STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155621	A. BUILDING 00 B. WING	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVER BEND NURSING AND REHABILITATION	3400 STOCKER DR EVANSVILLE, IN 47720

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00445556. Complaint IN00445556 - No deficiencies related to allegations are cited. Survey dates: November 6, 7, 8, 12, 13,14, 2024. Facility number: 000442 Provider number: 155621 AIM number: 100266570 Census Bed Type: SNF/NF: 54 SNF: 6 Total:60 Census Payor Type: Medicare:4 Medicaid:50 Other:3 Total:60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 26, 2024.	F 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 12/13/24, the annual licensure survey completed on November 14, 2024. The facility respectfully asks for a desk review.	
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice Based on interview and record review, the facility failed to ensure SNF-ABN (Skilled Nursing Facility-Advanced Beneficiary Notice) and NOMNC (Notice of Medicare Non-Coverage) Forms were provided following the end of	F 0582	**It is the practice of this facility to assure that residents are provided with the SNF-ABN and NOMNC forms following the end of Medicare skilled**	12/13/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Eric Ross	Administrator	12/12/2024

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	Medicare skilled services for 2 of 2 residents who discharged from Medicare services and remained in the facility. (Resident 9 and Resident 215) Findings include: 1. On 11/12/24 at 10:35 A.M., the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review Forms were reviewed. The form indicated Resident 9 received Medicare Part A Skilled Services starting 8/26/24. The form indicated the last covered day of Part A services was 10/18/24. The form indicated Resident 9 did not receive a SNF-ABN (Skilled Nursing Facility-Advanced Beneficiary Notice) Form because she skilled out of therapy services. Resident 9 was provided a Notice of Medicare Non-Coverage (NOMNC) Form, dated 10/14/24, which indicated Resident 9's Medicare coverage would end on 10/18/24. On 11/12/24 at 10:40 A.M., the Social Services Director (SSD) indicated that Resident 9 remained in the facility. The SSD further indicated that Resident 9 did not receive a SNF-ABN form and should have. 2. On 11/12/24 at 10:35 A.M., the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review Forms were reviewed. The form indicated Resident 215 received Medicare Part A Skilled Services starting 6/24/24. The form indicated the last covered day of Part A services was 7/31/24. The form indicated she did not receive SNF-ABN (Skilled Nursing Facility-Advanced Beneficiary Notice) and NOMNC (Notice of Medicare Non-Coverage) forms because she was discharged from therapy before the end of her covered days.		**services. The corrective action taken for those residents found to be affected by the deficient practice include:** Resident 9 remains in the facility. Resident 215 discharged from the Facility. **Other residents that have the potential to be affected have been identified by:** An Audit was completed on all residents who received Medicare Part A Skilled Services And skilled out of Medicare services In the past 30 days. No issues Were identified. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** Social Services Director, Business Office Manager, and Director of Rehab were Re-educated by Administrator That any resident who is receiving Medicare Part A skilled Services Must be notified in writing with A SNF-ABN and NOMNC when they skill out of therapy services. **The corrective action taken to monitor performance to assure**	

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	On 11/12/24 at 10:40 A.M., the Social Services Director (SSD) indicated that Resident 215 remained in the facility following the end of Medicare Part A coverage. She further indicated her last dated NOMNC was in 2022 and she had not received a NOMNC or SNF-ABN since then. At that time, the SSD indicated that she was still trying to learn about the Medicare Part A coverage process and did not fully understand the requirements. On 11/12/24 at 1:47 P.M., the Administrator provided a current Beneficiary Notices: SNF ABN and Notice of Medicare Non-Coverage (NOMNC) policy, dated 4/15/18, that indicated "A Notice of Medicare Non-Coverage (NOMNC) and SNF ABN must be delivered by the SNF at the end of a Part A stay ... The SNF ABN is issued when Part A services end and resident is staying in facility post Medicare stay". 3.1-4(f)(2)		**compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews all residents (if applicable) to assure that a SNF-ABN and NOMNC has been issued for any resident who received Medicare Part A Skilled Services and has skilled out of Medicare services. The Administrator, or designee, will complete this tool Weekly x 6 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements Based on record review and interview the facility failed to provide the proper work for a resident emergently transferred to the hospital in 1 of 1 residents reviewed for hospitalization. (Resident 7) Findings include: On 11/08/24 at 7:34 A.M., Resident 7's clinical record was reviewed. Diagnoses included but were not limited to fracture of neck and disorders of bone density.	F 0622	**It is the practice of this facility to assure that residents who transfer/discharge from the facility have transfer paperwork in their medical record The corrective action taken for those residents found to be affected by the deficient practice include:**	12/13/2024

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	The clinical record lacked any transfer paperwork when Resident 7 was emergently transferred to the hospital after a fall that resulted in a fractured neck. During an interview on 11/8/24 at 2:00 P.M., the DON (Director of Nursing) indicated that she could not locate any transfer forms and that there should have been papers sent with resident to the hospital. During an interview on 11/14/24 at 10:30 A.M., the DON indicated that the face sheet, bed hold policy, and other information should be sent when a resident was sent to the hospital. 3.1-12(a)(5) 3.1-12(a)(9)(A)(B)(C)		Resident 7 remains in the facility **Other residents that have the potential to be affected have been identified by:** An audit was completed by the DON for all residents who were transferred to the hospital in the past to ensure that the clinical record contained transfer paperwork. All issues were corrected. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** All nurses were educated by DON or Administrator that the clinical record must contain transfer paperwork when transferring a resident to the hospital. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews all residents (if applicable) to assure that transfer paperwork is included in the resident's medical record	

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			when they are transferred to the hospital. The Administrator, or designee, will complete this tool Weekly x 6 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on record review and interview the facility failed to notify the Ombudsman office in 1 of 4 residents reviewed for hospitalization. (Resident 7) Findings include: On 11/08/24 at 7:34 A.M., Resident 7's clinical record was reviewed. Diagnoses included but were not limited to fracture of neck and disorders of bone density. The Current Quarterly MDS (Minimum Data Set) Assessment indicated Resident 7 is moderately cognitively impaired. The clinical record lacked any transfer paperwork when Resident 7 was emergently transferred to the hospital after a fall that resulted in a fractured neck on 7/27/24.	F 0623	**It is the practice of this facility to assure that transfer notification is sent to the Ombudsman. The corrective action taken for those residents found to be affected by the deficient practice include:** Resident 7 remains in the facility. **Other residents that have the potential to be affected have been identified by:** An audit was completed on all residents who transferred to the hospital in the last 30 days for notification to the ombudsman of	12/13/2024

