STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155148	A. BUILDING 00 B. WING	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

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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 IN00403761 and IN00404545. Complaint IN00403761 - No deficiencies related to the allegations are cited. Complaint IN00404545 - No deficiencies related to the allegations are cited. Survey dates: May 21, 22, 23, 24, 25, 2023 Facility number: 000069 Provider number: 155148 AIM number: 100288980 Census Bed Type: SNF/NF: 83 SNF: 5 Total: 88 Census Payor Type: Medicare: 3 Medicaid: 74 Other: 11 Total: 88 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 2, 2023.	F 0000	***The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.*** ***This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Compliant Survey Revisit on or after June 26,2023.***	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as			

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

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	defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure residents who were self administering medications were assessed for capability to self administer medications and had orders for medication self-administration for 2 of 2 residents observed with medications in their rooms. (Resident 36 and Resident 51) Findings include: 1. During observation and interview on 5/22/23 at 10:15 A.M., Resident 51 was lying in bed. There was a small plastic cup of pills sitting on his bedside table. No staff were in or near the room. Resident indicated they were his pills and he did not know if he was going to take them. He did not take the pills during the interview. During an interview with the DON on 5/25/23 at 9:24 A.M., she indicated Resident 51 does not have a self-administration assessment or order and does not have the cognitive ability to self-administer his own medications. On 5/25/23 at 8:49 A.M., Resident 51's clinical records were reviewed. Diagnoses included, but were not limited to, encounter for orthopedic aftercare following surgical amputation above left knee, Type 2 diabetes mellitus with foot ulcer, vascular dementia, unspecified severity, with other behavioral disturbance The most recent Significant Change Minimum Data Set (MDS) Assessment, dated 3/29/23, indicated the resident has moderate cognitive impairment and requires extensive assistance of 2 for bed mobility, transfers, and toileting,	F 0554	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Residents 36 and 51 do not self-administer medication, resident who self-administer medication will be assessed for capability to self-administer medications and have orders for self-administration of medications. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents under the care of the facility have the potential to be affected by the alleged deficient practice. · An audit was completed on all resident's IDT for all residents who self- administer medication to ensure assessment of capability and order are in place. · Observational rounds of residents were completed to ensure that no medications are left bedside. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Nursing staff will be in serviced on self-administration policy and not leaving medications at bedside.	06/26/2023

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	supervision and setup for eating, and is total dependence for bathing. The current physician orders lacked an order for medication self-administration. The most current care plan, most recently reviewed on 5/22/23, lacked an intervention for medication self-administration. 2. During an observation on 5/21/23 at 8:40 A.M., Resident 36 was observed sitting on the side of the bed with the bedside table in front of her. At that time, Resident 36 put an unknown amount of pills in her hand and took them. At that time, Resident 36 indicated that staff is never in the room when she takes her medication. During an observation on 5/22/23 at 8:56 A.M., Resident 36 was sitting on the side of the bed. At that time, a prescription inhaler and saline mist bottle were sitting on her bedside table. On 5/23/23 at 8:36 A.M., Resident 36's clinical record was reviewed. Diagnosis included, but were not limited to, hypertension, depression, diabetes mellitus, and hyperlipidemia. The most recent significant change MDS (minimum data set) assessment indicated Resident 36 was cognitively intact. Resident 36's clinical record lacked a self administration of medications assessment. Resident 36's current orders lacked an order to self administer medications. Resident 36's clinical record lacked a care plan to self administer medications. During an interview on 5/24/23 at 1:45 P.M.,		· Observational rounds will be completed daily by DNS/designee to ensure no medications are left at bedside. · Observation rounds will be completed daily by DNS/designee to ensure residents who self-administer medication have assessment and order. 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 DNS/designee will be responsible for the completion of the Medication Pass Quality Assurance Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	Licensed Practical Nurse (LPN) 3 indicated Resident 36 had a new order for saline gel at the bedside, but did not have any other medications that were self administered. The facility's policy on medication self-administration, received from the DON on 5/25/23 at 9:30 A.M., and dated 1/2015, indicated: 1. The interdisciplinary team will assess the competence of the resident to participate by completing the "Self-Administration of Mediation Assessment" observation 2. A physician order will be obtained specifying the resident's ability to self-administer medications and, if necessary, listing which mediations will be included in the self-administration plan 3. The resident will be assessed for continued self-administration of medications quarterly and with any significant change of condition. 3.1-11(a)			
F 0557 SS=E Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on observation, interview, and record review, the facility failed to maintain resident's dignity for 1 of 4 residents observed for incontinence care, and 1 of 2 observations of a meal. (Resident 62, Cottage Dining	F 0557	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · The facility will maintain the dignity Residents 62,41,75,70 and	06/26/2023

