 5/13/2024 at 7:35 A.M., Resident 32 indicated he had not received his showers timely. He indicated he had been waiting a week and this happened frequently. A record review was completed on 5/15/2024 at 12:05 P.M. Diagnoses included, but were not limited to: diabetes mellitus type 2 and obesity. A Quarterly Minimum Data Set (MDS) assessment, dated 2/7/2024, indicated Resident 32 required partial/moderate staff assistance for			

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	bathing. A 30-day review of the documented showers in the electronic health record for Resident 32 indicated his shower days were on Tuesday and Friday in the evening, and he received showers on 4/18/2024 at 10:54 P.M., 4/21/2024 at 2:42 A.M., 5/3/2024 at 4:53 A.M. and 11:37 P.M. and 5/16/2024 at 12:24 A.M. A Care Plan, dated 3/15/2021, indicated Resident 32 required assistance with his activities of daily living due to pain and arthritis in his left hip. Review of shower sheets for the month of May 2024, provided by the Director of Nursing (DON) on 5/17/2024 at 10:58 A.M., indicated Resident 32 had only one shower sheet dated 5/17/2024. The DON indicated this was all the completed shower sheets for Resident 32 available for the month of May. During an interview on 5/17/2024 at 11:20 A.M., CNA 17 indicated Resident 32 was scheduled to receive his showers on Tuesdays and Fridays according to the shower book. During an interview on 5/17/2024 at 1:44 P.M., the DON indicated she could not find any further shower sheets for Resident 32. Resident 32 should have received showers per the schedule of at least showers per week and if the resident refused a shower, the nurse needed to be notified, and the refusal should be documented in the medical record. A current policy was provided by the Director of Nursing on 5/17/2024 at 2:43 P.M. The policy titled, Shower/Bathing Policy", indicated, " ...If the resident refuses a shower, a bed bath will be			

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	offered and provided as per the residents' preference ...." 3.1-38(b)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and			

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	services to restore as much normal bowel function as possible. Based on observation, record review and interview, the facility failed to provide the appropriate care and services to prevent urinary tract infections related to a urinary catheter drainage bag on the floor for 1 of 3 residents reviewed for catheters. (Residents 65) Finding include: During an observation, on 5/15/2024 9:00 A.M., Resident 65 was in his wheelchair with his urinary catheter drainage bag dragging on the floor. During an observation, on 5/15/2024 at 10:52 A.M., Resident 65 was observed wandering in his wheelchair with the urinary catheter drainage bag dragging on the floor. During an observation, on 5/15/2024 at 11:25 A.M., a staff member was observed pushing Resident 65 to the dining room with the urinary catheter drainage bag dragging the floor. During an observation, on 5/15/2024 at 2:17 P.M., Resident 65 was wandering in his wheelchair with the urinary catheter drainage bag dragging on the floor. During an interview, on 5/16/2024 at 3:28 PM QMA 15 indicated the drainage bag should not be in the floor. During an observation, on 5/16/2024 at 3:30 P.M., Resident 65 was lying in bed with the urinary drainage bag laying directly on the floor. During an interview, on 5/16/2024 at 3:28 P.M., QMA 15 indicated the drainage bag should not	F 0690	It is the practice of this facility to provide care and services to prevent urinary tract infections by properly positioning catheter bags off the floor. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* Resident 65 no longer resides in the facility. *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* All residents with a foley catheter have the potential to be affected by the deficient practice. All residents with catheters were reviewed to ensure catheter bags were positioned off the floor. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* /p> *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits (5) residents with catheters to ensure catheter bags and tubing are positioned below the bladder and free of touching the floor. This performance improvement tool will be	07/05/2024

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	be in the floor. During an observation, on 5/17/2024 at 11:35 A.M., Resident 65 was sitting in his wheel chair in the dining room with the urinary drainage bag next to him in the wheel chair, above the level of his bladder During an interview, on 5/17/2024 at 11:40 A.M., QMA 14 indicated the drainage bag should not be in the wheelchair A record review was completed on 5/15/2024 at 9:26 A.M. for Resident 65. Diagnoses included, but were not limited to urinary tract infection, acute kidney failure, dementia, diabetes mellitus, and retention of urine. An Admission MDS (Minimum Data Set) assessment, dated 5/1/2024, indicated the resident required maximum assistance with bathing, toileting, and showering and received Macrodantin (antibiotic) 50 mg (milligrams) 1 capsule two times a day for urinary tract infection. A current Care Plan, dated 4/28/2024, indicated the resident currently has a urinary catheter #16 Foley with 10 cc balloon due to: Urinary Retention. Interventions included, but were not limited to: "...Catheter Assessment quarterly and as needed to assess the need for continued use of the catheter. Change my catheter bag as ordered. Keep the catheter system as closed as much as possible. Notify my MD of any signs of infection. Offer me fluids frequently. Provide catheter care as per facility policy. Report signs of UTI (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain, low back/flank pain, malaise, nausea/vomiting, chills, fever, foul odor, concentrated urine, blood in urine)..."		completed by the DON/ Designee on (5) residents with catheters weekly for four weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made;* 7/5/24	