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	The clinical record lacked any transfer information sent to the ombudsman for the hospitalization on 7/17/24. During an interview on 11/8/24 at 2:00 P.M., the DON (Director of Nursing) indicated that she could not locate any transfer forms and that there should have been papers sent with resident to the hospital. During an interview on 11/12/24 at 1:03 P.M., the Social Service Director indicated she needs to send the list after each of the d/c or transfer During an interview on 11/13/24 at 8:30 A.M., the Social Service Director indicated she does not have the transfer notification for the 7/27/24 incident that should have been sent to the Ombudsman. On 11/13/24 at 3:15 P.M., the Social Service Director provided an email from Ombudsman Office that indicated "... when residents are transferred on an emergency basis to an acute care facility and are expected to return to the building, the information regarding the transfer can be provided in one monthly list to the State LTC (Long Term Care) Ombudsman portal..." 3.1-12(a)(6)(A)(iv)		the transfer. No other issues were noted. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** Administrator re-educated the Social Services Director that all transfers to the hospital must be reported to the Ombudsman. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews all residents (if applicable) to assure that transfers to the hospital are reported to the Ombudsman. The Administrator, or designee, will complete this tool weekly x 6 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	

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F 0625 SS=E Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on record review and interview, the facility failed to provide notification of transfer and bed hold policy to residents or their representative in 4 of 4 residents reviewed for hospitalizations. (Resident 7, Resident 51, Resident 53, Resident 57) Findings include: 1. On 11/08/24 at 7:34 A.M., Resident 7's clinical record was reviewed. Diagnoses included but were not limited to fracture of neck and disorders of bone density. The Current Quarterly MDS (Minimum Data Set) Assessment indicated Resident 7 is moderately cognitively impaired. The clinical record lacked any transfer paperwork and bed hold policy when Resident 7 was emergently transferred to the hospital after a fall that resulted in a fractured neck on 7/27/24. During an interview on 11/8/24 at 2:00 P.M., the DON (Director of Nursing) indicated that she could not locate any transfer forms and that there should have been papers sent with resident to the hospital. 2. On 11/08/24 at 2:08 P.M. Resident 51's clinical record was reviewed. The most recent Quarterly MDS (Minimum Data Set) Assessment on 9/17/2024 indicated the resident was cognitively intact, was independent in mobility, always continent, and had diagnoses that included but was not limited to cellulitis. Resident 51 had hospitalizations on 4/28/2024, 5/7/2024, and 11/8/2024. The record lacked a bed	F 0625	**The corrective action taken for those residents found to be affected by the deficient practice include:** A licensed nurse transferred resident #7 to the hospital on 7/26/2024. Resident #7 returned to the center on 7/27/2024. Resident #7 has had no other transfers out of the center. A bed hold policy was sent out to the hospital with Resident # 51 on 11/8/2024. Resident #51 returned to the center on 11/9/2024 and remains in the facility. Resident #53 had a transfer out of the facility on 11/19/2024. A bed hold policy was sent out with resident #53 by the licensed nurse. Resident #53 returned to the facility on 11/19/2024 and remains in the facility. Resident # 57 no longer resides in the facility. **Other residents that have the potential to be affected have been identified by:** The Director of Nursing (DON), Administrator (ADM)/designee conducted an audit of all transfers out of the center in the past week to determine a bed hold policy was sent with the resident during	12/13/2024

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	hold policy being provided to the resident for all three of the hospital transfers. 3. On 11/12/24 at 10:51 A.M., Resident 53's clinical record was reviewed, the diagnoses included, but were not limited to, diabetes mellitus type two and peripheral vascular disease. The most recent Quarterly MDS (Minimum Data Set) Assessment on 10/31/2024 indicated the resident was cognitively intact, used a wheelchair, required substantial to maximum assistance with transfering and toileting, required partial to moderate assistance with showering, and required supervision with bed mobility, was incontinent, and had an amputation. Resident 53's clinical record indicated hospitalizations on 9/17/2024 and 10/15/2024. The record lacked a bed hold policy being provided to the resident for both of the hospital transfers. 4. On 11/08/24, at 1:51 P.M., Resident 57's clinical record was reviewed, diagnoses included, but was not limited to, cancer, and hospice care. The most recent Quarterly MDS (Minimum Data Set) Assessment on 9/26/2024 indicated the resident was not cognitively intact. Resident 57's clinical record indicated they had been hospitalized on 11/5/2024. The record lacked a bed hold policy being provided to the resident for the hospital transfer. On 11/12/24 at 4:00 P.M., the DON (Director of Nursing) provided a current, non-dated policy "Changes in Resident Condition or Status." The policy indicated the facility will notify the resident...of changes in the resident condition or status...nursing service will be responsible for notifying the resident...as each case applies...the		discharge on 11/18/2024. All residents transferred to the hospital had a Bed Hold Notice policy sent upon discharge with a copy uploaded to their medical record. **The measures or systematic changes** **that have been put into place to** **ensure that the deficient practice** **does not recur include:** The DON or designee conducted reeducation with all licensed nurses to include agency nurses beginning on 11/18/2024 regarding the center policy, Bed Hold Notice. The reeducation included A Bed Hold Notice will be given to residents who are transfers with a copy made for the resident's medical record. **The corrective action taken to monitor** **performance to ensure compliance** **through quality** assurance is: The DON, ADM or designee will conduct daily audits of all resident transfers to the	

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	resident is involved in an accident that results in injury...it is necessary to transfer the resident to a hospital..." 3.1-12(a)(6)(A) 3.1-12(a)(25)		hospital x2 weeks including weekends, then 3x weekly for 2 weeks, then weekly x8 weeks and once monthly x1 month with any concerns identified corrected upon discovery. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the review process	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, interview, and record review, the facility failed to ensure the development of a resident's comprehensive care plan for 3 of 3 residents reviewed for behaviors, accidents, and nutrition. (Resident 39, Resident 15, Resident 58) Findings include:	F 0656	**The corrective action taken for those residents found to be affected by the deficient practice include**: Resident # 39 behavior care plan was developed on 11/14/2024 by the MDS nurse. Resident #58 Behavior care plan	12/13/2024

