STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155234	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESTRIDGE HEALTH CARE CENTER	125 W MARGARET AVE TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 11, 12, 13, 14, and 17, 2023 Facility number: 000139 Provider number: 155234 AIM number: 100266410 Census Bed Type: SNF/NF: 47 Total: 47 Census Payor Type: Medicare: 4 Medicaid: 43 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 28, 2023.	F 0000	**Submission of this Plan of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the Statement of Deficiencies. The Plan of Correction is prepared and submitted because of the requirement under State and Federal law.** **Please accept this Plan of Correction as our credible allegation of compliance.** **Please find enclosed this Plan of Correction for this survey.** **Due to the low scope and severity of the survey findings, please find the sufficient documentation providing evidence of compliance with the Plan of Correction. The documentation serves to confirm the Facility's allegation of compliance. Thus, the Facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance feel free to contact me.**	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Gustus	MSN, RN Consultant	05/15/2023

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	§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 appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with			

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	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 and implement a comprehensive person-centered care plan for 1 of 1 resident reviewed for edema (Resident 26). Findings include: On 4/11/23 at 2:28 p.m., Resident 26 was observed sitting up in her bed in her room. The resident was wearing a hospital gown. Resident 26 had skin that was dry, scaly, and peeling to bilateral upper extremities (arms), chest, and neck. Her bilateral upper extremities were very red and swollen. Resident 26's record was reviewed on 4/14/23 at 10:43 a.m. The profile indicated the resident diagnoses included, but were not limited to, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), type II diabetes (a chronic condition that affects the way the body processes blood sugar), hypertension (elevated blood pressure), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), anasarca (generalized swelling throughout the body), and chronic respiratory failure with hypoxia (a condition that results in the inability to effectively exchange carbon dioxide and oxygen, and induces chronically low oxygen levels or chronically high carbon dioxide levels).	F 0656	F 656 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** The noted resident was not negatively affected by the alleged deficient practice. Resident #26 care plan has been reviewed and updated to reflect the rash/edema/erythema noted on her leg's chest abdomen and bilateral upper extremities. The Resident's care plan also updated to reflect the new diagnosis of Steven Johnson Syndrome. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** No residents were affected by the alleged deficient practice; however, all residents have the potential to be affected. All residents' care plans will be reviewed to ensure that comprehensive person-centered care plans for each resident is implemented and reflects their	05/26/2023

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	A quarterly Minimum Data Set (MDS) assessment, dated 1/3/23, indicated the resident had no cognitive impairment and required a 2-person physical assist with bed mobility, transfers, and toilet use. Review of progress note, dated 3/14/23, indicated Nurse Practitioner (NP) was in the facility and noted Resident 26 had a rash/erythema (redness) noted to her legs, chest, abdomen, and bilateral upper extremities. A recommendation was made for a dermatology referral for the resident. Review of progress note, dated 3/16/23, indicated NP was in the facility today and noted Resident 26 had slight worsening rash/erythema and was spreading from chest to her neck. Review of progress note, dated 3/21/23, indicated NP was in the facility and noted Resident 26 had increased diffuse erythema to bilateral upper extremities, chest, and neck. Dry scaly rash, peeling, scattered pustules (red tender bumps with white pus at their tips) on bilateral upper extremities, chest, and neck. Review of progress noted, dated 4/11/23, indication NP was in the facility and noted Resident 26 had scaly, peeling rash all over body with erythema. The note further indicated the hospital had diagnosed the resident with Steven Johnson Syndrome (a rare serious disorder of the skin and mucous membranes). During an interview, on 4/13/23 at 2:37 p.m., Director of Nursing (DON) indicated the Assistant Director Nursing (ADON) updated care plans and or initiates them at the morning meetings. The care plans are initiated and updated if there is a change of resident's condition or a new physician's		current condition. Any noted discrepancies will be immediately corrected. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The facility's policy for "Care Plan Development and Review" has been reviewed and no changes are indicated at this time. All staff will be re-educated on the facility policies. The in-service will focus on development and implementation of comprehensive person-centered care plans and care plan updating to reflect changes in resident status. A monitoring tool has been implemented. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The DON or designee will be responsible for completing the monitoring tool to ensure that all residents have comprehensive person-centered care plans implemented and that care plans are updated per facility policy. Care Plans will be reviewed on ten residents on scheduled workdays as follows: Ten residents reviewed weekly for four weeks, then ten reviewed monthly thereafter.	

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	orders. During an interview, on 4/17/23 at 2:20 p.m., Regional Nursing Consultant indicated a care plan was not implemented for Resident 26's skin condition to her upper extremities, neck, and chest. On 4/11/23 at 9:49 a.m., the Regional Nursing Consultant provided a document, with a revised date of 9/2017, titled, "Care Plan Development and Review," and indicated it was the policy currently being used by the facility. The policy indicated, " ...the facility shall develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident's rights, that include measurable objective and timeframes to meet a resident medical, nursing, and mental and psychosocial needs that are identified on the comprehensive assessment ...." 3.1-35(a)		Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis of compliance until 100% compliance is achieved.	
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 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			

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	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 ensure a resident and their representative attended care plan meetings and that the results of the care plan meetings were reviewed with the resident and representative for 1 of 16 residents reviewed for care plan meetings (Resident 21), and failed to ensure care plans were updated for 2 of 16 residents reviewed for care plans (Residents 17 and 20). Findings include: 1. During an interview, on 4/11/23 at 11:12 a.m., Resident 21 indicated he could not remember attending a care plan meeting. He had no family who would attend in his place. Resident 21's was record reviewed on 4/17/23 at 8:47 a.m. The resident was admitted on 3/3/17, for diagnoses which included, but were not limited to, heart failure (a condition that develops when your heart doesn't pump enough blood for your body's needs) and Parkinson's disease (a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and	F 0657	F 657 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident #21. 17, and 20 were not negatively affected by the alleged deficient practice. Resident #21, and their representative were invited to a care plan meeting, and if they chose not to attend the results of the care plan meeting were reviewed with the resident #21 and representative. Resident #17 care plan reviewed and updated to reflect any infections and any recent changes in current condition. Resident #20's care plan was reviewed and updated to reflect and recent changes in condition and changes in interventions related to falls, fractures, and seizure like activity.	05/26/2023