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	On 5/17/2024 at 8:00 A.M., the Director of Nursing provided the policy titled, "Catheter Care, Urinary", dated 2014, and indicated the policy is the one currently used by the facility. The policy indicated: "... The purpose of this procedure is to prevent catheter- associated urinary tract infections... 3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder... b. Be sure the catheter tubing and drainage bag are kept off the floor...." 3.1-41(a)(2)			
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for			

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	installing and maintaining bed rails. Based on observation, interview and record review, the facility failed to assess the use of a side rail before maintaining the bedrail in the upright position for 1 of 5 Residents (Resident 42) reviewed for accidents. Finding Includes: During an interview, on 05/13/2024 at 11:50 A.M., Resident 42 indicated he had a fall and he was supposed to use "this" to get up. (The resident then pointed to his siderail on the right side of the bed) A record review was completed on 5/16/24 at 11:36 A.M., Diagnoses included, but were not limited to: heart failure, rhabdomyolysis, hypoxemia, fall on same level, difficulty in walking, muscle weakness, vascular dementia, bradycardia, hypertension, anemia, bells palsy, dyspnea and insomnia. A Quarterly MDS (Minimum Data Set) assessment, dated 4/17/2024 indicated Resident 42 had moderate cognitive cognition, utilized wheelchair for ambulation and was at risk for falls. A Nursing Progress Note, dated 3/2/2024 at 4:42 A.M., indicated Resident 42 was found sitting on floor beside his bed. Resident indicated he had slid off of his bed and denies any injury. Resident was assessed and assisted, no injury noted. DON, NP and family were notified. Facility to start neuro sheet. A Care Plan, with a revision date of 12/1/2023, indicated Resident 42 was at risk for falls related to Cognitive impairment, balance deficits, alcohol withdrawal, Bell's palsy, obesity and neuropathy.	F 0700	It is the practice of this facility that a resident be assessed for the use of bedrails prior to maintaining the bedrail in the upright position *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* A bedrail assessment was completed on resident 42 that determined the residents use of bedrails was appropriate. *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* All residents with a condition that indicates the need for bedrails have the potential to be affected by the alleged deficient practice. All residents' beds were reviewed to determine if bedrails were in use. All residents with bedrails on their beds have current bedrail assessments completed in the EHR that accurately reflect bedrail use based on resident condition. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* The policy "Use of Bedrails" will be reviewed by the IDT. An in-service will be held with the licensed nursing staff and maintenance on the policy for assessing to determine the appropriateness of bedrails based on resident	07/05/2024

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	A Fall Risk Evaluation was completed on 3/2/2024 and indicated Resident 42's balance was not normal and he required assistive devices. An Interdisciplinary Team (IDT) Note, dated 3/2/2024, indicated a siderail was to be applied to Resident 42's bed, as an intervention to assist with positioning. During an interview, on 05/16/2024 at 01:48 P.M., the Director of Nursing indicated there was no side rail assessment completed prior to adding the intervention and one should have been completed. A policy was provided on 5/16/2024 at 2:22 P.M., by the Director of Nursing. The policy, titled, "Use of Bed Rails" indicated, "...3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using bed rails. When used for mobility or transfer, an assessment will include a review of the resident's: a. bed mobility, b. ability to change positions, transfer to and from bed or chair, and to stand and toilet, c. potential risks with the use of bed rails, and d. that the bed's dimensions are appropriate for the residents size and weight...." 3.1-45 (1)(2)		condition and symptoms prior to the application of rails. A performance improvement tool has been developed to audit that the current assessment reflects the bedrail use accurately and if it is determined that bedrails need to be applied to the bed, an assessment has been completed prior to application of the rails. *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits (5) residents at random to ensure residents have been assessed prior to the application of bedrails, the residents condition warrants the use of bedrails and the bedrail assessment on current residents with bedrails has been completed within the past quarter and remains appropriate. This performance improvement tool will be completed by the Director of Nursing/ Designee weekly for four weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made;* 7/5/24	

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F 0732 SS=D 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. §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.			