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	1. On 11/6/23 at 11:15 A.M., Resident 39 was observed sitting in wheelchair in dining room eating puzzle pieces. On 11/7/24 at 2:42 P.M., Resident 39's clinical record was reviewed. Diagnoses included, but were not limited to, unspecified dementia without behavioral disturbance and cognitive communication deficit. The Current Quarterly MDS (Minimum Data Set) Assessment dated 9/20/24 indicated Resident 39 was severely cognitively impaired. Resident 39 needs substantial assistance with transferring and mobility. There were no behaviors noted during the 7 days look back period. Current Physician Orders included, but were not limited to: Monitor for Side Effects of Anti-Depressant Medications which may include but not limited to: Dystonia Tremors Confusion Tardive Dyskinesia Dry Mouth Blurred Vision Constipation Urinary Retention Hypotension Sedation/Drowsiness Increased falls/dizziness Anxiety/agitation Headache Insomnia Blurred Vision Tachycardia Sweating/rashes every shift. If side effects present document in progress notes initiated 7/15/24. Monitor for Side Effects of Anti-Anxiety Medications which may include but not limited to: Dystonia Dry mouth Blurred Vision Constipation Urinary Retention Hypotension Sedation/Drowsiness Increased falls/Dizziness Anxiety/Agitation Headache Blurred Vision Sweating/rashes every shift and document if progress notes if present initiated 7/15/24.		was updated by the Social Services Director (SSD) on 11/12/2024 to reflect interventions for retaliation, using loud words on 11/12/2024 Resident # 15 Nutrition Care Plan was reviewed by the Registered Dietitian and updated to reflect current needs on 11/13/2024. **Other residents that have the potential to be affected have been identified by:** All residents of the facility have the potential to be affected. The Director of Nursing, MDS nurse or Designee completed an audit of all resident care plans with behaviors and or significant change to determine a care plan was developed and implemented to meet the needs of the residents. Areas of concern were corrected upon discovery. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The DON or designee conducted reeducation with the MDS nurse, Social Service Director (SSD) regarding the development and implementation of a comprehensive person-centered care plan for each resident; in addition, re-educated included all residents who present with behaviors, significant weight loss or discharged from hospice will have a care plan developed and implemented to meet the needs of	

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	On 11/5/23 at 7:43 A.M., in a care plan note the Social Service Director and the family discussed Resident 39's recent behaviors and agreed that a memory care would be a better fit. On 11/8/24 at 3:40 P.M., the current care plan lacked a care plan for increasing behaviors. On 11/12/24 at 3:25 P.M., Resident 39 was observed sitting in wheelchair in dining room talking with other residents with a doll in their lap. During an interview on 11/13/24 at 9:45 A.M., the Social Service Director indicated there should be a care plan addressing behavior. 2. On 11/07/24 at 1:38 P.M., Resident 58's clinical record was reviewed. Diagnoses included, but were not limited to, dysphagia following cerebral vascular disease and speech and language deficits following cerebrovascular disease. The current Quarterly MDS Assessment indicated Resident 58 was cognitively intact. Resident 58 requires partial assistance dressing and transferring. Has had no behaviors during that time. Physician orders include, but were not limited to, Behavior Monitoring requested for PTSD (Post Traumatic Stress Disorder) every shift and as needed initiated on 8/5/24. During an interview on 11/6/24 at 10:18 A.M., Resident 58 indicated he was moved to current room because of not getting along with former roommate. During an interview on 11/7/24 at 2:10 P.M., the		the resident. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** The MDS nurse, SSD or Designee will conduct random audits of 5 resident care plans to determine residents with behaviors, and with a significant change to include discharged from hospice have a care plan developed and implemented daily for two weeks including weekends then three times a week times two weeks then weekly x 8 weeks then every other week times 8 weeks then monthly times 1 months then as determined by the Quality Assurance Performance Improvement committee (QAPI) with corrective action upon discovery by the MDS nurse, SSD or designee. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the review process	

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	Social Services Director indicated that Resident 58 and the roommate had an altercation when words were exchanged due to the roommate making noises which finally caused Resident 58 to retaliate with loud words. She indicated that there was no documentation of that incident in the record or form concerning the transferring of rooms at the time it occurred. She indicated the incident time got away from her. The record lacked any care plan regarding retaliating behaviors resulting in the transferring to new room. 3. On 11/08/24 at 3:05 P.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, dysphagia and gastro-esophageal reflux disease without esophagitis. The Significant Change MDS Assessment indicated that the resident was cognitively intact. The resident needed supervision with eating and was dependent on transferring, toileting, and dressing. There was significant weight loss noted. Current physicians orders included, but were limited to: lacked an order to weigh patient. ProStat (protein supplement) 30 ml (Mil liters) BID (Two times a day), dated 8/15/24 Mighty Shake (nutritional supplement) at lunch dated 8/15/24 Centrum Silver multivitamin daily dated 8/15/24 The current care plan indicated the resident was at risk for significant weight loss related to poor intake dated 8/4/24. Interventions included but were not limited to Med pass nutritional			

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	155621	A. BUILDING 00 B. WING	11/14/2024

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	supplement, as ordered, dated 2/23/24. Nutritional supplement started Mighty Shakes 8/15/24. Monitor weight and food intake dated 11/3/23. No revision has been noted to the care plan for weight intervention. Current weight recorded included: 10/7/2024 at 3:24 P.M. 164.6 Lbs. Mechanical Lift 8/19/2024 at 3:38 P.M. 168.6 Lbs. Mechanical Lift 8/15/2024 at 4:18 P.M. 168.6 Lbs. Mechanical Lift 8/3/2024 at 6:37 P.M. 166.8 Lbs. Mechanical Lift 7/1/2024 at 12:29 P.M. 200.1 Lbs. Standing 6/10/2024 at 1:16 P.M. 206.4 Lbs. Standing 5/6/2024 at 6:11 P.M. 175.2 Lbs. Sitting On 11/8/24 at 3:05 P.M., the weight calculator indicated that the resident had a 20.25 pound(lbs) weight loss from 7/1/24 at 200 pounds to 10/7/24 165.6 pounds. A Dietitian Progress noted dated 2/9/24 at 1:43 P.M., indicated a weight warning and the Dietitian requested Mighty Shakes with lunch for extra calories. A Dietitian Progress note dated 8/3/24 at 6:37 P.M., indicated the resident had a weight warning of a 3 % (Percent) weight change from 7/1/24 to 8/3/24 and no recommendations were made. The resident was on hospice at that time. A Dietitian Progress Note dated 8/14.24 at 2:39 P.M., indicated the resident had been discharged from hospice service with no documentation of			