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	difficulty with balance and coordination). A significant change Minimum Data Set (MDS) assessment, dated 9/27/22, indicated the resident had no cognitive deficit. Review of documents, titled, "Care Plan Notification Logs," dated June 2022, September 2022, December 2022, February 2023, and April 2023, provided by the Social Services Director (SSD), indicated the following: a. The June 2022 document indicated the resident and his Power of Attorney (POA) had been notified on 5/27/22, for a meeting on 6/9/22. The form lacked documentation if the resident and/or his POA had attended the meeting, and if not, the reason why. b. The September 2022 document indicated the resident and his POA had been notified on 8/25/22, for a meeting on 9/14/22. The form lacked documentation if the resident and/or his POA had attended the meeting, and if not, the reason why. c. The December 2022 document indicated the resident and his POA had been notified on 11/22/22, for a meeting on 12/21/22. The form lacked documentation if the resident and/or his POA had attended the meeting, and if not, the reason why. d. The February 2023 document indicated the resident and his POA had been notified on 1/18/23, for a meeting on 2/15/23. The form lacked documentation if the resident and/or his POA had attended the meeting, and if not, the reason why. e. The April 2023 document indicated the resident and his POA had been notified on 4/4/23, for a		***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** No residents were affected by the alleged deficient; however, all residents have the potential to be affected. An audit of all residents' care plans will be completed to ensure that all comprehensive care plans are current and reflect each resident's current condition. Review of all resident or representative invitation to care plan meeting shall be conducted. If resident or representative choose not to attend the facility shall attempt to review the results of the care plan meeting with the resident or representative all discrepancies, if any noted, will be immediately corrected. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The facility's policy for "care plan timing and revisions" has been reviewed and no changes are indicated at this time. The nurses and Social Service will be re-educated on the policy with a special focus inviting Resident and Representative to care plan meetings and if they choose not to attend to document why and	

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	meeting on 4/16/23. The form lacked documentation if the resident and/or his POA had attended the meeting, and if not, the reason why. During an interview, on 4/17/23 at 12:09 p.m., the SSD indicated neither the resident nor his representative had been present for care plan meetings for some time. There was not any documentation that the results of the care plan meetings had been discussed with the resident or his representative, since they were not present at the care plan meetings. There also was no documentation of why the resident nor his representative had not attended the meetings. During an interview, on 4/17/23 at 1:38 p.m., Resident 21 indicated he could not remember that he had ever been invited to a care plan meeting. During a telephone interview, on 4/17/23 at 2:07 p.m., the resident's POA indicated it had been quite some time since she had received an invitation to a care plan meeting. She also could not remember the last time she was notified of the results of a care plan meeting she had not attended. On 4/11/23 at 9:49 a.m., the Regional Nurse Consultant provided a document, with a revision dated of 9/17, titled, "Care Plan Development and Review." and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...11. Residents, family member(s)/resident representatives are encouraged to be involved with the development and ongoing review of the care plan. The right to participate in the development and implementation of his or her person-centered plan of care, includes, but is not limited to: (i) The right to participate in the planning process...Care Plan		attempt to review results of care plan with Resident and or Representative according to facility policies. The in-service will also focus on updating care plans to ensure the care plans are current and reflect the resident current condition. A monitoring tool has been implemented. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The DON or designee will be responsible for completing the monitoring tool to ensure that all residents and or representative are invited to care plan meetings and if they choose not to attend proper documentation and attempts to review results of care plan meeting with Residents or Representative has occurred and properly documented. Audits will occur as follows: ten residents reviewed on scheduled workdays as follows: Two times weekly for two weeks, then weekly for two weeks, then monthly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the	

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	Conference: ...4. If resident, family member(s)/resident representative are not available to be present for the...care plan conference, family member(s)/resident representative shall be contacted by the care plan coordinator or Director of Nursing to discuss the care plan. 5. Interdisciplinary care plan meetings will be held with all disciplines, residents and family member(s)/resident representatives...."2. Resident 17's record was reviewed on 4/12/23 at 2:26 p.m. The profile indicated the resident diagnoses included, but were not limited to, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), type II diabetes (a chronic condition that affects the way the body processes blood sugar), hypertension (elevated blood pressure), complete traumatic amputation at level between unspecified hip and knee (above the knee surgical amputation of left side). A quarterly Minimum Data Set (MDS) assessment, dated 4/3/23, indicated the resident had a moderate cognitive impairment and required a 2-person physical assist with bed mobility, transfers, and toilet use. A physician's order, dated 4/7/23, indicated doxycycline hyclate (antibiotic to treat bacterial infections) 100 milligrams (mg), by mouth twice daily for 7 days. A discharge summary from the wound center, dated 4/7/23, indicated a bacteria identified in wound by culture on left amputation site. A final report of laboratory test, dated 4/10/23, indicated a positive bacteria infection of Resident 17's left amputation site. The infection consisted of mixed gram-positive skin flora (bacteria with		monitoring practices on the basis of compliance until 100% compliance is achieved.	