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	Based on observation and interview, the facility failed to post the daily nursing staffing at the beginning of the shift. Finding includes: During an observation, on 5/13/2024 at 7:34 A.M., the nursing staff posting was dated 5/11/2024. During an interview, on 5/17/2024 at 8:26 A.M., the Director of Nursing (DON) indicated night shift completes the nursing staff posting for the next day. The third shift should have posted the nursing staffing by midnight. A policy was provided by the DON on 5/17/2024 at 3:43 P.M. The policy titled, "Posting Direct Care Daily Staffing Numbers", indicated, " ...Our facility will post, on a daily basis for each shift the number of nursing personnel responsible for residents ...."	F 0732	It is the practice of this facility to post nurse staffing data as specified on a daily basis at the beginning of each shift. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* An accurate nursing schedule was posted immediately which reflected the current date. *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* All residents have the potential to be affected by the alleged deficient practice. The nursing schedule will be posted each day with accurate information. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* The policy “Posting Direct Care Daily Staffing Numbers” will be reviewed by the IDT. An in-service will be held with the licensed nursing staff on the policy and necessity of posting staffing information on a daily basis. A performance improvement tool has been developed to audit that the posted staffing sheet reflects the information for the current date.	07/05/2024

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			How the corrective actions will be monitored to ensure the deficient practice does not recur; A performance improvement tool has been initiated that randomly audits five (5) days to ensure that staffing sheets are accurate with the current date. This performance improvement tool will be completed by the Director of Nursing/Designee weekly for four weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made;* 7/5/24	
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 general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate			

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	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 observation, record review and interview, the facility failed to ensure narcotics were counted and documented every shift for 1 of 2 narcotic count log books reviewed. (Skilled Hall) Finding includes: A medication storage observation of the Skilled Hall medication cart was completed, on 5/16/2024 at 6:47 A.M., with LPN 4. The the narcotic log book there were 30 missing signatures from 4/16/2024 thru 5/15/2024. During an interview, on 5/16/2024 at 6:53 A.M., LPN 4 indicated the narcotic log sheets should be signed every shift. On 5/16/2024 at 10:35 A.M., the Director of Nursing provided the policy titled, "Controlled	F 0755	It is the practice of this facility that an account of all controlled drugs is maintained and periodically reconciled. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice* No residents were found to have been affected by the alleged deficient practice. *How other resident 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 are administered narcotics have the potential of being affected by the deficient	07/05/2024

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	Substance",undated, and indicated the policy was the one currently used by the facility. The policy indicated"...9. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and thru nurse going off duty must make the count together...." 3.1-25(3)(2)		practice. The narcotic count sheets on all medications carts were audited for missing signatures and will be corrected if indicated. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* The policy “Controlled Substance” will be reviewed by the IDT. An in-service will be held with the licensed nursing staff and QMA’s on the policy and necessity of signing each shift that all medications have been accounted for. A performance improvement tool has been developed to audit that narcotic sheets have been signed between the off going and oncoming nurse/QMA each shift. *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits (5) days on all medication carts to ensure narcotic count signatures are present between the off going and oncoming nurse/QMA each shift. This performance improvement tool will be completed by the Director of Nursing/Designee weekly for four weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated.	

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			Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made;* 7/5/24	
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. Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared, served and delivered in a sanitary manner in 1 of 1 kitchens. This had the potential to affect 67 of 67 residents who consumed food from the kitchen.	F 0812	/p> *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice* /p> *How other resident having the*	07/05/2024

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	Findings include: . During an observation of the kitchen on 5/13/2024 at 7:42 A.M., with Cook 16, the following was observed: the freezer had a bag of waffles, a bag of pancakes, 2 pizzas, a bag of broccoli, a bag of hamburger patties, 4 bags of cereal and a bag of chicken strips that were all undated and opened. the prep counter had crumbs and a grease like substance on top the storage bins were dirty with dried crumbs stuck to the lid the delivery cart had dried food particles and crumbs covering the top the dishwasher was dirty on the top and covered with crumbs the cooler had an undated bowl of fruit and salad. During an interview, on 5/13/2024 at 8:07 A.M., Cook 16 indicated the items should have been dated and /or thrown out if expired and the counters, storage bins, delivery cart and dishwasher should have been cleaned.. 2. During a continuous observation, on 5/13/2024 from 8 :16 A.M. to 8:24 A.M., six observations were made of LPN 5 placing her thumb on the food surface of dinner plates and touching the rim of cups with her fingers while serving food to residents. During an observation, on 5/13/2024 at 9:12 A.M., QMA 9 was observed carrying a meal tray without a cover in hall. During an interview, on 5/13/2024 at 9:15 A.M., QMA 9 indicated the plate should have been covered. During an interview, on 5/13/2024 at 2:17 P.M., the Dietary Manager indicated the staff should not		*potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* a name="_Hlk169177792">All food that was in the freezer and cooler was labeled with dates of delivery. Food items that are opened are dated with open and discard date. A cleaning schedule has been implemented to ensure kitchen areas are kept clean. Nursing staff will be in-serviced on the procedure for hand placement when delivering food and keeping food covered in the halls when being delivered. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* The policies “Cleaning and Sanitation of Food Service Areas, General Food Preparation and Handling, and Delivery Cart Cleaning” will be reviewed by the IDT. An in-service will be held with the dietary department on storage and labeling of food and kitchen sanitation and the nursing department on food delivery. A performance improvement tool has been developed to monitor food storage and labeling, kitchen sanitation and delivery of food. *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly	