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	weight noted. Nutrition Assessments were documented on 3/8/24 and 2/24. During an interview on 11/13/24 at 1:00 P.M., the Dietitian indicated that everyone should be weighed according to facility policy unless order states differently. She missed quarterly nourishment assessment but made a note in August. During an interview on 11/13/24 at 3:50 P.M., the DON (Director of Nursing} indicated that was the policy of the facility to weigh resident once a month. On 11/13/24 at 4:15 P.M., the DON (Director of Nursing) provided a current policy "Care Plan, Comprehensive Person-Centered" revised 9/2022. The policy indicated " ...the comprehensive, care centered care plan will: aid in preventing or reducing in the resident's functional status...care plan interventions are chosen after careful data gathering...when possible, interventions address the underlying source of the problem and not just addressing symptoms or triggers..." 3.1-35(a) 3.1-35(b)(7)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on interview and record review, the facility failed to ensure care plan conferences were completed quarterly for 2 of 2 residents reviewed for quarterly care plan conferences. (Resident 13 and Resident 29)	F 0657	**The corrective action taken for those residents found to be affected by the deficient practice include**: Resident # 13 care conference was held on 12/13/24.	12/13/2024

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	Findings include: 1. On 11/8/24 at 10:15 A.M., Resident 13's clinical record was reviewed. Resident 13's diagnoses included, but were not limited to, dementia and anxiety. A Significant Change MDS (Minimum Data Set) Assessment, dated 10/8/24, indicated Resident 13's cognition level was not assessed due to diminished cognition level and Resident 13 was dependent on staff for toileting, bathing, and transfers (staff do all of the work). On 11/13/24 at 3:23 P.M., the Social Services Director provided documents titled Care Conference Note, and indicated, during the past year, a quarterly care plan conference had not been held for Resident 13 between 3/20/24 and 9/25/24. 2. On 11/8/24 at 12:48 P.M., Resident 29's clinical record was reviewed. Resident 29's diagnoses included, but were not limited to, multiple sclerosis, involuntary eye movements, and calculus of the kidneys. An Annual MDS (Minimum Data Set) Assessment, dated 8/13/24, indicated Resident 29 was cognitively intact and was dependent on staff (staff do all of the work) for eating, toileting, bathing, and transfers. On 11/13/24 at 3:23 P.M., the Social Services Director provided documents titled Care Conference Note, and indicated, during the past year, a quarterly care plan conference had not been held for Resident between 4/4/24 and 8/21/24, through 11/14/2024.		Resident # 29 care conference was held on 11/21/24. **Other residents that have the potential to be affected have been identified by:** All residents of the facility have the potential to be affected. The Administrator or Designee completed an audit of all resident care plan schedules to determine a care plan meeting had been scheduled and the resident and responsible party were invited to attend. Areas of concern were corrected upon discovery. The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include: The ADM/Designee conducted reeducation with the SSD regarding the requirement that residents and resident responsible parties are to be invited to participate in a care plan conference every quarter, with significant change and annually. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** The MDS nurse, SSD or Designee will conduct random audits of 4 resident MDS assessment schedule to determine care plan meeting were scheduled and residents and responsible parties were invited to attend the meeting weekly times 4 weeks, then 4	

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	During an interview on 11/14/24 at 11:22 A.M., the Social Services Director stated care plan conferences should be held at least quarterly. On 11/14/24 at 11:51 A.M., the Director of Nursing provided a document titled "Care plans, comprehensive person-centered", revised 9/22, that indicated "The interdisciplinary team must review and update the care plan at least quarterly in conjunction with the required quarterly MDS assessment." 3.1-35(d)(2)(B)		random residents monthly times 5 months then as determined by the Quality Assurance Performance Improvement committee (QAPI) with corrective action upon discovery. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the review process	
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident Based on observation, interview, and record review, the facility failed to provide person centered engagement activities for 1 of 1 resident reviewed for dementia care. (Resident 13) Finding includes: On 11/6/24 at 10:51 A.M., Resident 13 was observed in the common area. Resident 13's wheelchair was positioned in a way her vision was parallel with the television screen with a large plant blocking the view of the television. On 11/7/24 at 10:45 A.M., Resident 13 was observed in the common area. Resident 13's wheelchair was positioned with the back of her	F 0679	**It is the practice of this facility to assure that residents are provided with person centered engagement activities. The corrective action taken for those residents found to be affected by the deficient practice include:** Resident 13 remains in the Facility and is offered activities Per her preference	12/13/2024

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	wheelchair was facility the television screen. On 11/8/24 at 10:08 A.M., 10:32 A.M., 10:48 A.M., and 11:47 A.M., Resident 13 was observed in the common area. Resident 13's wheelchair was facing the television screen and the television was on the menu screen. On 11/13/24 at 2:20 P.M, the the activities assistant was hosting bingo in the dining room. Resident 13 was not offered to attend activities in the dining room and remained in the common area in front of the television. On 11/8/24 at 10:15 A.M., Resident 13's clinical record was reviewed. Resident 13's diagnoses included, but were not limited to, dementia and anxiety. A Significant Change MDS (Minimum Data Set) Assessment, dated 10/8/24, indicated Resident 13's cognition level was not assessed due to diminished cognition level and Resident 13 was dependent on staff for toileting, bathing, and transfers (staff do all of the work). Resident 13's care plan included, but was not limited to: Involve in daily activities. Encourage continue socialization outside her room. Provide 1:1 conversation throughout the day. Involve in decision making process by offering simple choices. Revised on: 6/14/17 Resident will continue to join in group activities by being provided with necessary materials to participate. Revised on: 4/5/22 Resident maintains and enjoys a comfortable		**Other residents that have the potential to be affected have been identified by:** Any resident who is unable to Take themselves to activities. No other issues noted. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** Activities department was re-educated That all residents must be involved in Activities per their preferences and Those that cannot or don't wish to Participate in activities must be Provided with one on one activity. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews all residents (if applicable) to assure that they are offered activities per their preference. The Administrator, or designee, will complete this tool Weekly x 6 months. Any issues identified will be immediately	

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	balance between independent, self-initiated activities, and group calendar events, but may need reminders for upcoming events, support through offers of leisure materials, and assistance to and from activities. Revised on: 12/14/22 Resident will participate in desired activities to the best of their ability in regards to their visual loss and hearing loss, with appropriate adaptations provided. Date Initiated: 7/29/24 Seat resident close to group leader to facilitate clear hearing and vision. Date Initiated: 7/29/24 The clinical record, including progress notes, assessments, and documents, lacked documentation of invitation to or participation of activities from the last activities care plan revision, 7/29/24, to 11/14/24. During an interview on 11/14/24 at 10:56 A.M., CNA 26 indicated Resident 13 will participate in group activities if brought by staff but she was unable to bring residents who required assistance to activities due to a personal restriction. On 11/14/24 at 11:51 A.M., the Director of Nursing provided a policy titled "Activities Recreation Administration", revised 3/23, that indicated "The activities recreation department shall communicate effectively to promote optimal resident care. Complete written progress notes at least every 90 days and as needed in the clinical record. Participate in the interdisciplinary care planning process. Maintain attendance records will be kept for small, large, and individual activities." 3.1-33(a)		corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	