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	thick cell walls) and a few proteus mirabilis (a species had been shown to cause infection from the colonized skin and oral mucosa of patients and personnel working in a hospital or long-term care facility). A care plan, dated 2/18/23, and revised on 4/14/23, indicated the resident had a diabetic wound to left above knee stump site. Interventions included, but were not limited to, treatment as ordered, monitor for signs or symptoms of infection, and notify physician if observed. Resident 17's record lacked a care plan addressing the infection of the left stump site and the physician's order for antibiotic use. During an interview, on 4/13/23 at 2:37 p.m., Director of Nursing (DON) indicated the Assistant Director Nursing (ADON) updated the care plans every morning during their morning meetings. She would update the care plans with any new antibiotic orders or change in resident's condition. The DON indicated Resident 17's care plan was not updated. During an interview, on 4/14/23 at 9:55 a.m., Qualified Medication Aide (QMA) 9 indicated Resident 17 would finish an antibiotic 4/14/23 for an infection to her left stump site. 3. During an observation on, 04/12/23 at 9:33 a.m., Resident 20 was sitting in recliner with her left foot elevated on her wheelchair. The bedside table was next to her with items within reach. A grey orthotic boot was on the right lower leg. Resident 20 indicated she broke her ankle after a fall at the facility. During an interview on, 04/13/23 at 9:45 a.m., the Director of Nursing (DON) indicated the resident			

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	was lowered to the floor during the incident in March. Review of the medical record indicated diagnosis of, "Unspecified physeal fracture of lower end of right fibula, subsequent encounter for fracture with routine healing," dated 03/31/2023. On, 04/13/23 at 10:10 a.m., the DON provided and identified a document titled, "Accident Incident Report and Investigation," and a document identified as an ambulatory visit summary, from the local hospital, dated 3/31/23. The reports indicated Resident 20 had fell out of her wheelchair and was lowered to the floor by staff on 3/29/23 at 7:09 p.m. A state reportable investigation, dated 3/29/23, indicated, the plan of care has been evaluated and updated accordingly as a preventative measure after the incident. On 04/13/23 at 11:25 a.m., the Corporate Nurse Consultant, provided a copy of Resident 20's care plans. The Corporate Nurse Consultant indicated when the resident fell, they recorded the information on the incident report. They ordered an x-ray of the ankle and a referral to bone and joint and to keep her immobile until she went to get the x-ray. During an interview on 4/13/23 at 12:07 p.m., the Corporate Nurse Consultant provided and identified a document dated 3/29/23 to 3/30/23, titled, "Root Cause Analysis and Three-day IDT review." The documentation within, indicated the nurse saw the resident convulsing and falling out of her chair. The nurse lowered the resident to the floor. Possible contributing factors were the chair. There were no new orders. The nursing representative met with the resident on 3/30/23 to			

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	address non-compliance and potential negative outcomes, including but not limited to the following: more falls, falls with injury, and spoke with the resident about cleaning her cluttered room. The report indicated identified the root cause of the fall as convulsions that were nurse witnessed. The newly implemented intervention was that the nurse kept the resident at the nurses' station for the rest of the shift. The day 1 IDT review, dated, 3/30/23, indicated the Nurse Practitioner (NP) came to assess the resident. The area where staff marked if the care plan was reviewed/updated was blank. Page three of the IDT review document, Day 2 IDT Review, dated 3/31/23, indicated Resident 20 was now complaining of pain and had an X-ray at Bone and Joint 3/31/23. The form indicated the care plan was reviewed and updated. Day 3 IDT review, dated 4/1/23, indicated the new/revised interventions included Bone and Joint order to wear boot times 2 weeks until next appointment. The care plan was reviewed /updated. The Director of Nursing, (DON) and the Corporate Nurse Consultant were intervivewed on 04/13/23 at 1:25 p.m. The DON indicated after a fall she took the incident report to morning meeting. The IDT (Intradisciplinary team) reviewed the incident. They looked for what "sticks out as a cause of the fall." They used a facility form to come up with cause. The DON indicated the nurse determined what interventions were to be put into place at the time of the fall. The nurse recorded the interventions on paper. The Corporate Nurse Consultant indicated interventions were included on the incident report form. The DON indicated			

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	the NP told her to educate the resident about keeping off of her foot and an order for an x-ray was obtained. On, 04/13/23 11:25 a.m. the Corporate Nurse Consultant provided a document, dated 10/2/21, titled, falls. Resident 20 had multiple risk factors for falls such as: non adherent with transfers. Dates following initial care plan entry were 1/20/22, 3/24/22, 11/7/22, 9/1/22, 12/16/22, and 3/10/23. The intervention, dated 3/31/23, indicated, "Keep boot on until follow up appt in 2 weeks". The Care plan titled, falls, dated, 10/14/21, 12/15/21, 3/1/22, 3/23/22, 5/23/22, 8/26/22, 11/27/22, and ending on 1/12/23, did not reflect updated interventions related to fall resulting in injury. The following additional care plans submitted by the corporate nurse consultant, were, toileting, ADL assist required, Last update indicated, 4/12/23. No new interventions indicated. Care plan titled "pain," last updated on 4/12/23, with focus of Right distal tubular fracture had no new interventions. The care plan record was not complete with updated focus and dated interventions for falls, fractures, or seizure like activity. Review of the assignment sheet did not reflect interventions related to falls or fracture other than to wear boot when ambulating with rolling walker. Care plan did not indicate dated immediate post fall interventions related to suspected fracture and risk for injury. The comprehensive care plan did not indicate updated approaches in accordance with resident change of condition or seizure activity.			