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	have their fingers beyond the rim of the plate or cup during meal service and all meals should be delivered covered. All items in storage and in the coolers should be dated with arrival date and discard date and discarded when expired. On 5/15/2024 at 1:30 P.M., the Dietary Manager provided the policy titled, "Labeling and Dating, dated 5/2018 and indicated this is the current policy being used. The policy indicated"...Label with the date item is placed in storage and the date of discard..." On 5/16/2024 at 12:09 P.M., the Dietary Manager provided the policy titled, "Employee Sanitary Practices", dated 7/23 and indicated this is the current policy being used. The policy indicated"...Clean equipment and work units after use. All small equipment, counters, delivery carts are to be cleaned after each use. Storage bins and dishwasher are to be cleaned daily...." On 5/16/2024 at 12:11 P.M., a policy was requested related to correctly delivering meals during dining and one was not provided. This relates to Complaint IN00434221 and Complaint IN00434242 3.1-21(i)(3)		audits (5) days for food storage, kitchen sanitation and food delivery. This performance improvement tool will be completed by the Dietary Director/Designee weekly for four weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made;* 7/5/24	
F 0880 SS=K 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.			

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	§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; (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			

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	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 provide nursing services in a safe and sanitary manner to prevent the transmission of communicable diseases and infections related to not sanitizing the glucometer (portable machine used to test blood sugar levels) between uses for 2 of 16 residents (Residents 29 & 5) randomly observed for glucose monitoring. The facility identified 2 of the 5 residents with bloodborne communicable disease who resided in the facility used the shared glucometer. (Residents 28 & 38) This deficient practice resulted in a high potential risk for disease transmission for the 16 residents in the facility who required glucometer blood sugar testing. The facility also failed to ensure services were effectively provided to prevent the development	F 0880	It is the practice of this facility to provide nursing services in a safe and sanitary manner to prevent the transmission of communicable diseases and infections. *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice* The glucometers that were stored on the medication cart were removed and disinfected. Resident 29 and resident 5 were assigned their own individual glucometer to be stored in a bag. QMA 2 was in-serviced on the procedure for glucometer checks and	07/05/2024

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	of infections for 1 of 1 resident reviewed for indwelling urinary catheter care (Resident 33), 1 of 1 resident randomly observed for accessing an ice chest (Resident 3), 3 of 3 residents randomly observed for nursing care by 2 of 3 nursing staff (Resident 4, Resident 7, Resident 46, LPN 2, CNA 8), and 1 of 1 resident reviewed for respiratory care. (Resident 54). The immediate jeopardy began on 5/13/24 when facility staff was observed attempting to complete glucometer blood sugar testing on a resident after prior resident testing without the shared glucometer being sanitized. There were two residents requiring blood glucose testing in the facility who were also identified as having a bloodborne disease. The Executive Director (ED) was notified of the immediate jeopardy at 3:46 P.M. on 5/15/24. The immediate jeopardy was removed on 5/17/2024 at 2:2:7 P.M., but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. During a continuous random observation on 5/13/2024 from 11:08 A.M. through 11:26 A.M., QMA 2 was observed to go in Resident 29's room with the glucometer to check a blood sugar. At 11:10 A.M., QMA 2 was observed to leave the resident's room, place the glucometer on top of the medication cart, and place the glucometer in the right-side top drawer of the medication cart without sanitizing the device.		disinfection. Resident 33 had a basin placed under his urinary drainage bag to keep it from touching the floor. The ice in the ice chest was removed and the chest sanitized. A sign was placed on the chest for notification “employee use only” LPN 2 was educated on handwashing C.N.A 8 was in-serviced on handling of soiled linens, glove use, and handwashing Resident 54 respiratory equipment for the Bi-pap was disinfected and placed in a storage bag *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* All residents that reside in the facility have the potential of being affected by the alleged deficient practice. Glucometers were individually assigned and placed on the medication cart for all residents that get blood glucose checks. All licensed nurses and QMA’s were in-serviced on the proper procedure for glucometer checks and disinfection. All residents with catheters were reviewed to ensure, if resident utilizes a low bed, a basin is available to contain the urinary drainage bag as a barrier. Signs were placed on all ice chests to indicate “employee use only”. Ice chests will be kept out	