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F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision Based on interview, observation, and record review, the facility failed to ensure a resident received proper treatment to maintain vision abilities by assisting in arrangements for vision services for 1 of 1 residents reviewed for vision impairment. (Resident 29) Finding includes: During an interview on 11/6/24 at 10:39 A.M., Resident 29 was observed wearing cloudy glasses and indicated she had not been assessed by vision or dental services in over a year and was having difficulty with her current prescription. On 11/8/24 at 12:48 P.M., Resident 29's clinical record was reviewed. Resident 29's diagnoses included, but were not limited to, multiple sclerosis, diplopia (double vision), involuntary eye movements. An Annual MDS (Minimum Data Set) Assessment, dated 8/13/24, indicated Resident 29 was cognitively intact, was dependent on staff (staff do all of the work) for eating, toileting, bathing, and transfers, has vision impairment, and wears corrective lenses. Care plan interventions included, but were not limited to: Arrange consultation with eye care practitioner as required. Date Initiated: 8/24/23 Ensure that glasses are clear and in good repair. Date Initiated: 8/24/23	F 0685	**It is the practice of this facility to assure that residents are receive proper treatment and assistive devices to maintain vision and hearing abilities. The corrective action taken for those residents found to be affected by the deficient practice include:** An Eye appointment has been Scheduled for resident 29. **Other residents that have the potential to be affected have been identified by:** An Audit was completed on all residents to identify anyone who has not received proper treatment to maintain vision abilities. All residents identified have been scheduled for services. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** Social Services Director was	12/13/2024

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	Admission documents, dated 7/8/21, indicated Resident 29 gave verbal consent to health services including vision, hearing, dental, and podiatry assessments while in the facility. The clinical record lacked documentation that indicated Resident 29 had been evaluated by vision services or offered transportation to be evaluated by vision services since 4/7/23. During an interview on 11/13/24 at 9:18 A.M., the Social Services Director indicated if residents want health services such as vision screenings they should come to social services and ask for it; if they are unable to ask for it themselves, it would be agreed upon admission and discussed during care plan conferences. On 11/13/24 at 11:51 A.M., the Director of Nursing provided a policy titled Care of Visually Impaired Resident that indicated "it is our responsibility to assist the resident and representative in locating resources, scheduling appointments, and arranging transportation to obtain needed services." 3.1-39(a)(2)		Re-educated by Administrator That all residents must receive proper treatment to maintain vision and hearing abilities. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews all residents with a quarterly assessment to ensure that they have received proper treatment to maintain vision abilities. The Administrator, or designee, will complete this tool Weekly x 6 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and interview the facility failed to appropriately care for and maintain a resident's suprapubic catheter leading to infection at the catheter insertion site	F 0690	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** • The DON/designee	12/13/2024

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	and multiple urinary tract infections for 1 of 1 resident reviewed for urinary tract infections and urinary catheter. (Resident 47) Finding includes: On 11/8/2024 at 10:19 A.M., Resident 47's clinical record was reviewed. Resident diagnoses included, but was not limited to, hemiplegia from cerebral vascular event, hemiparesis, cancer of prostate, diabetes mellitus type 2, coronary artery disease, and peripheral vascular disease. An Annual MDS (Minimum Data Set) Assessment, dated 10/26/2024, indicated the resident was mild to moderately cognitively impaired, had no behaviors regarding rejection of care, required extensive assistance by 2 staff members in bed mobility, transferring, and toileting. The MDS also indicated Resident 47 had an indwelling suprapubic catheter and a history of prostate cancer. Physician orders for Resident 47 included, but was not limited to: Change suprapubic catheter monthly and as needed for occlusion or dislodgement, every day shift every month on the 1st of the month, dated 6/1/2024. Clindamycin HCl (antibiotic) Oral Capsule 300 MG, 1 capsule by mouth four times a day for suprapubic site drainage for 7 days, dated 11/10/2024 Macrobid Oral Capsule (antibiotic) 100 MG, give one capsule by mouth two times a day for urinary tract infection until 11/8/2024, dated 11/4/2024. That order was discontinued on 11/1/2024 in order		obtained orders for routine catheter care for Resident #47 How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? • Other residents who have urinary catheters have the potential to be affected • The DON/designee will review the electronic medical record to identify current residents who have catheters and will ensure that catheter care orders are in place. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** • The DON/designee will provide reeducation to licensed and certified nursing assistants on the requirement that urinary catheter care is routinely being performed and that catheters are changed per physician orders and documented in the clinical record. • The DON/designee will complete routine auditing to ensure that newly admitted residents, and residents who have new orders for urinary catheters have orders for routine urinary catheter care. • The DON/designee will complete routine auditing to ensure that catheters are changed per physician orders.	

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	to switch resident to Clindamycin. The clinical record lacked orders for maintenance or routine care of catheter besides changing it monthly. Care plans for Resident 47 included, but were not limited to: I have a need for enhance barrier precautions due to urostomy use, dated 7/31/2024. Interventions included: follow facility's infection control policies and procedures when cleaning or disinfecting room, handling soiled linen, disinfecting equipment, have personal protective equipment available for staff and visitors, practice good handwashing, teach resident and caregiver the chain of infection and methods of transmission, and use principles of infection control. All interventions dated 7/31/2024. The resident has a urinary tract infection, dated 11/1/2024. Interventions included: the resident's urinary tract infection will resolve without complications by the review date, administer antibiotic therapy as ordered and observe for/document side effects and effectiveness, check at least every 2 hours for incontinence and provide peri care and apply barrier cream as needed, encourage fluid intake, encourage/assist resident with hand washing after being toileted and before/after meals, observe for/document/report to MD as needed for signs and symptoms of urinary tract infection i.e.)frequency, urgency, malaise, foul smelling urine, dysuria, fever, nausea and vomiting, flank pain, suprapubic pain, hematuria, cloudy urine, altered mental status, loss of appetite, behavioral changes; obtain lab and diagnostic work as ordered, report results to MD and follow up as indicated; obtain vital signs as ordered or facility		**How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • The DON/designee will complete routine auditing to ensure that newly admitted residents, and residents who have new orders for urinary catheters have orders for routine urinary catheter care. Auditing to occur: with each new catheter daily x's 4 wks, then 4 residents wkly x's 4 wks, then 4 residents monthly x's 4 months for a total of 6 months of monitoring. Any findings ill be addressed as noted below. • The DON/designee will complete routine auditing to ensure urinary catheters, suprapubic catheter and urostomy care is provided per physician orders daily x's 4 wks, then 4 residents wkly x's 4 wks, then 4 residents monthly x's 4 months for a total of 6 months of monitoring. Any finding will be addressed as noted below. • The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6	