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	Room-Resident 41, Resident 75, Resident 70, Resident 31) Findings include: 1. On 5/23/23 at 9:51 A.M., CNA (Certified Nurse Aide) 25 and QMA (Qualified Medication Aid) 54 were observed to assist Resident 62 with incontinence care. During care, CNA 25 indicated "At least he didn't get naked today. I shouldn't talk too soon". After checking Resident 62's brief, QMA 54 asked CNA 25 "Are we going to need a new diaper?". After care was performed, CNA 25 indicated staff should respect resident dignity by speaking with the resident while performing care, explain what they were doing, and try to ease the resident. 2. On 5/25/23 at 8:13 A.M., breakfast was observed in the Cottage Dining Room of the dementia unit. At that time, there were 11 residents seated in the dining room. CNA 25 was observed speaking loudly to Therapist 41 about the residents sitting in the dining room. CNA 25 indicated that Resident 62 was "ok yesterday, then he was acting up during lunch". CNA 25 then indicated Resident 41 was "ok about 90% of the time" and was easier to give showers than the other residents. Therapist 41 indicated to CNA 25 that Resident 75 was "so cute" while sitting across from the resident. CNA 25 spoke to Therapist 41 from across the room about a conversation her and Resident 70 had the previous day. Therapist 41 then got up and walked to CNA 25 where they both discussed Resident 31's medications, behavior, and other medical status while CNA 25 was assisting Resident 31 to eat. During an interview on 5/25/23 at 10:16 A.M., the		31while in cottage dining room and during incontinence care. · QMA 54, CAN 25, Therapist 41 were inserviced on communication with residents while providing care and services. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents under the care of the facility have the potential to be affected by the alleged deficient practice. · Other residents were interviewed to ascertain if residents are treated with respect when care and services are being provided. · Observational rounds were completed to ensure that residents are provided dignity during incontinence care. · Observational rounds of residents were completed to ensure resident dignity is upheld in dining rooms. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · All staff will be educated on dignity and privacy during incontinence care and in resident dining rooms. · Observational rounds will be completed daily by DNS/designee	

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	DON (Director of Nursing) indicated staff should not talk to other staff members while assisting residents to eat or in the dining room with other residents. Staff should only be attentive to the resident they were attending. On 5/25/23 at 7:28 A.M., a current Resident Rights policy, revised 11/2016, was provided and indicated "All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care" 3.1-3(a)		to ensure resident dignity is upheld during incontinence care and while in resident dining rooms. 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 DNS/designee will be responsible for the completion of the Dignity and Privacy Quality Assurance Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status			

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	(that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on observation, interview, and record	F 0580	What corrective action(s) will be	06/26/2023

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	review, the facility failed to provide notification of change for 2 of 5 residents reviewed for notification. A resident's representative was not notified timely of an accident , and a representative was not notified of a letter a resident received related to a change of doctor. (Resident 62, Resident 35) Findings include: 1. During an interview on 5/22/23 at 11:11 A.M., Resident 62's daughter and POA (power of attorney) indicated she had not been notified of a recent fall in a timely manner. She indicated Resident 62 had fallen one evening and was sent to the ER (emergency room), where he received stitches to the forehead. She indicated the staff did not notify her until 3:00 A.M. the following morning. At that time, Resident 62 had already returned to the facility. On 5/23/23 at 8:55 A.M., Resident 62's clinical record was reviewed. Diagnosis included, but were not limited to, dementia, anxiety, and depression. The most recent quarterly MDS (minimum data set) Assessment, dated 4/10/23, indicated Resident 62 was severely cognitively impaired. Progress notes included, but were not limited to, the following: 4/16/23 at 5:00 P.M., Resident 62 had fallen forward out of his chair and hit his head on the floor. Immediate pressure was applied to his head, and an ambulance was called. The ambulance arrived at 5:30 P.M., and the resident was transported to the hospital for treatment. The note lacked documentation that the resident's POA was notified of the fall or transport to the hospital.		accomplished for those residents found to have been affected by the deficient practice? · Resident representative 62 will be notified in a timely manner of any accident and resident representative 35 will be notified of change of physician. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents have the potential to be affected by the alleged deficient practice. · An audit will be completed by DNS/designee to identify residents that have an accident or change of physician, and notifications will be completed for those who have not had notifications. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Daily audits of facility activity report will be completed by DNS/designee to review any new accidents and ensure that notifications have been made. · Licensed staff will be educated by DNS/designee on notification of MD, family, and administration for any resident that has an accident or changes in physician. · Any change of physician will be reviewed during clinical	