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	On, 04/17/23 09:55 a.m., the Corporate Nurse Consultant provided and identified a policy titled, "Care Plan Development and Review." The policy indicated, "...Communication to personnel ..., 2, care plan interventions specific to direct care personnel will be included in the direct caregiver's assignment sheet, or similar tool in use..." On, 04/14/23 at 12:29 p.m., the Corporate Nurse Consultant, provided and identified a document titled, Fall Prevention Program." The documented indicated, "... Procedure 1 ..., interventions will be addressed on the CNA (certified nurse aide), assignment sheet. 5 ..., Interventions shall then be communicated to appropriate disciplines per additions to assignment sheets, etc. 7 ..., The resident's plan of care should be updated to reflect fall prevention review, interventions implemented, or to denote current interventions remain appropriate after each fall. 11, Unit Managers/Charge Nurses are responsible to ensure interventions are implemented as discussed...." 3.1-35(a)(2) 3.1-35(e)			
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			

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	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 services to restore as much normal bowel function as possible. Based on observation, record review, and interview, the facility failed to ensure a resident's indwelling urinary catheter (a catheter which is inserted into the bladder, via the urethra and remains in to drain urine) drainage bag was kept from contact with the floor for 1 of 2 residents reviewed for catheter and urinary tract infection (UTI-common infections that happen when bacteria enters the urethra, and infect the urinary tract) (Resident 34). Findings include: During an initial pool observation, on 4/11/23 at 11:26 a.m., Resident 34's was in her recliner. Her	F 0690	F 690 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident #34 was not negatively affected by the alleged deficient practice. Resident #24's physician was contacted and has been updated of resident current condition with emphasis placed on lack of UTI or complications related to alleged citation. Resident #24 Foley catheter	05/26/2023

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	indwelling urinary catheter bag was observed hanging from her trash barrel and was in contact with the floor, next to her recliner. During a random observation, on 4/12/23 at 10:39 a.m., the resident was sitting in her recliner, in a reclined position. Her indwelling urinary catheter bag was hooked and hanging on the bracket of the footrest of the recliner. The catheter bag was observed in contact with the floor. During a random observation, on 4/12/23 at 1:24 p.m., the resident was observed sitting in her recliner, in a reclined position. Her indwelling urinary catheter bag was hooked and hanging on the bracket of the footrest of the recliner. The catheter bag was observed in contact with the floor. During a random observation, on 4/13/23 at 9:27 a.m., the resident was observed sitting in her recliner, in a reclined position. Her indwelling urinary catheter bag was hooked and hanging on the bracket of the footrest of the recliner. The catheter bag was observed in contact with the floor. During a random observation, on 4/14/23 at 9:36 a.m., staff were observed getting the resident out of bed. She was taken from her bed to her recliner. The resident's indwelling urinary catheter bag was hung from the resident's trash barrel. The catheter bag was observed to be in contact with the floor. Resident 34's record was reviewed on 4/14/23 at 8:46 a.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified dementia (a mental disorder in which a person loses the ability to think, remember, learn, make decisions, and solve problems), obstructive		drainage system was placed in a position so that bag and tubing not touching the floor and below the level of the bladder. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** No residents were affected by the alleged deficient; however, all residents that have Foley Catheters have the potential to be affected. An audit of all resident's was completed to ensure that all residents drainage systems and tubing placed in a position to ensure not touching floor and below the level of the bladder receiving the insulin as ordered and the blood glucose tests are being completed as ordered. All discrepancies, if any noted, were immediately corrected. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The facility's policy for "Urinary Drainage System" has been reviewed and no changes are indicated at this time. The nursing staff will be re-educated on the	

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	uropathy (a disorder of the urinary tract that occurs due to obstructed urinary flow), urinary retention (a condition in which urine cannot empty from the bladder), and personal history of UTIs. A significant change Minimum Data Set (MDS) assessment, dated 12/14/22, indicated the resident had severe cognitive deficit and had a urinary catheter. A catheter assessment, dated 12/19/22, and updated on 1/4/23, indicated the resident had an indwelling urinary catheter that was initiated in the hospital on 12/10/22, due to diagnosis of obstructive uropathy leading to retention of urine. A care plan, dated 11/21/22 and updated on 4/6/23, indicated the resident was at risk for developing UTIs. A care plan, dated 12/16/22 and updated on 4/6/23, indicated the resident required a Foley (a type of indwelling urinary catheter) due to a diagnosis of obstructive uropathy. A review of the resident's current medication regimen indicated the resident was not on any antibiotic (ATB-medicines that fight infections caused by bacteria) and no documentation of a current UTI was observed. During an interview, on 4/14/23 at 10:06 a.m., Certified Nursing Assistant (CNA) 7 indicated she had noticed that the resident's catheter bag was in contact with the floor and understood that it should not be in contact with the floor. During an interview, on 4/14/23 at 11:18 a.m., the Nurse Consultant indicated urinary catheter bags		facility policies with a special focus on positioning drainage bag and tubing so that not touching the floor. A monitoring tool shall be implemented. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The DON or designee will be responsible for completing the monitoring tool to ensure that all residents that have Foley catheters are positioned so that the bag and tubing are not touching the floor. The associated audits will be reviewed on all residents with catheters on scheduled work days as follows: Three times weekly for two weeks, then weekly for two weeks, then monthly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings on an ongoing basis. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis of compliance until 100% compliance is achieved.	