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	protocol and notify MD as needed. All interventions were dated 11/1/2024. The resident has a suprapubic catheter, dated 11/1/2024. Interventions included: resident will be/remain free from catheter-related trauma through review date, position catheter bag and tubing below level of the bladder, check tubing for kinks each shift/per policy, monitor and document intake and output as per facility policy, observe for/document pain/discomfort due to catheter. All interventions dated 11/1/2024. Resident 47's lab results indicated the organism Klebsiella pneumoniae had grown in most recent urine culture. The most recent culture of suprapubic catheter insertion site Methicillin-resistant Staphylococcus aureus had grown. Resident 47's September 2024 Medication/Treatment Administration Record indicated the following: Order for suprapubic catheter change monthly and as needed for occlusion or dislodgement, 9/1/2024 when catheter change was due, the record was incomplete. The record did indicate the resident's catheter was changed in the PRN (as needed) administration category on 9/22/2024. Resident 47's October 2024 Medication/Treatment Administration Record indicated the following: Order for suprapubic catheter change monthly and as needed for occlusion or dislodgement, 10/1/2024 RN indicated "n", meaning no, when the catheter change was due. There was no record of any PRN catheter changes that month.		months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the review process.	

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	Resident 47's October 2024 Medication/Treatment Administration Record indicated the following: Order for suprapubic catheter change monthly and as needed for occlusion or dislodgement, 11/1/2024 when catheter change was due, the record was incomplete. There was no record of any PRN catheter changes that month. On 11/7/2024 at 2:38 P.M., CNA (Certified Nurses Aide) 15 and CNA 21 were observed to be putting Resident back to bed from wheel chair. A mechanical lift was used to assist the resident's transfer. The mechanical lift sling that was used, was previously used on Resident 47's room mate and was not washed between use. Both CNAs caring for Resident 47 did not wear a gown for enhanced barrier precautions during care. On 11/12/2024 at 10:10 A.M., Resident 47's catheter bag was observed to be lying on the floor while the resident was in bed. On 11/14/2024, at 9:28 A.M., RN (Registered Nurse) 5 indicated that a suprapubic catheter site should have been cleansed daily with soap and water, the area dried, and the catheter secured to the resident's abdomen with an anchor dressing. Indicated that should have been in the resident's Treatment Administration Record to have signed off on daily. Also indicated that CNA (Certified Nurses Aides) sometimes have done the care when it was needed. RN 5 indicated they could not find the order or task in the TAR, but that it used to be there. Also indicated that the resident's suprapubic catheter is to be changed monthly and as needed for occlusion, was not sure when it had been changed last an did not know why the TAR did not show the task as completed in the months of October and November 2024. RN 5 indicated			

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	the catheter bag is emptied of urine at least once per shift or as needed. On 11/14/2024 at 10:00 A.M., CNA 15 indicated that they occasionally did suprapubic catheter care on Resident 47, if needed. Also indicated that they had been inserviced on suprapubic catheter care. The DON (Director of Nursing) on 11/14/2024, at 10:02 A.M., indicated a resident's suprapubic catheter site should have been washed with soap and water, making sure catheter is secure, daily, by a nurse, but CNA's should have been cleaning around it as well if it was needed. DON indicated CNA's have not been inserviced on suprapubic catheter care. A staff nurse (RN) job description provided by the Administrator on 11/14/2024 at 10:00 A.M., indicated the nurse was to "receive and transcribe written, verbal, and telephone orders to the chart, MAR, TAR, etc, and assures execution of same". As well as, the nurse is "responsible for competent administration of care and treatments according to physician orders and facility policy and procedure including at minimum". A Suprapubic Catheter Care policy was provided by the Administrator on 11/14/2024 at 10:50 A.M., it did not indicate frequency that the specific care should occur. An Enhanced Barrier Precautions policy was provided by the Administrator on 11/14/2024 at 11:53 A.M., it indicated "EBP's employ targeted gown and glove used during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact			

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	resident care activity. Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include (but not limited to) transferring. EBP's are indicated for resident's with wounds, and or indwelling medical devices regardless of Multi-drug Resistant Organism colonization". At 1:00 P.M. on 11/14/2024, suprapubic catheter care was performed by RN 5. Catheter tubing was not secured with an anchor dressing prior to RN 5 performing care. 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on interview, observation, and record review, the facility failed to ensure a resident was offered sufficient fluid intake to maintain proper hydration and health for 1 of 1 residents reviewed for hydration. (Resident 29) Finding includes: During an observation on 11/6/24 at 10:41 P.M., Resident 29 was laying in bed. Resident 29's call light (touch pad) was laying on the dresser to the right of her bed out of her reach. An empty cup labeled "11/5/24 NOC" was on the bedside table. Resident 29 indicated she did not feel she received enough fluids and had to call for staff to give her drinks because of her physical condition, but was unable to call for staff assistance when her call light is out of reach. On 11/8/24 at 12:48 P.M., Resident 29's clinical record was reviewed. Resident 29's diagnoses included, but were not limited to, multiple	F 0692	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** • Nursing staff filled Resident #29 bedside water cup with fresh ice water during the survey process on 11/6/24. Cups are replaced every 24 hours; however, fresh water is provided every shift, or more often as indicated if no fluid restriction orders. The cup dated 11/5/24 was within the 24-hour time frame. • Resident #29 does not have an order for a fluid restriction. Resident #29 was provided with a 24 oz hydration cup with bite valve while up in wheelchair and while in bed. Resident #29's care plan and CNA Kardex have been updated	12/13/2024