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	4/16/23 at 9:26 P.M. Resident returned from the hospital with 12 stitches to the left brow. The right arm had a skin tear and was wrapped in gauze. 4/17/23 at 12:00 A.M. Resident with recent fall with injuries. Laceration to left brow, bruising to left orbit, and steri-strips to left elbow. 4/17/23 at 2:14 A.M. "[POA] noted [sic] of fall event at this time as well as ER visit and injuries sustained during event ... This writer apologized for late notification ..." On 5/24/23 at 12:35 P.M., a grievance form, dated 4/17/23, was provided and indicated "[Resident 62's] daughter called upset no one called her before her dad went to hospital. She said they called after he came back hospital [sic] [and] started off with "I'm so sorry". At first she thought to herself her dad died. It was a 2:30 A.M. call. She said she wished she would have been notified before he went to hospital so she could have been there with him at hospital. She also stated since they waited to call after he was back someone could have called at a later time. She was upset with how it was all communicated to her" At that time, the DON (Director of Nursing) indicated the reason Resident 62's POA was not notified was the fall occurred in the middle of the night. When it happened they were trying to get him to the ER because of bleeding and they were worried about his safety. The DON indicated the POA was notified the following morning during day shift. During an interview on 5/25/23 at 8:35 A.M., RN (Registered Nurse) 23 indicated any time a resident had an injury, the nurse should notify the		meetings, with notification to resident representative to be completed and documented. 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 DNS/designee will be responsible for the completion of the Change of Condition Quality Assurance Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	POA right away. She indicated if the nurse needed to stay with the resident and could not call right away, they should call as soon as possible after assisting the resident or after the resident was transported to the ER. 2. On 5/21/23 at 9:34 A.M., Resident 35 was observed sleeping in his bed. On 5/24/23 at 9:08 A.M., Resident 35's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and encephalopathy. The most recent significant change MDS Assessment, dated 4/13/23, indicated Resident 35 was moderately cognitively impaired. Progress notes included, but were not limited to, the following: 4/30/23 5:35 P.M. "Res [Resident's] daughter request [sic] ... Also found letter in his drawer, addressed to him, stating '[doctor name] retiring [sic] from [Hospital Name] Senior care' and is asking why she wasn't informed of this change. Note placed in SS [social services] for call [sic] [daughter's name] ASAP [as soon as possible] regarding concerns. States she is returning to Georgia this night." During an interview on 5/25/23 at 11:23 A.M., LPN (Licensed Practical Nurse) 45 indicated residents' mail should be delivered to the receptionist at the front office then activity staff would pass mail out to residents. At that time, she indicated the nursing staff did not notify family representatives about the retiring doctor because they were told that the residents and responsible parties should have received a letter and were notified by the upper management of the facility. During an interview on 5/25/23 at 11:24 A.M.,			

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	Activities Staff 48 indicated usually they would pass mail on to the residents. She would ask all residents if they want any assistance opening or reading their mail whether they were cognitively impaired or not. During an interview on 5/25/23 at 11:27 A.M., the SSD (Social Services Director) indicated she had a note on her desk concerning Resident 35's daughter being upset about finding the letter in her dad's room and not being notified about his doctor retiring. At that time, she indicated she called and spoke to the daughter and told her that they assumed residents and their families had been notified by the doctor's office. During an interview on 5/25/23 at 11:40 A.M., the Administrator indicated each resident and resident family representatives, whether the resident was or was not cognitively impaired, was supposed to be notified about (doctor's name) retirement by a letter sent from the doctor's office. At that time, the Administrator indicated the facility did not do formal notification of family representatives. On 5/25/23 at 7:28 A.M., a current Fall Management Policy, revised 8/2022, was provided and indicated "The family will be notified immediately by the charge nurse of falls with injury ... If there are no injuries, notify the family during day or evening hours (if a fall occurred during the middle of the night, wait until morning)" On 5/25/23 at 7:28 A.M., a current Resident Rights Policy, revised 11/16, was provided and indicated "Facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care			

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	professionals responsible for his or her care" On 5/25/23 at 7:28 A.M., a current Resident Change of Condition Policy, revised 11/18, was provided and indicated "It is the policy of this facility that all changes in resident condition will be communicated to the physician and family/responsible party, and that appropriate, timely, and effective intervention takes place ... The responsible party will be notified that there has been a change in the resident's condition and what steps are being taken" 3.1-5(b)(2)			
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means			

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	155148	A. BUILDING 00 B. WING	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH PARK NURSING CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710