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	and/or tubing should always be placed in a way so as not to come into contact with the floor. On 4/14/23 at 11:26 a.m., the Nurse Consultant provided a document, with a revision date of 1/20, titled, "Urinary Drainage Bag Maintenance," and indicated it was the policy currently being used by the facility. The policy indicated, "...Rule: ...Urinary drainage bag should not be allowed to touch the floor...Use The Following Procedure To Secure The Drainage Bag...2...Do not allow the urinary drainage bag or tubing to touch the floor...." 3.1-41(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure nebulizer tubing and a mouthpiece for nebulizer medication administration were dated, timed, and signed for 1 of 1 resident observed for respiratory equipment. Findings include: During an initial pool observation on, 04/12/23 at 09:33 a.m. Resident 20 was sitting in her recliner in her room with her right leg propped on wheelchair	F 0695	F 695 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident #20was not negatively affected by the alleged deficient practice. Resident #20 was assessed and displays no SXS of	05/26/2023

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	in front of her. The nebulizer machine was observed on the floor behind the resident's recliner. Tubing and mouthpiece used to administer medication were on the floor. During a random observation on, 04/13/23 at 10:08 a.m. The nebulizer machine remained on the floor behind the resident's recliner with the tubing on the floor. Resident 20's record was reviewed on 4/13/23 at 10:30 a.m., Diagnosis included, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). During a random observation, on 04/14/23 at 09:10 a.m., the nebulizer machine and tubing were on the floor, behind the resident's recliner. During interview, on 04/14/23 at 10:58 a.m., the Director of Nursing (DON) observed a nebulizer machine with tubing and mouthpiece laying on the floor. The DON indicated this was not the property of the facility and the resident did not have an order for a nebulizer treatment. The facility policy for storage of facility equipment would be that they would place tubing in a baggie and date it. A physician's order, dated 10/10/22, indicated Albuterol sulfate solution for nebulization; 2.5 milligram (mg) per (/) 3 milliliter (mL) (0.083 %); give 1 vial via nebulizer every 6 hours as needed. The Minimum Data Set (MDS) assessment, dated 4/11/23., indicated the nebulizer treatment had not been administered in the last 14-day review period.		respiratory infection or complications. Resident #20's physician was updated on resident current condition. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** No residents were affected by the alleged deficient; however, all residents receiving nebulizer medications have the potential to be affected. An audit of all residents receiving nebulizer medications shall be completed to ensure that the all nebulizer equipment is stored properly, and not on the floor as per facility policy. Shall any concerns be identified; immediate corrective action will follow. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The facility's policy for "Nebulizer Treatment" has been reviewed and no changes are indicated at this time. The nursing staff have been re-educated on the facility policies with a special focus on proper storage of nebulizer equipment when not in use. A monitoring tool shall be implemented.	

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	A review of Resident 20's care plan, dated 10/1/21, indicated a care plan focus of Chronic Obstructive Respiratory Disease, (COPD). The record did not indicate a date of each intervention. An intervention, dated 10/1/23, Albuterol per MD order indicated under focus. On 04/14/23 11:24 a.m. the Corporate Nurse Consultant, provided and identified a document as a current facility policy, dated 10/25/2015, titled, Nebulizer Treatment Documentation. The policy indicated, "Procedure, ...9, Disassemble device and rinse the mouthpiece and nebulizer cup with sterile water. Shake mouthpiece and nebulizer cup to remove excess water. Place equipment in a bag to be maintained in residents' room ...." 3.1-47(a)(6)		***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The DON or designee will be responsible for completing the monitoring tool to ensure all resident's nebulizer equipment is stored properly as per facility policy. The audits will be scheduled on workdays as follows: at least five residents will be audited two times weekly for two weeks, then weekly for two weeks, then monthly thereafter. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis of compliance until 100% compliance is achieved.	
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical,			

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	mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on observation, interview, and record review, the facility failed to ensure staff were competent with knowledge of cleaning the glucometer (blood glucose meter, an instrument for measuring the concentration of glucose [sugar] in the blood) for 1 of 1 observation of blood glucose monitoring (Resident 46). Finding includes: During an observation of blood glucose monitoring, on 4/14/23 at 11:12 a.m., Qualified	F 0726	F 726 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** None of the residents were negatively affected by the alleged deficient practice. Nursing staff involved were immediately re-educated regarding facility a policy	05/26/2023

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	Medication Aide (QMA) 12 completed the Accuchecks (blood glucose monitoring) on Resident 46 with the resident's glucometer, then proceeded to the medication cart, retrieved a disinfecting wipe, briefly wiped the glucometer with the wipe, immediately placed the wet glucometer into the case, and zipped close the case. QMA 12 indicated, she was unsure how to clean the glucometer. On 4/14/23 at 11:24 a.m., the Nurse Consultant indicated staff should clean and disinfect the glucometer after every Accuchecks. QMA 12 should have cleaned the glucometer for 30 seconds to a minute on a clean barrier, then placed the dried glucometer into glucometer case after the Accuchecks was completed. On 4/14/23 at 12:50 p.m., the Nurse Consultant provided and identified an undated document as a current facility policy, titled, "Evencare G2 Blood Glucose Monitoring System." The policy indicated, "...Cleaning and disinfecting your meter...1. Wash hands with soap and water and dry thoroughly...2. Inspect for blood, debris, dust, or lint anywhere on the meter...3. To clean the meter, use a moist (not wet) lint-free cloth dampened with mild detergent. Wipe all external areas of the meter...including both front and back surfaces until visibly clean...4. To disinfect your meter, clean the meter with one of the validated disinfecting wipes listed below...Medline Micro-Kill Bleach Germicidal Bleach Wipes...Wipe all external areas of the meter...including both front and back surfaces until visibly clean...Allow the surface of the meter or lancing device to remain wet at room temperature for the contact time listed on the wipe's directions for use...." At the same time, the Nurse Consultant provided and identified a document as a current facility policy		regarding cleansing of glucometer equipment Resident #26 was assessed for potential complication, and Resident #26's physician was updated on Resident's current condition. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** There were no residents affected by this alleged deficient practice, but all residents with blood sugar checks via glucometer have the potential to be affected. A Nursing staff in-service will be conducted with focus on cleaning glucometer equipment after use per the facility policies. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The facility's policy for "glucometer care/cleansing" has been reviewed and no changes are indicated at this time. The nursing staff will be re-educated on the facility policies with a special focus on cleaning glucometer equipment after use. A monitoring tool shall be implemented. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur,***	