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	sclerosis, hydronephrosis, and calculus of the kidneys. An Annual MDS (Minimum Data Set) Assessment, dated 8/13/24, indicated Resident 29 was cognitively intact, was dependent on staff (staff do all of the work) for eating, toileting, bathing, and transfers, received diuretic medication during the seven day lookback period, and had facility acquired pressure wounds. Current physician orders included, but were not limited to: Furosemide (diuretic medication) oral tablet 20 MG (milligrams) Give 1 tablet by mouth one time a day for edema; start date 6/9/24 Offer 360cc fluids four times a day for hydration; start date 6/17/24 Care plans included, but were not limited to: Recurrent signs and symptoms of urinary tract infection history, revised on 10/10/23 The resident has dehydration or potential fluid deficit related to decreased fluid intake, diuretic use, revised on 7/27/24 Resident needs assistance, encouragement and supervision with fluid intake in order to meet daily requirements. Date initiated 9/20/22 A document titled Nephrology Assessment, dated 10/17/24, indicated Resident 29 was admitted to the hospital for kidney stones and urinary tract infection related sepsis. A nursing progress note, dated 10/25/24 at 2:47		to reflect her preference. • Resident #29 had an order for and was being provided with an additional 360ml water four times per day. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? • **Other residents who have a preference for additional water at bedside outside of the large Styrofoam cup with fresh ice water every shift have the potential to be affected.** • The DON/designee conducted visual observation rounds of the facility to determine all residents have fluid at the bedside in reach of the resident and fluids are being offered to residents who could not request fluids. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** • The DON/designee will provide reeducation to licensed and certified nursing staff are to pass fresh ice water every shift, offer fluids every two hours, make sure call lights are in reach of the resident while in room enabling them to request fluids, and notify the physician of any signs and symptoms of dehydration.	

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	P.M., indicated Resident 29 had returned to the facility from the hospital. A nutritional risk assessment document, dated 10/30/24, indicated Resident 29 was at risk for dehydration due to recurrent infection and diuretic use, and an estimated 1600-1900 mL (milliliters) of fluid was needed each day. The most recent lab report with a collection date of 10/31/24, indicated an abnormal high BUN (blood urea nitrogen) level of 25 (Normal level of BUN is between 8-23). During an interview on 11/13/24 at 4:17 P.M., The Director of Nursing indicated residents were not monitored closely for exact fluid intake unless on a fluid restriction and nurses should assess for signs of dehydration each shift. On 11/14/24 at 11:51 A.M., the Director of Nursing provided a policy titled Hydration Clinical Protocol, dated 9/17, indicated "The staff, with the physician's input will identify and report to the physician individuals with signs and symptoms or lab test results that might reflect existing fluid and electrolyte imbalance. The physician and staff will identify significant risk for fluid and electrolyte imbalance; for example individuals who are taking diuretics and who are not drinking well. The staff will provide supportive measures such as supplemental fluids as indicated." 3.1-46(b)		**How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • The DON/designee will complete routine observations to ensure that residents have fresh water available at bedside. Observations to occur: 4 random residents wkly x's 4 wks, then 4 random residents monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed as noted below. • The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the review process.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, interview, and record review, the facility failed to ensure routine	F 0755	**What corrective actions will be accomplished for those**	12/13/2024

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	medications were available and dispensed according to physician's orders and stored in an organized manner for 2 of 2 residents reviewed for medication storage. (Resident 15, Resident 47) Findings include: 1. On 11/13/24 at 2:00 P.M., during an observation of medication cart for 200 unit there was no Prostat (protein supplement) for Resident 15. On 11/08/24 at 3:05 P.M., Resident 15's clinical record was reviewed. Diagnoses included, but were not limited to, dysphagia and gastro-esophageal reflux disease without esophagitis. Current physician orders included, but were not limited to: ProStat (protein supplement) 30 ml (Mil liters) BID (Two times a day), dated 8/15/24. Mighty Shake at lunch dated 8/15/24. Centrum Silver multivitamin daily dated 8/15/24. During an interview on 11/13/24 at 2:05 P.M., QMA (Qualified Medicine Aide) 9 indicated Resident 15 did not have the medication. QMA 9 indicated the medication was from [Resident Name] and [Resident Name] both discharged from the facility. She indicated she thought that was how to get the medication. 2. On 11/8/2024 at 10:19 A.M., Resident 47's clinical record was reviewed, the diagnoses included, but were not limited to, pressure ulcer of right buttock- stage two (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or		**residents found to have been affected by the deficient practice?** Resident #15 wound healing supplement was received and labeled by a licensed nurse on 11/13/2024. Resident #47 wound healing supplement was received from Pharmacy and labeled on 11/13/2024. **How other residents have the potential to be affected by the same deficient practice will be** identified and what corrective actions will be taken? All residents with wound healing supplements have the potential to affected. The DON/designee conducted visual observation audits of the facility medication carts to determine all residents who have orders for a wound healing supplement, have the supplement available and labeled with the residents name. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee will provide reeducation to licensed nurses and medication aides regarding routine medication are too be available to administer to residents per physicians' orders to include wound healing supplements. The reeducation included medications	

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	open/ruptured blister), and pressure ulcer of right heel- stage three (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.), hemiplegia (one-sided muscle paralysis) from cerebral vascular event, hemiparesis (one-sided muscles weakness), cancer of the prostate, diabetes mellitus type 2, coronary artery disease, and peripheral vascular disease. Current physician orders included, but were not limited to: ProStat AWC SF (sugar-free wound healing supplement) 30ml two times a day for supplement, dated 7/17/2024. The Medication Administration Record/Treatment Administration Record for the month of October 2024 indicated the following: Administration of ProStat AWC SF 30ml two times a day for supplement, 10/4/2024 evening dose was incomplete, 10/16/2024 evening dose indicated resident received 60mL (milliliters), 10/21/2024 evening dose "x", 10/29/2024 evening dose "x", 10/31/2024 evening dose "x". The Medication Administration Record/Treatment Administration Record for the month of November 2024 indicated the following: Administration of ProStat AWC SF (wound healing supplement) 30ml two times a day for supplement, 11/2/2024 60mL administered at evening dose, 11/3/2024 60mL administered at morning dose and again at evening dose, 11/4/2024 "x" for evening dose, 11/9/2024		are not shared between residents and if a medication is not available to administer, the physician is to be notified for further orders. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine observations of medication carts to ensure that residents wound healing supplements are available and labeled with the residents name. Observations to occur: 4 random residents wkly x's 4 wks, then 4 random residents monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed as noted below. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the review process.	