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	other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, interview, and record review, the facility failed to ensure resident privacy was maintained for 1 of 4 residents observed for medication administration, 1 of 5 residents observed for incontinence care, and 1 random observation. The privacy curtain and door were not shut during medication injection administration, the window curtains were not shut during incontinence care, and a computer screen was left up with resident information visible. (Resident 346 and Resident 62) Findings include: 1. On 5/23/23 at 7:05 A.M., a computer screen with resident information visible was observed unattended on the A Hall. Resident 346's information, including, but not limited to, name, age, date of birth, room number, and medication information, were visible on the computer screen. The computer screen was continuously observed until 7:47 A.M., when LPN (Licensed Practical Nurse) 3 entered the area and shut the computer screen. During the time of observation, housekeeping, therapy services, and nursing staff walked by the computer, and Registered Nurse	F 0583	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · The facility will ensure resident privacy will be maintained for residents during medication administration and incontinence care. Facility will ensure privacy curtain and door are shut during medication administration for resident 62. Facility will ensure resident privacy by monitoring resident information on unattended computer screens. · RN7, LPN 3, CAN 25 and QMA 54 were educated on privacy by DNS/designee. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents under the care of the facility have the potential to be affected by the alleged deficient	06/26/2023

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	(RN) 7 walked by the computer 4 times and moved the cart from the middle of the hallway up against the wall without shutting the screen. 2. On 5/23/23 at 7:47 A.M., LPN (Licensed Practical Nurse) 3 was observed to administer insulin in the arm to Resident 346 in the resident's room without closing the door or privacy curtain. During an interview on 5/25/23 at 9:38 A.M., the Administrator indicated that when giving an injection, staff should either pull the privacy curtain closed or shut the resident's door in order to maintain privacy. The Administrator further indicated that staff should either log out, dim the computer screen, or shut the computer screen before walking away to hide the resident information.3. On 5/23/23 at 9:51 A.M., CNA (Certified Nurse Aid) 25 and QMA (Qualified Medication Aid) 54 were observed to provide incontinence care for Resident 62. Resident 62's bed was closest to the window. Staff did not close the window blinds. During an interview on 5/25/23 at 10:23 A.M., the DON (Director of Nursing) indicated blinds should be closed when providing incontinence care to residents to respect privacy. On 5/25/23 at 7:28 A.M., a current Resident Rights Policy, revised 11/16, was provided but lacked information related to resident privacy. At that time, the DON indicated it was the facility's policy to respect privacy. 3.1-3(o) 3.1-3(p)		practice. · Observational rounds of residents were completed to ensure residents are provided privacy during incontinence care and medication administration. · Observational rounds were completed to ensure that resident information is not available on unattended computer screens. · Residents were interviewed to ensure resident privacy is maintained. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Nursing staff will be educated on resident privacy during incontinence care and medication administration. · Nursing staff will be educated on resident information is not available on unattended computer screens. · Observational rounds will be completed daily be DNS/designee to ensure resident privacy and that no resident information is available on unattended computer screens. 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 DNS/designee will be responsible for the completion of	

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			the dignity and privacy Quality Assurance Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure each resident received supervision and consistent implementation of interventions to prevent falls for 1 of 3 residents reviewed for falls. Resident 31 had a fall that resulted in a fracture to right femur. (Resident 31) Finding includes: During an interview on 5/21/23 at 11:14 A.M.,	F 0689	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Each resident receives adequate supervision and assistive devices to prevent accidents. · Resident 31 has new interventions implemented to assist in preventing future falls. Care plans were updated. How will you identify other	06/26/2023

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	Resident 31's spouse indicated Resident 31 had fallen several times and recently had a fall that resulted in sutures and staples. He was concerned that the falls resulted from a lack of staffing on the unit. He indicated he had been to management several times with the concern, and was told that Resident 31's falls could have been prevented if there was more staff. He indicated during the most recent fall, the CNA (Certified Nurse Aide) had left all the residents on the hall to get report from another CNA in another hall. At that time, Resident 31 was in her room and had gotten up by herself to walk toward the door. Her alarm was sounding, but because of the lack of staff on the unit, they did not get to her until she was on the floor in the doorway. On 5/23/23 at 8:48 A.M., Resident 31's clinical record was reviewed. Diagnosis included, but were not limited to, Alzheimer's disease, dementia, anxiety, and psychotic disorder. The most recent quarterly MDS (minimum data set) Assessment, dated 4/17/23, indicated Resident 31 was severely cognitively impaired, required extensive assistance of two staff for bed mobility and transferring, extensive assistance of one staff for toileting, and had experienced one fall since admission with no injury. A current falls care plan, dated 2/1/19, included the following interventions: Resident to be laid down after she is done eating prior to removing hall trays, dated 5/8/23. Resident activity to use hands, dated 12/16/22. Velcro shoes, dated 9/19/22. Resident to be at afternoon activities, dated 9/10/22. Floor mat with alarm. Check placement and function every shift, dated 6/2/21. Offer resident to speak with husband on the		residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents under the care of the facility have the potential to be affected by the alleged deficient practice. · An audit was completed on all resident's IDT fall reviews and fall interventions to ensure care plans are accurate to ensure the plan of care is accurate related to the residents at risk for falls. Any intervention identified as not present on the care plan will be corrected to current plan of care for fall prevention on or before 06/20/2023. · Observational rounds of residents were completed and reviewed for adequate supervision and assistive devices and interventions in place. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Nursing staff will be educated on resident profiles and resident fall interventions by the DNS/designee. · Observational rounds will be completed daily by DNS/designee to ensure resident fall interventions are in place. How the corrective action (s) will be monitored to ensure the	