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	At 11:26 A.M., QMA 18 was observed to take the same glucometer out of the top drawer and go into Resident 5's room. QMA 18 used a lancet to obtain a blood sample for the blood sugar check. When QMA 18 went to place the testing strip with the glucometer up to Resident 5's finger, QMA 18 was stopped from completion of the testing. When questioned about the practice of sanitation when blood sugars were obtained, QMA 18 indicated she should have cleaned the glucometer, and confirmed she had not cleaned the glucometer since the prior resident's blood sugar test had been completed. On 5/13/2024 at 11:43 A.M., a list of residents residing in the facility with bloodborne pathogens was requested from the Director of Nursing. On 5/13/2024 at 2:09 P.M., the list of residents with bloodborne pathogens provided by the DON was reviewed. The list indicated there were three residents with viral hepatitis C, one resident with hepatitis B, and one resident with human immunodeficiency virus (HIV) disease that reside in the facility. Two of these five residents, through record review, were identified to require blood sugar checks, Residents 28 and 38. During an interview on 5/16/2024 at 1:20 P.M., the Director of Nursing indicated the proper procedure for blood glucose monitoring included the following: wash hands, don gloves, place the glucose monitor on a clean field, place a new lancet with a spring load that is disposable on the clean field, wipe the area with an alcohol wipe, obtain the blood sample, discard the lancet into a sharps container, clean the device after use, and place it in the proper storage device after cleaning. The appropriate disinfectant used to clean the device was Microdot bleach wipes with a sit time		of hallway areas unless being used by staff. All nursing staff will be in-serviced on infection control practices for urinary drainage bag storage, ice chest storage, handwashing, handling soiled linens, glove use and B-pap equipment storage. All residents with Bi-pap machines were audited to ensure tubing and masks were properly secured in storage bags. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* The policies “Obtaining a Fingerstick Glucose Level, Catheter Care, Urinary, Ice Chests, Personal Protective Equipment – Using gloves, Laundry and Bedding, Soiled, Handwashing/Hand Hygiene, and Equipment Management” will be reviewed by the IDT. An in-service will be held with the nursing staff on the policies . A performance improvement tool has been developed to monitor blood glucose checks, glucometer disinfection, urinary drainage bag placement, ice chest use, handwashing, soiled linen handling, glove use and storage of Bi-pap equipment. *How the corrective actions will be monitored to ensure the deficient practice does not recur;*	

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	on the machine of 1 minute. a. A record review for Resident 29 was completed on 5/15/24 at 2:30 P.M. Diagnoses included, but were not limited to, type 2 diabetes mellitus. A Quarterly Minimum Data Set (MDS) assessment, dated 4/25/24, indicated the resident was cognitively intact. A Care Plan, dated 7/23/2023, indicated Resident 29 had a diagnoses of diabetes mellitus which placed him at risk for medical complications. The goal indicated to have no medical complications through the next review on 7/26/2024, with an intervention of blood sugar checks as ordered by the physician. A Physician's Order, dated 2/7/24, indicated blood sugar (BS) testing before meals and at bedtime related to type 2 diabetes mellitus. b. A record review for Resident 5 was completed on 5/15/24 at 2:21 P.M. Diagnoses included, but were not limited to, diabetes mellitus type 2, carrier of MRSA (methicillin-resistant Staphylococcus aureus), resistance to vancomycin, and ESBL resistance (extended-spectrum beta-lactamases) A Quarterly MDS assessment, dated 4/18/24, indicated the resident was cognitively intact. Diagnoses included diabetes mellitus and multi-drug resistant organism. She received insulin injections. A Physician's Order dated 2/7/2024, indicated blood sugar checks before meals, bedtime, and as needed. A Care Plan, revised on 4/19/2024, indicated		A performance improvement tool has been initiated that randomly audits (5) staff/residents weekly for proper disinfecting of the glucometer, signage on the ice chest, handwashing, handling of soiled linen, Bi-pap equipment storage, glove use and positioning of catheter bags so as not to touch the floor. This performance improvement tool will be completed by the Director of Nursing/Designee as directed on the Directed Plan of Correction Audit Tools. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made;* 7/5/24	