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	and the facility's wipe's directions for use, titled, "Micro-Kill Bleach Germicidal Bleach Wipes," which indicated, "...Cleaning Procedure: Blood/body fluids must be thoroughly cleaned from surfaces/objects before application of Micro-Kill Bleach Germicidal Bleach Wipes...Contact Time: Allow surface(s) to remain visibly wet for 30 seconds to kill the bacteria and viruses...." 3.1-14(i)		***i.e., what quality assurance program will be put into place?*** The DON or designee will be responsible for completing the monitoring tool to ensure glucometers are cleansed according to facility policies. This monitoring will occur on scheduled workdays as follows: review of cleansing glucometer equipment twice weekly for two weeks and then weekly for two weeks and then monthly thereafter. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring o on the basis of compliance until 100% compliance is achieved.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure monitoring of an anticoagulant medication (a medication used to prevent and treat blood clots in blood vessels and the heart) for 1 of 5 residents reviewed for unnecessary medications (Resident 12). Findings include: On 04/11/23 11:30 a.m., Resident 12's medical record, dated 8/1/18, indicated a diagnosis of coronary artery disease (CAD - a condition that affects your coronary arteries, which supply blood to your heart, plaque buildup narrows or blocks one or more of your coronary arteries). The most recent Minimum Data Set (MDS) assessment, dated 4/3/23, identified the resident used an anticoagulant. A Physicians order, dated 7/25/22, indicated Resident 12 took one tablet of Aspirin [OTC] tablet, chewable; 81 mg; by mouth by mouth every morning. A review of the medical record did not indicate a system in place for monitoring of side effects or adverse effects related to administration of anticoagulant medication.	F 0757	F757 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident #12 was not negatively affected by the alleged deficient practice. Resident #12 was assessed for possible complications related to anticoagulant medication. No complications were noted. Resident #12's physician was updated regarding resident current condition. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** There were no residents affected by this alleged deficient practice, but all residents on anticoagulant medications have the potential to be affected. An audit has been completed to ensure that all	05/26/2023

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	A review of Medication administration record (MAR) did not indicate monitoring of side effects of the anticoagulant medication. On, 04/13/23 at 11:25 a.m., Review of Resident (12) care plan, titled, anticoagulant, dated 5/8/19, indicated intervention, " ...5...in the event of occult or overt bleeding hold the medication until the physician has been notified. Signs of occult or overt bleeding include, bleeding gums, bruising, tarry stools, hematemesis-coffee ground emesis and hematuria...." A care plan identified as anticoagulant had six interventions. Number two of the six interventions indicated to monitor for signs and symptoms of adverse reaction: diarrhea, headache, hemorrhage, hepatitis, fever, rash, bruises easily. On, 04/17/23 at 8:47 a.m., the Corporate Nurse Consultant provided and identified a document, dated 10/2024, titled, Nursing Policies and Procedures, Anticoagulant Therapy. Purpose: Awareness of anticoagulant therapy encourages monitoring and early detection of adverse reactions. On, 04/17/23 at 9:57 a.m., the Corporate Nurse Consultant, provided and identified a document as a current facility policy, titled, "Care Plan Development and Review." The Corporate Nurse Consultant indicated this was their policy for review of medication side effects. They monitored for psychotropic medications. They did not sign off anything for monitoring of side effects of anticoagulants. This was identified in the care plan. On, 04/17/23 at 10:00 a.m., the resident care plan		residents on anticoagulant medication are being properly monitored for potential complications. A Nursing staff in-service will be conducted with focus on proper monitoring of complication of all resident's receiving anticoagulant medications per the facility policies. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The facility's policy for "Anticoagulant Medications" has been reviewed and no changes are indicated at this time. The nursing staff will be re-educated on the facility policies with a special focus on monitoring residents for potential side effects when receiving anticoagulant therapy, and how to indicate proper monitoring. A monitoring tool shall be implemented. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The DON or designee will be responsible for completing the monitoring tool to ensure that residents receiving anticoagulant medications are properly monitored for potential adverse	

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	indicated they were to monitor for side effects. On, 04/17/23 at 10:39 a.m., the Corporate Nurse Consultant provided and identified a document titled, "Wing: South," and indicated this was the assignment sheet for residents on the south wing. A review of document did not indicate any monitoring of anticoagulant side effects or monitoring for signs and symptoms of occult or overt bleeding. The corporate nurse consultant indicated they did not have a place to record it. If there was an issue the MD would be notified. On 04/17/23 at 11:57 a.m. the Corporate Nurse Consultant indicated she had spoken with provider of Matrix care. There was a place in the MD orders for monitoring of anticoagulant. When they ran a report, it was overlooked for this resident. 3.1-48(a)(3)		effects. This monitoring will occur on scheduled work days as follows: review 10 residents on anticoagulants twice weekly for two weeks and then 10 residents weekly for two weeks and then 10 residents monthly thereafter. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring on the basis of compliance until 100% compliance is achieved.	
F 0761 SS=D 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 and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			