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	phone when she appears anxious, dated 11/20/20. Encourage resident to lay down in the afternoon, dated 10/14/20. Bed against the wall, dated 4/19/20. Non-skid socks at bedtime, dated 3/31/20. Visual reminder to the call light, dated 12/9/19. Call light in reach, dated 10/23/19. Personal items in reach, dated 10/23/19. Fall events included the following: Fall 1 9/10/22 at 3:12 P.M. Resident was sitting in her wheelchair in the dining room prior to the fall, got up out of her wheelchair, and fell. The fall was unwitnessed by staff. All staff were in other resident's rooms assisting them. The fall event indicated all fall interventions were in place and effective at that time, and would continue to monitor. An IDT (Interdisciplinary Team) meeting, dated 9/12/23, indicated fall was witnessed, and the new intervention would be to have the resident attend afternoon activities. The falls care plan was updated with new intervention on 9/10/22. Fall 2 9/16/22 at 2:27 P.M. Nurse was notified by staff that resident was sitting in the hall on the floor. Resident 31 was observed sitting on buttocks with legs outstretched. A wheelchair was observed behind her. Fall was witnessed. The fall event indicated resident was bent down to "mess with" her shoes, and fell out of the wheelchair. The immediate intervention was to shorten the cord on the tabs alarm. The clinical record lacked an IDT meeting related to the fall. The falls care plan was updated with intervention "Velcro shoes" on 9/19/22. Fall 3		deficient practice will not recur, i.e., what quality assurance program will be put into place? · The DNS/designee will be responsible for the completion of the Fall Program Quality Assurance Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	12/15/22 at 1:50 P.M. Nurse was notified by staff that resident was in the floor in the dining room. Resident 31 was observed laying on her back with her legs extended out. Resident 31 had a small red area above her right ear. Fall was unwitnessed. The fall event indicated the resident had been trying to stand up and staff would assist her back down in her chair. An IDT meeting, dated 12/16/22, indicated the new intervention would be to shorten the alarm string (completed on previous fall), and redirect to activity to use her hands. The falls care plan was updated with intervention for resident activity to use hands on 12/16/22. Fall 4 4/2/23 at 6:01 P.M. Resident was attempting to transfer self in the dining room from her wheelchair to another chair. Staff heard a chair scoot across the floor and then heard the alarm sounding. Resident 31 slid to the floor before staff could reach her. Fall was witnessed. The immediate intervention was to lay resident down in bed. An IDT meeting, dated 4/4/23, indicated the new intervention would be to place resident in bed after finishing dinner. Fall 5 5/7/23 at 6:30 P.M. Nurse was notified by staff that resident was on the floor. Resident was observed outside of room 153 with an alarm clip attached to her back. Resident 31's wheelchair was noted alarming in room 155. At 6:00 A.M. the following day, a CNA notified the nurse that the resident was crying and grabbing at her right hip and right leg while attempting to assist her out of bed. An x-ray was ordered and showed an acute, displaced right femoral neck fracture (hip fracture). Resident 31 was sent to the ER (emergency room) for treatment. An IDT meeting, dated 5/8/23,			

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	indicated the new intervention would be to have antithrust cushion to the wheelchair, and resident to be laid down after she is finished eating prior to removing hall trays. The care plan was updated 5/8/23 to include lying the resident down after meals before removing hall trays, but lacked any new intervention related to an antithrust cushion to the wheelchair. A radiology report, dated 5/8/23, indicated Resident 31 had a current fracture of the right femoral neck with displacement of the distal fragment. On 5/23/23 at 9:11 A.M., Resident 31 was observed sitting in the common area in a Broda chair during an exercise activity. A blanket was observed over her lap, and her feet were up. There was no hand activity observed in her lap or hands. On 5/23/23 at 1:32 P.M., Resident 31 was observed sitting in the dining area with her spouse. Resident was observed in a Broda chair with a blanket over her. There was no hand activity observed in her lap or hands. On 5/24 23 at 8:55 A.M., Resident 31 was observed in the dining area with a robe on. There was no hand activity observed in her lap or hands. During a continuous observation on 5/25/23 from 7:39 A.M. until 9:10 A.M., the following was observed: Resident 31 was observed sitting at a table with 2 other residents. She was observed sitting in a regular wheelchair facing the wall from across the table. An activity cloth was observed in her lap, but the resident was unaware of it, not			