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	Resident 5 had a diagnoses of diabetes mellitus which placed her at risk for medical complications with an intervention of blood sugar checks as ordered by the physician. c. A record review for Resident 28 was completed on 5/13/2024 at 2:11 P.M. Diagnoses included, but were not limited to, personal history of other infectious and parasitic diseases, unspecified viral hepatitis B without hepatic coma, and diabetes mellitus type 2. A Quarterly MDS assessment, dated 4/24/2024, indicated Resident 28 was cognitively intact. Diagnoses included viral hepatitis and diabetes mellitus. A Physician/Nurse Practitioner Note, dated 3/8/2024 at 11:49 A.M., indicated lab results were received. HBsAg (a protein that indicates an active or chronic hepatitis B infection), Anti-HBC IgM (an antigen that indicates a new infection with hepatitis B), Hep B Core Ab IgM (antibody that indicates past or ongoing hepatitis B) were all positive. A Physician/Nurse Practitioner Note, dated 3/8/2024 at 10:43 P.M., indicated lab results came back positive for acute hepatitis B, and the DON had notified the county health department of the positive hepatitis B result. The county health department indicated Resident 28 needed to be in contact isolation and seen by infectious disease. A Physician/Nurse Practitioner Note, dated 3/12/2024 at 10:42 A.M., indicated the Nurse Practitioner informed the DON that Resident 28 should be placed in a private room. A Physician's Order, dated 4/23/24, indicated			

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	blood sugar monitoring before meals and at bedtime. A Care Plan, revised 11/7/2023, indicated Resident 28 had a diagnoses of diabetes mellitus which placed him at risk for medical complications. The goal indicated to have no medical complications through the next review on 5/14/2024 with an intervention of blood sugar checks as ordered by the physician. During an interview, on 5/13/2024 at 2:58 P.M., Resident 28 indicated he had a continuous blood sugar monitor system the nursing staff used, but he had frequently received fingerstick blood sugar checks with the facility glucometer when his device was charging or if the nursing staff did not know how to use the device. d. A record review for Resident 38 was completed on 5/13/24 at 2:47 P.M. Diagnoses included but were not limited to, human immunodeficiency virus (HIV) disease, anogenital herpes viral infection, and diabetes mellitus type 2. A Quarterly MDS assessment, dated 4/24/24, indicated Resident 38 was cognitively intact. She had a diagnose of diabetes mellitus and received insulin injections. A Physician's Order, dated 12/6/23, indicated blood glucose monitoring before meals and at bedtime. The facility's most current policy was provided on 5/17/2024 at 5:37 A.M. The policy titled, "Blood Sampling-Capillary [Finger sticks]", indicated, " ...The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne disease to			

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	residents and employees ...1. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses ...." The immediate jeopardy that began on 5/13/24 was removed on 5/17/24 when the facility inserviced licensed nurses and QMAs regarding proper cleaning of glucometers after use and implemented a system of personal glucometers stored in a labeled bag for each resident. The noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy because of the facility's need for continued monitoring and inservicing of any absent and future staff. 2. During observations of Resident 33 on 5/13/2024 at 7:43 A.M. and 8:48 A.M., an indwelling catheter drainage bag could be seen touching the floor while hanging on the frame of the bed with the bed in the lowest position, and the dignity bag hung beside the indwelling urinary catheter bag, touching the floor, without a basin placed to keep the indwelling catheter drainage bag off the floor. A record review was completed on 5/15/2024 at 10:29 A.M. Diagnoses included, but were not limited to, obstructive and reflux uropathy, hydronephrosis, benign prostatic hyperplasia, and hemiplegia affecting dominant side. A Care Plan, revised 1/17/2024, indicated Resident 33 had an indwelling urinary catheter related to obstructive uropathy and hydronephrosis. The interventions included, but were not limited to, keeping a basin at the bedside to place the catheter in when the resident was in bed and			