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	§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 medications were labeled with the updated physician's order (Resident 46), and a supplement medication in the medication cart was labeled with the resident's name and room number (Resident 47) for 2 of 2 medication administration observations. Findings include: 1. During an observation of administration of insulin medication, on 4/14/23 at 12:01 p.m., Licensed Practical Nurse (LPN) 3 indicated Resident 46 was to receive 15 units of Humalog insulin medication subcutaneous (under the skin) injection three times a day before meals. The medication label on the insulin container indicated to inject 10 units subcutaneous three times a day before meals. LPN 3 indicated the physician's order for the Humalog insulin medication had changed, on 4/11/23, and a sticker should have been placed on the container to indicate the directions had changed for the insulin medication and she placed a label on the container which indicated, "change of directions." Resident 46's record was reviewed on, 4/17/23 at 10:43 a.m. Diagnosis included, but was not limited	F 0761	F 761 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Residents #46 and #47 were not negatively affected by the alleged deficient practice. Resident #46 and #47's medications, and supplements were audited to ensure that all medications and supplements were properly labeled, and direction change stickers placed when appropriate. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** There were no residents affected but all residents have the potential to be affected by this alleged deficient practice. An audit was conducted on all residents' medications to ensure that all medications and supplements are	05/26/2023

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	to, diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). A care plan, initiated on 1/3/23, indicated the resident had a diagnosis of diabetes mellitus and the resident was at risk for hyperglycemia (high blood sugar) and/or hypoglycemia (low blood sugar) with an intervention included, but not limited to, administer Humalog insulin per physician's order. A physician's order, dated 4/11/23, indicated to administer Humalog insulin solution 15 units subcutaneous, before meals, for diabetes mellitus. On 4/17/23 at 9:35 a.m., the Nurse Consultant indicated, when a physician order was changed, the nurse receiving the prescription change will record the change and attach a "change of directions" label on the medication container. At that time the Nurse Consultant provided and identified an undated document as a current facility policy, titled "Drug Label." The policy indicated, "...Prescription Label Changes...The nurse receiving the prescription change will record the change and attach a 'change of directions' label provided by the pharmacy to the package...The new order must be communicated to the pharmacy as other new prescription order via fax on a telephone order form...The 'change of direction' label will be maintained on the current package until a refill is needed and ordered. The refilled medication will be labeled with the new directions...." 2. During an observation of administration of supplement medication, on 4/17/23 at 9:24 a.m., Qualified Medication Aide (QMA) 14 indicated there was not a label with a resident's name on the container of the Sugar Free Active Liquid Protein		properly labeled, or direction change stickers applied when appropriate as per the facility Policy. If deficient practice noted, it was immediately corrected. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The facility's policy for "Medication Labeling" has been reviewed and no changes are indicated at this time. The nursing staff have been re-educated on the facility policies with a special focus on medication and supplement labeling and applying dosage change sticker when appropriate according to facility policy. A monitoring tool shall be implemented. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The DON or designee will be responsible for completing the monitoring tool to ensure that all residents' medications are properly labeled and if dosage change sticker should have been applied one has been applied. The associated audits will be completed on scheduled workdays as follows: Two times weekly for two weeks, then weekly for two weeks, then monthly thereafter.	

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	supplement, but Resident 47 was scheduled, per a physician's order, to receive 60 milliliters (mL) of the Sugar Free Active Liquid Protein for wound healing. QMA 14 placed 60 mL of the supplement into a medication cup and administered the supplement to Resident 47. Resident 47's record was reviewed on, 4/17/23 at 10:03 a.m. Diagnosis included, but was not limited to, complete traumatic amputation (removal) of one right lesser toe. A care plan, initiated on 4/3/23, indicated the resident had a non-pressure related skin condition on the right foot with an intervention included, but not limited to, administer sugar free liquid protein per physician's order. A physician's order, dated 4/10/23, indicated to administer Sugar Free (SF) Active Liquid Protein 60 mL three times a day. On 4/17/23 at 10:06 a.m., the Nurse Consultant indicated, all medications and supplements, including the over the counter medication of the Sugar Free Active Liquid Protein, should have a label with the resident's name and room number on the container. The Nurse Consultant provided and identified an undated document as a current facility policy, titled "Drug Label." The policy indicated, "...Non-prescription medication not dispensed from the pharmacy must be in the manufacturer's original, sealed container and identified with the resident's name and room number...." 3.1-25(j) 3.1-25(m) 3.1-25(n)		Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings on an ongoing basis. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices on the basis of compliance until 100% compliance is achieved.	

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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. Based on observation, interview, and record review, the facility failed to ensure proper handling of food during 1 of 2 dining observations. Findings include: During a dining observation, on 4/11/23 at 12:14 p.m., Certified Nursing Aide (CNA) 8 served an unidentified resident his tray of food. CNA 8 took the resident's roll out of the package with bare hands and placed it on the plate. CNA 8 then began to feed the resident his food. CNA 8 held the outside skin of the baked potato with bare hands and fed the resident the baked potato.	F 0812	F812 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** None of the residents were negatively affected by the alleged deficient practice. Nursing staff have been re- educated regarding serving food and drink according to facility policy. ***How other residents having the***	05/26/2023

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	During an interview, on 4/13/23 at 1:42 p.m., Qualified Medication Aide (QMA) 12 indicated staff should not be touching residents' food with their bare hands. During an interview, on 4/14/23 at 11:46 a.m., the Dietary Manager (DM) indicated staff should not be touching residents' food with their bare hands. On 4/14/23 at 12:08 pm., the DM provided a document, with a date of May 2018, titled, "Glove Use & Meal Service," and indicated it was the policy currently being used by the facility. The policy indicated, " ...4. Employees may not touch ready to eat foods with bare hands, gloves must be worn ...." 3.1-21(i)(3)		***potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** There were no residents affected by this alleged deficient practice, but all residents have the potential to be affected. A Nursing staff in-service will be conducted with focus on serving food and drink items per the facility policies. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The facility's policy for "Dining Services" has been reviewed and no changes are indicated at this time. The nursing staff will be re-educated on the facility policies with a special focus on serving resident foods and drinks during dining services. A monitoring tool shall be implemented. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The DON or designee will be responsible for completing the monitoring tool to ensure food and drink is served per facility policies and without touching food with bare hands. This monitoring will occur on scheduled workdays as follows: review of serving dining	