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	acknowledging or touching it. A food cart was brought to the unit at 7:51 A.M. After all residents had finished the meal, CNA 25 and Activities 35 were observed to remove dishes and trays, and load the food cart. The food cart was taken out of the dining area at 8:54 A.M. At that time, CNA 25 and CNA 31 assisted another resident to their room. The food cart was taken off of the unit at 8:56 A.M. At 8:59 A.M., CNA 25 and CNA 31 assisted another resident into her wheelchair and into their room. At that time, CNA 25 indicated to CNA 51 in the hall all of the residents that needed assisted to their rooms, but did not mention Resident 31's name. At 9:10 A.M., QMA (Qualified Medication Aide) 33 asked Resident 31 if she wanted to go to exercises. The resident indicated she did, and QMA wheeled her down the hall. During an interview on 5/25/23 at 9:15 A.M., CNA 25 indicated she used her own judgement related to keeping Resident 31 up after meals or assisting to lay down. She indicated because she was awake more, she liked to keep her up between breakfast and lunch. During an interview on 5/25/23 at 10:15 A.M., the DON (Director of Nursing) indicated an IDT meeting should have been conducted after each fall or accident. She indicated she was aware that a meeting was not documented after Resident 31's 9/16/22 fall, and thinks they may have completed one, but forgot to save it in the computer. During an interview on 5/25/23 at 11:05 A.M., RN (Registered Nurse) 23 indicated Resident 31 used to have a pull tab alarm that was currently discontinued. She indicated staff tries to keep her			

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	near at all times and engaged in some sort of activity. RN 23 indicated discontinuing the pull tab alarm had contributed to her falls, and she needed to have it again. She indicated though it did not prevent falls, staff was able to get to her before she fell with the alarm. During an interview on 5/25/23 at 11:19 A.M., the DON indicated the pull tab alarm was discontinued when the resident returned from the hospital after the most recent fall on 5/7/23 because upon her return, she was in a Broda chair. She indicated now that she was in a regular wheelchair, they were still discussing the need for the pull tab alarm to be reinstated. On 5/25/23 at 7:28 A.M., a current Fall Management Policy, revised 8/2022, was provided and indicated "It is the policy of [company name] to ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related to falls ... The care plan will be reviewed and updated, as necessary" 3.1-45(a)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs			

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	and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure proper storage of medications for 3 of 3 medication carts observed. Loose pills were observed in the medication cart drawers (Cottage Unit, A Hall, F Hall). Findings include: 1. On 5/23/23 at 9:09 A.M., the Cottage Unit (Dementia unit) medication cart was reviewed. The following loose pills were observed in the bottom of the drawers: 1 yellow oval pill with marking "003" 1 yellow circle pill with a heart marking 1 white circle pill with marking "ML89" 1 white oval pill with marking "APO" 2 dark yellow circle pills with marking "C" 1 white oval pill with marking "597" 2 white circle pills with marking "L150" 4 brown with black specks circle pills with illegible markings 4 white circle pills with marking "TCL340" At that time, QMA (Qualified Medication Aide) 15 indicated that a nurse is supposed to clean out	F 0761	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Medications for cottage unit, F hall and A Hall will be observed to have proper medication storage and drawers will remain free of loose pills. · Medications carts for Cottage unit, Fhall and A hall were cleaned, and all loose medications were destroyed per policy. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents under the care of the facility have the potential to be affected by the alleged deficient practice. · Audit completed to ensure proper medication storage and no	06/26/2023