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	ensure the bed was in the lowest position. A Significant Change MDS assessment, dated 2/20/2024, indicated Resident 33 had an indwelling urinary catheter. A Physician's Order, dated 2/21/2024, indicated Resident 33 was to receive indwelling urinary catheter care every shift. During an observation on 5/16/2024 at 9:07 A.M. and 5/17/2024 at 8:28 A.M., Resident 33's bed was in the lowest position and the indwelling catheter drainage bag placed in a dignity bag and touched the floor without a basin in place. During an interview on 5/17/2024 at 8:08 A.M., the DON indicated when a resident's bed was in the low position, a basin should be placed underneath the indwelling catheter drainage bag. She indicated the indwelling drainage catheter bag should not touch the floor. The facility's most current policy was provided by the DON on 5/17/2024 at 8:00 A.M. The policy titled, "Catheter Care, Urinary", indicated, " ...Be sure the catheter and tubing and drainage bag are kept off the floor...." 3. During a random observation on 5/17/2024 at 2:43 P.M., Resident 3 was observed retrieving ice with her bare hand from the community ice cooler in the hallway and placing the ice in her Styrofoam cup. Two staff members, RN 13 and another unidentified staff member, were talking at the medication cart by the nurse's station and the community ice cooler. RN 13 and the unidentified staff member did not intervene and limit Resident 3's access to the community ice cooler.			

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	At 5/17/2024 at 2:55 P.M., RN 13 was informed of Resident 3 getting into the ice cooler with her bare hand. RN 13 indicated Resident 3 knew better, and asked if she was standing there when this occurred. A record review for Resident 3 was completed on 5/17/2024 at 3:02 P.M. Diagnoses included, but were not limited to, dermatitis and parasitic environmental infestation. A Quarterly MDS assessment indicated Resident 3 had severe cognitive impairment. The facility's most current policy was provided by the Director of Nursing on 5/17/2024 at 3:14 P.M. The policy titled, "Ice Machine and Ice Storage Carts" indicated, 1. Ice-making machines, ice storage chests/containers, and ice can all be contaminated by: a. Unsanitary manipulation by employees, residents, and visitors ...d. Improper storage or handling of ice. 22. To help prevent contamination of ice machines, ice storage chests/containers or ice, staff shall follow these precautions: a. Limit access to ice machines or ice storage chests/containers to employees only ...." 4. During an observation on 5/14/2024 at 2:42 P.M. with QMA 15, Resident 4's left foot had a quarter-sized blister on the inner aspect of the left heel. The dressing was halfway off with no date and a foul odor was noted. On 5/14/2024 at 3:00 P.M., LPN 2 was observed doing a skin treatment to Resident 4 foot. LPN 2 washed her hands and applied gloves. She then opened a gauze package and a calcium alginate package. She placed the packages back on a towel that was under the resident's left leg. She opened a sure prep pad and a mepilex dressing. LPN 2 dated the dressing and then removed her gloves			

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	and applied another pair of gloves, without sanitizing her hands. She moistened a gauze pad with normal saline and cleansed the area to Resident 2's left heel. LPN 2 removed her gloves and applied new gloves, again without washing her hands. LPN 2 then applied the calcium alginate and the mepilex dressing. She indicated she needed more tape and gloves. LPN 2 removed her gloves, placed them in the trash, then left the room with the trash bag, without washing her hands. LPN 2 returned and applied new gloves without washing her hands. LPN 2 then taped the dressing and removed her gloves. During an interview on 5/14/2024 at 3:17 P.M., LPN 2 indicated she should have washed her hands after removing her gloves. 5. On 5/16/2024 at 3:44 A.M., CNA 8 was observed providing perineal care to Resident 7. CNA 8 applied gloves and unfastened the resident's brief and tucked it under the resident's buttocks. Using a washcloth, CNA 8 completed perineal care. CNA 8 then put the dirty washcloth on the headboard of the bed. During the time she was washing the buttocks, the washcloth had fallen on the floor. The resident had had a small bowel movement. The aide used the brief to wipe away the stool. She removed the brief and put it on the floor. CNA 8 then put all the dirty linens on the floor. After the peri care was completed, with her dirty gloves still on, CNA 8 touched the residents' blankets, moved the call light to the bed, touched the bed control and the resident's pillow. CNA 8, with her dirty gloves still on, then went into the hallway to get a trash bag. She returned and placed the dirty linens in the bag and the trash in a bag and placed the bags in the hallway by the resident's door. CNA 8 then removed her gloves and walked down to the dining room to wash her hands.			