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			room twice weekly for two weeks and then weekly for two weeks and then monthly thereafter. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring of dining services on the basis of compliance until 100% compliance is achieved.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-			

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	(i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed			

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	professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to ensure the documentation of psychotropic medications (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) administered for 1 of 5 residents reviewed for unnecessary medications (Resident 24). Findings include: 1. Resident 24's record was reviewed on 4/13/23 at 10:02 a.m. The profile indicated the resident's diagnoses included, but were not limited to, schizoaffective disorder (a mental health problem where you experience psychosis as well as mood symptoms), bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), and visual hallucinations (seeing things that aren't real, like objects, shapes, people, animals or lights). A significant change Minimum Data Set (MDS) assessment, dated 3/8/23, indicated the resident had no cognitive deficit and received antipsychotic medications (the main class of drugs used to treat people with schizophrenia). A physician's order, dated 3/7/23, indicated Seroquel (antipsychotic medication) 300 milligrams (mg), 2 tablets, by mouth at bedtime. The March 2023 Medication administration record (MAR) lacked documentation of the evening dose	F 0842	F842 ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident #24 was not negatively affected by the alleged deficient practice. An audit was conducted to ensure that Resident #24 is receiving medication as ordered. Resident #24's Physician has been updated on Residents current condition. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?*** There were no residents affected by this alleged deficient practice, but all residents have the potential to be affected. A Nursing staff in-service will be conducted with focus on proper documentation of medication after administration and facility policies regarding how to document medications in the event of internet failure. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?***	05/26/2023

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	being administered on 3/10/23 and 3/24/23. No documentation of resident refusal observed. 2. Resident 24's profile indicated the resident's diagnoses included, but were not limited to, polyneuropathy (the simultaneous malfunction of many peripheral nerves throughout the body), pain unspecified, irritable bowel syndrome (a disorder of the intestines commonly marked by abdominal pain, bloating, and changes in a person's bowel habits), constipation unspecified (a condition in which stool becomes hard, dry, and difficult to pass, and bowel movements don't happen very often), and insomnia (common sleep disorder causing difficulty falling asleep). A significant change Minimum Data Set (MDS) assessment, dated 3/8/23, indicated the resident had no cognitive deficit, reported frequent pain rated at 6 out of 10, and received opioid medication (a class of drug used to reduce moderate to severe pain). A physician's order, dated 8/5/22, indicated hydrocodone-acetaminophen (a combination preparation of the analgesic [a drug that reduces pain] acetaminophen and the opioid hydrocodone) 5-325 milligrams (mg) tablet, 1 by mouth daily for pain. The March 2023 medication administration record (MAR) lacked documentation of the evening dose having been administered on 3/10/23 and 3/24/23. No documentation of resident refusal was observed. A physician's order, dated 9/19/22, indicated lactulose solution (a synthetic sugar used to treat constipation) 10 grams/15 milliliters (ml), by mouth twice daily. The March 2023 MAR lacked documentation of the evening dose having been administered on 3/10/23. No documentation of		The facility's policy for "Medication Administration" has been reviewed and no changes are indicated at this time. The nursing staff will be re-educated on the facility policies with a special focus on proper documentation of medication administration and how to document in the event of internet failure according to facility policies. A monitoring tool shall be implemented. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** The DON or designee will be responsible for completing the monitoring tool to ensure medication administration is properly documented according to facility policies and in the event of internet outage medications are documented as per facility policy. This monitoring will occur on scheduled workdays as follows: review documentation of medication administration at least twice weekly for two weeks and then weekly for two weeks and then monthly thereafter. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring on the basis of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155234	A. BUILDING 00 B. WING	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	resident refusal was observed. A physician's order, dated 10/24/22, indicated house barrier cream (a product applied directly to the skin surface to help maintain the skin's physical barrier, providing protection from irritants and preventing the skin from drying out) to buttocks, every shift. The March 2023 MAR lacked documentation of the evening dose having been applied on 3/10/23 and 3/24/23. No documentation of resident refusal was observed. A physician's order, dated 10/28/22, indicated Biofreeze 4% gel (provides penetrating pain relief for sore muscles, backaches, sore joints, and arthritis), apply to bilateral (both sides) shoulders, back and hips, twice daily. The March 2023 MAR lacked documentation of the evening dose having been applied on 3/10/23. No documentation of resident refusal was observed. A physician's order, dated 2/13/23, indicated Melatonin (helps control the body's sleep cycle) 3 mg. Give with 5 mg to equal 8 mg total dose, at bedtime. The March 2023 MAR lacked documentation of the evening dose having been administered on 3/10/23. No documentation of resident refusal was observed. A physician's order, dated 2/27/23, indicated Linzess capsule (a medication used in adults to treat irritable bowel syndrome with constipation) 290 micrograms (mcg) daily. The March 2023 MAR lacked documentation of the evening dose having been administered on 3/10/23. No documentation of resident refusal was observed. During an interview, on 4/13/23 at 10:22 a.m., the Director of Nursing (DON) indicated they had been having issues with some of the older nurses		compliance until 100% compliance is achieved.	

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	working within the electronic medical record (EMR) system. On 4/13/23 at 12:04 p.m., the Corporate Nurse provided a document, with a revision date of 4/17, titled, "Medication Administration," and indicated it was the policy currently being used by the facility. The policy indicated, "...Guidelines for Medication Administration: ...21. Always record the dose of medication on the MAR after resident consumption. 22. Refusal of medication(s) will be identified by...documenting on the...MAR...the date, time, and reason, if known...." 3.1-50(a)(1) 3.1-50(a)(2)			