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	the medication cart once a week. 2. On 5/23/23 at 9:18 A.M., the F Hall medication cart was reviewed. The following loose pills were observed in the bottom of the drawers: 1 red and white oval gel capsule 1 yellow oval capsule with marking "IP 102" 1 brown with black specks circle pill with illegible markings 1 red circle pill with a triangle marking and marking "15 x2" 1 white circle pill with no marking 1 blue oval pill with marking "LU" 1 white circle pill with marking "PLIVA 433" 1 white circle with marking "2083 V" 1 yellow circle pill with a heart marking 1 green oval pill with marking "V75" 1 red circle pill with marking "Xa" 1 yellow circle pill with marking "ML88" 1 white circle pill with marking "C21" (1) 1/2 white circle pill with illegible markings 1 red triangle pill with marking "Xa" (1) 1/2 yellow circle pill with illegible markings At that time, RN (Registered Nurse) 17 indicated that loose pills should be disposed of in the sharps container. RN 17 indicated she was unsure who was responsible for cleaning the medication carts. 3. On 5/23/23 at 9:35 A.M., the A Hall medication cart was reviewed. The following loose pills were observed in the bottom of the drawers: 1 white circle pill with marking "TCL340" 1 brown with black specks circle pill with illegible markings 1 white oval pill with marking "Z16" (1) 1/2 white rectangle pill with marking "1003" (2) 1/2 white circle pill with illegible markings At that time, LPN (Licensed Practical Nurse) 3 indicated that loose pills should be disposed of in		loose medications in drawers. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Nurses will be educated by the DNS/designee on appropriate medication storage and keeping the drawers free of loose pills. · Observational rounds will be completed daily by DNS/designee daily to ensure that all open medications in carts are stored properly and no loose medications in drawers. 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 DNS/designee will be responsible for the completion of a medication storage QA Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	the drug buster. LPN 3 indicated that there is no set schedule or person responsible for cleaning out the medication carts. On 5/23/23 at 12:55 P.M., the Director of Nursing (DON) provided a current medication storage policy titled Storage and Expiration Dating of Medications, Biological's, revised 7/21/22, which indicated "Facility should ensure that the medications and biological's for each resident are stored in the containers in which they were originally received". 3.1-25(j)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			

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	Based on observation and interview, the facility failed to ensure food was stored appropriately in 2 of 2 kitchen observations. Food containers were found not labeled in the the dry storage area, walk-in freezer, and 1 shelf in the kitchen area above the sink. (Kitchen) Findings include: On 5/21/23 between 8:45 A.M. and 9:15 A.M., during the initial kitchen tour the following was observed: Dry goods storage areas: box of 1/2 full box of chocolate caked mix that was open and not labeled. 1 large multiserving bottle of Heinz Ketchup, open, and undated. 1 large multiserving bottle of Heinz Mustard, open, and undated. 1 106 ounce large dented can of pumpkin dated 10/6 walk in freezer: 5 boxes of bread on the floor box of biscuits open, not dated On 5/21/23 between 9:15 A.M. and 9:30 A.M., during the initial kitchen tour the following was observed: 2 boxes of corn starch open, not dated. During an interview on 5/21/23 at 8:48 A.M., the dietary manager acknowledge that the boxes of bread should not be on the floor but on the milk crates. During an interview on 5/25/23 at 9:37 A.M., the dietary manager indicated that once a product was opened it should be dated. He indicated once condiments are open, it should be dated and refrigerated for ninety days. A box of biscuits	F 0812	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Open items of food will be dated. · Food will be stored in a sanitary manner. · Chocolate cake mix, Heinz ketchup and mustard, can of pumpkin and boxes of biscuits were destroyed. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ·Culinary staff will be educated on food safety, food storage and label and dating of food products. ·Residents who receive meals prepared by the facility have the potential to be affected by the alleged deficient practices. ·Observational rounds were conducted by culinary manager/designee to ensure appropriate label and dating and food storage. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? ·Observations will be made by culinary manager/Designee to ensure that food in freezer is	06/26/2023

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	once opened in the freezer is dated and closed. On 5/25/23 at 10:25 A.M., a current Food Storage policy revised 5/23, was provided and indicated "...Food items that are not considered potentially hazardous including commercially prepared...ketchup, mustard.., will be labeled when opened...should be used within 90 days of opening. 12.c... foods should be covered or wrapped tightly, labeled and dated...dry storage... all items should be covered....labeled and dated." 3.1-21(i)(2) 3.1-21(i)(3)		stored appropriately and dated. ·Observations will be made by the culinary manager /Designee to ensure that food products are labeled, dated, and stored appropriately. 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 DNS/designee will be responsible for completing the food storage quality assurance tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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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 ensure infection control practices were followed for 2 of 4 residents observed for incontinence care, and during medication administration. Gloves were not changed between dirty and clean tasks during care, and glucometer machines were not cleaned according to the cleaning packet instructions and facility policy. (Resident 62, Resident 29, Hall A medication cart) Findings include: 1. On 5/23/23 at 9:51 A.M., CNA (Certified Nurse Aid) 25 and QMA (Qualified Nurse Aid) 54 were observed to assist Resident 62 with incontinence care. Prior to touching the resident, CNA 25	F 0880	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? · Facility will ensure proper cleaning of glucometer according to cleaning packet instructions on A hall. · CNA 25, QMA 54, were inserviced with skills validation completed on proper infection control protocols by DNS/Designee · RN 7 was inserviced on glucometer cleaning by DNS/Designee · The facility will ensure	06/26/2023