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	6. During an observation on 5/16/2024 at 4:03 A.M., CNA 8 applied gloves, then assisted Resident 46 to the bathroom. When asked if the resident was wet, she removed the extra pad and stated he was wet (with her gloved hand touching it). With her now dirty gloved hand, she opened the resident's room door and went into the hallway to retrieve a trash bag. CNA 8 then placed the linens in the bag and, with the same gloved hand, left the room again to get a towel. She returned and applied a gown to the resident without removing her dirty gloves and washing her hands. She then assisted the resident back to bed, straightened the comforter and moved the resident's pillow with her dirty gloved hands. During an interview on 5/16/2024 at 4:10 A.M., CNA 8 indicated she should have removed the gloves and washed her hands. On 5/16/2024 at 4:50 A.M., the Director of Nursing provided the policy titled, "Handwashing/Hygiene", dated January 2019, and indicated the policy was the one currently use by the facility. The policy indicated,"...6. Use an alcohol -based hand rub alternatively, or soap (antimicrobial or non-antimicrobial) and water for the following situations: ... d. Before performing any non-surgical invasive procedures; e. Before and after handling an invasive device (e.g., urinary catheters) ... g. Before handling clean or soiled dressings, gauze pads, etc.; ...k. After handling uses dressings, contaminated equipment, etc., l. After removing gloves... Applying and Removing Gloves. 1. Perform hand hygiene before applying non-sterile gloves. 2. Perform hand hygiene upon removal...." On 5/16/2024 at 4:50 P.M., the Director of Nursing			

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	provided the policy titled, "Perineal Care', dated 2/2018, and indicated the policy was the one currently used by the facility. The policy indicated, " ...9. Discard disposable items into designated containers. 10. Remove gloves and discard into designated container. 11. Wash and dry hand hands thoroughly. 12. Reposition the bed covers. Make the resident comfortable ... 14. Clean wash basin and return to designated storage area. 15. Clean the bedside stand. 16. Wash and dry hands thoroughly ...."7. During an observation on 5/13/2024 at 2:13 P.M., Resident 54 was observed in her bed. The bilevel positive airway pressure (BiPAP) mask and tubing were resting directly on the floor under her bed and clothes were observed laying on top of the mask and tubing. During an observation on 5/13/2024 at 3:58 P.M., Resident 54 was seated on her bed. The BiPAP mask was located on the bed and the tubing was on floor, under the bed. During an observation on 5/14/24 at 10:36 A.M., Resident 54 was not in her room. The BiPAP mask was located on a bedside table with a breakfast plate and the tubing was observed wrapped around the bedside table and was visibly dirty 3.1-8(a) 3.1-41(a)(2)			
F 0925 SS=E Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation, interview and record review, the facility failed to maintain an effective pest control program related to gnats in residents	F 0925	It is a practice of this facility to maintain an effective pest control program so the facility is free of	07/05/2024

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	rooms and in common areas in the facility in 1 of 4 units observed for environment. (200 Hall). Finding includes: On 5/16/2024, from 1:48 P.M. through 2:36 P.M., an environmental tour was conducted with the Administrator and the Maintenance Director. The following observations contained the following concerns: - Room 227 the bathroom had 3 gnats. During an interview with Resident 32, on 5/16/2024 at 1:33 P.M., he indicated he has had concerns about gnats being in his room and had complained to staff about them. A pest control invoice was received on 5/17/2024, and indicated the last pest management was on 4/17/2024, and was due next on 5/17/2024, then scheduled monthly. On 5/16/24 at 2:45 P.M., the Director of Housekeeping indicated there was no policy regarding environmental cleaning. On 5/16/24 at 2:57 P.M., the Housekeeping Supervisor provided an untitled form which indicated the following tasks a housekeeper should be providing to each resident's room, 7 days a week: -Empty all trash, cans, cups and wrappers from room and bathroom. -Clean mirror, sink, counter, toilet, toilet risers and rails. -Wipe down all flat surfaces (dresser, window sill, side tables and night stand. -Sweep and mop-under the bed, room and bathroom.		pests *What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice* The room of resident #32 (room 227) was sprayed for pests. *How other resident having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;* All residents have the potential to be affected by the deficient practice. All rooms throughout the facility were sprayed for pests and will be treated twice weekly. *What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;* The policy “Departmental (Maintenance)” will be reviewed by the IDT. An in-service was held with the Maintenance Director on the policy. A performance improvement tool has been developed to audit areas of the facility to ensure it is free of gnats and pest control has sprayed as scheduled. *How the corrective actions will be monitored to ensure the deficient practice does not recur;* A performance improvement tool has been initiated that randomly audits five (5) rooms/common areas to ensure areas are free of pests. This performance improvement tool will be	

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	This Federal deficiency relates to Complaints IN00434242 and IN00434221. 3.1-19(f)(4)		completed by the Maintenance Director/Designee weekly for four weeks; then monthly for three months, then quarterly x three. In the event any further concerns are identified the issue will be immediately corrected and additional training will be initiated. Results of the audit will be reviewed at the Quality Assurance Meeting at least quarterly. *By what date the systemic changes will be made;* 7/5/24	