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	sanitized her hands with hand sanitizer and put on a clean pair of gloves. CNA 25 then pulled the curtain, put a gait belt onto Resident 62, and assisted the resident into the bed. CNA 25 undressed the resident, and removed the used brief. With the same gloves, CNA wiped the resident during an active bowel movement, put on a clean brief, pulled up his pants, pulled up the blanket, and used the bed remote to lower the bed. CNA 25 then removed her gloves and sanitized hands with hand sanitizer. CNA 25 was not observed to wash her hands with soap and water prior to or after performing incontinence care. During an interview on 5/25/23 at 8:38 A.M., the Infection Preventionist indicated staff should change gloves in between dirty and clean tasks during resident care. She then indicated while staff should wash hands after incontinence care, foam was also appropriate. 2. During an observation on 5/24/23 at 1:25 P.M., Licensed Practical Nurse (LPN) 5 performed wound care. LPN 5 put gloves on and raised Resident 29's bed, pulled the blankets up to expose resident's feet, removed Resident 29's socks, placed a towel under her feel, then removed the dressings from the right and left feet. At that time, LPN 5 sprayed wound cleanser on each heel and wiped the wound with gauze. LPN 5 failed to change gloves before wound care was performed. During an interview on 5/25/23 at 8:38 A.M., LPN 5 indicated gloves should be changed between dirty and clean care. 3. On 5/23/23 at 7:07 A.M., LPN (Licensed Practical Nurse) 3 was observed cleaning resident glucometers. 4 glucometers were observed in the top left hand drawer of the medication cart on the A Hall stacked without a barrier in between or in individual packaging. LPN 3 obtained a single use		appropriate glove use during dirty and clean tasks while providing incontinence care for residents 62 and 29. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents under the care of the facility have the potential to be affected by the alleged deficient practice. · Observational rounds were completed for proper glucometer cleaning. · Observational rounds of residents were completed and reviewed for hand hygiene and glove use. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? · Nursing staff will be educated on glucometer cleaning per cleaning packet instructions. · Nursing and C.N. A's will be educated on proper hand hygiene and glove use. · Observational rounds will be completed daily by DNS/designee to ensure proper glucometer cleaning. · Observation rounds will be completed daily by DNS/designee to ensure proper glove use and	

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	Clorox Germicidal Bleach Wipe and cleaned the equipment for 2 minutes. LPN 3 then wiped off the cleaning solution with a paper towel, wrapped the equipment in the same paper towel, and set it on the medication cart. LPN 3 proceeded to clean another glucometer the same way. At that time, the back of the Clorox Germicidal Bleach Wipe package was reviewed and instructions included, but was not limited to, clean the equipment for 3 minutes and then let stand for 3 minutes. At that time, LPN 3 indicated that each resident had their own glucometer and they were to be cleaned for 2 minutes before and after each use. On 5/23/23 at 7:15 A.M., RN (Registered Nurse) 7 was observed cleaning 2 machines from the A Hall medication cart. RN 7 wiped the glucometer for 1 minute, wrapped it in a paper towel, and then set it on the medication cart. RN 7 proceeded to clean the other glucometer the same way. On 5/23/23 at 7:47 A.M., LPN 3 took a new glucometer out of a box for a resident. LPN 3 cleaned the machine for 2 minutes with a Clorox Germicidal Bleach Wipe and wiped the equipment dry with a tissue. During an interview on 5/25/23 at 8:38 A.M., the Infection Preventionist indicated that staff should wipe the machine with bleach wipes for 3 minutes and then let them air dry. She further indicated that the cleaning solution should not be wiped off with a paper towel. On 5/23/23 at 12:55 P.M., a current glucometer cleaning and testing policy, revised 1/2016, was provided by the Director of Nursing (DON) and indicated "Wipe entire external surface of the blood glucose meter with wipe for 3 minutes ... Allow meter to completely dry".		hand hygiene during incontinent care. 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 DNS/designee will be responsible for the completion of the Hand Hygiene Quality Assurance Tool weekly times 4 weeks, monthly times 6 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If a threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee.	

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	On 5/25/23 at 7:28 A.M., a current Hand Hygiene Policy, revised 12/2021, was provided and indicated hands should be washed when visibly soiled. The policy lacked information related to glove use during care. 3.1-18(b) 3.1-18(l)			