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	indicated 0mL were administered for evening dose. On 11/12/2024 at 3:00 P.M., RN 5 could not locate ProStat, wound healing supplement, for Resident when asked to observe the bottle, followed RN 5 at that time to supply room to look for ProStat. No ProStat could be found in supply room. On 11/13/2024 at 11:25 A.M. the DON (Director of Nursing) indicated that ProStat supplement had been reordered on 11/12/2024. Indicated that previously, Resident 47 had been given supplement out of supply ordered by the facility, but had ran out the previous day. During an interview on 11/13/24 at 2:10 P.M., the DON (Director of Nursing) indicated that each resident should have their own bottle of ProStat and with label. On 11/14/24 at 8:00 A.M., the DON provided a current policy "Storage of Medications" revised p 4/2007. The policy indicated "...indicated the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed..." 3.1-25(b)(7) 3.1-25(o)			
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on observation, interview, and record review, the facility failed to ensure it was free of a medication error rate of greater than 5 percent for 2 of 5 residents (Resident 50 and Resident 6) observed during medication pass. Two medication	F 0759	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?**	12/13/2024

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	errors were observed during 25 opportunities for error in medication administration. This resulted in a medication error rate of 8%. Findings include: 1. On 11/8/24 at 11:53 A.M., Licensed Practical Nurse (LPN) 3 was observed preparing a Humalog Insulin Pen for insulin administration for Resident 50. An AccuCheck (blood glucose test) indicated the resident had a blood glucose of 198 milligrams per deciliter (mg/dL). LPN 3 indicated the resident received sliding scale insulin and was to receive 3 units of insulin lispro (a fast acting insulin) for a blood glucose reading of 198 mg/dL. LPN 3 set the insulin pen to 3 units. She cleaned the tip of the pen, attached the needle, and administered 3 units of insulin to Resident 50 in her abdomen. LPN 3 did not prime the insulin pen before administration of the medication. 2. On 11/8/24 at 12:02 P.M., Licensed Practical Nurse (LPN) 3 was observed preparing a Novalog Insulin Pen for insulin administration for Resident 6. An AccuCheck (blood glucose test) indicated the resident had a blood glucose of 145 milligrams per deciliter (mg/dL). LPN 3 indicated the resident received sliding scale insulin and was to receive 2 units of insulin aspart (a fast acting insulin) for a blood glucose reading of 145 mg/dL. LPN 3 set the insulin pen to 2 units. She cleaned the tip of the pen, attached the needle, and administered 2 units of insulin to Resident 23 in his abdomen. LPN 3 did not prime the insulin pen before administration of the medication.		Resident #6 received no negative outcome as a result of insulin pen not being primed before administration of insulin. Resident #50 received no negative outcome as a result of insulin pen not being primed before administration of insulin. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents with insulin administered via insulin pen have the potential to affected. The DON/designee conducted visual observation audits of residents receiving insulin via insulin pen to determine the insulin pen was primed before insulin dose was draw into pen for administration with corrective action upon discovery. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee provided reeducation to licensed nurses regarding insulin pens are to be primed before the physicians ordered dose of insulin is drawn up into pen for administration to ensure the prescribed dose of insulin is administered to the resident.	

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	On 11/8/24 at 12:16 P.M., Registered Nurse (RN) 5 indicated insulin pens did not need to be primed before insulin administration. On 11/8/24 at 12:27 P.M., the Humalog Insulin Pen instruction manual, revised July 2023, was reviewed. It indicated "Prime before each injection. Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin. To prime your pen, turn the dose knob to select 2 units. Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Continue holding your pen with needle pointing up. Push the dose knob in until it stops, and "0" is seen in the dose window. Hold the dose knob in and count to 5 slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat priming steps 6 to 8, no more than 4 times. If you still do not see insulin, change the needle and repeat priming steps 6 to 8". On 11/8/24 at 12:30 P.M., the Novalog Insulin Pen instruction manual, revised 2/2023, was reviewed. It indicated "Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: Turn the dose selector to select 2 units. Hold your NovoLog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If		**How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine observations of insulin administration to ensure that insulin pens are primed before the dose of insulin is drawn up to administer. Observations to occur: 4 random residents wkly x's 4 wks, then 4 random residents monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed as noted below. **The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the review process.**	

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	you do not see a drop of insulin after 6 times, do not use the NovoLog FlexPen ...". On 11/12/24 at 1:47 P.M., the Administrator provided an Insulin Administration policy, revised September 2014, that indicated "The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system(s) prior to their use". 3.1-48(c)(1)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals 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. (300 Hall, 400 Hall, 200 Hall) Findings include: 1. On 11/7/24 at 10:15 A.M., the medication cart for rooms 310 to 317 was reviewed. The following loose pills were observed in the bottom of the drawers: 1 blue oval capsule with marking "RDY493" 2 red circle pills with marking "PH32" 1 light blue circle pill with marking "F3" 1 light blue circle pill with marking "M64" 1 white circle pill with marking "G5" 1 white circle pill with marking "489" 1 yellow circle pill with marking "LUPIN" 1 red circle pill with marking "US5" 1/2 white rectangle pill with partial marking "5" 2. On 11/7/24 at 10:30 A.M., the 400 hall medication cart was reviewed. The following loose	F 0761	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** A licensed nurse removed the loose pills from the medication carts for rooms 310 to 317 and 400 hallway on 11/7/2024. The medication aide removed the loose pills from the upstairs medication carts on 11/7/2024. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** No resident was affected as a result of loose pills located in the medication carts. The DON/designee conducted visual observation audits of medication carts to determine medication	12/13/2024

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	155621	A. BUILDING 00 B. WING	11/14/2024

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	pills were observed in the bottom of the drawers: 1 small white pill with marking "P10" 1 small white pill with marking "HP23" 1 red oval pill with marking "894" 1 white oval pill with marking "A6" 1/2 white circle pill with partial marking "8" 3. On 11/7/24 at 2:09 P.M., the upstairs medication cart was reviewed. The following loose pills were observed in the bottom of the drawers: 1 large white circle pill with marking "SC" 2 white oval pills with marking "L484" 1 orange oval pill with marking "750" 1 brown capsule with marking "CREON 1212" 1 blue and white capsule with marking "DLX60" 2 brown speckled circle pills with marking "TCL080" 3 small orange circle pills with marking "2 ½" 1 orange circle pill with marking "G" 2 orange circle pills with marking "R333" 1 white circle pill with marking "253" 1 white circle pill with marking "TV" 3 white circle pills with marking "TV2204" 1 white circle with no markings 1 red circle pill with marking "5" 1 red circle pill with marking "LUPIN" 1 white oval pill with marking "A6" 1/2 white circle pill with marking "P10" On 11/7/24 at 10:20 P.M., Registered Nurse (RN) 5 indicated that medication carts were cleaned out every two weeks on night shift. Loose pills were disposed of in the drug buster or sharps container. On 11/12/24 at 1:47 P.M., the Administrator provided a current Storage of Medications policy, revised April 2007, that indicated "Drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which		was stored properly with no loose pills located in the bottom of the medication cart with corrective action upon discovery. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee provided reeducation to licensed nurses and medication aides regarding medication is to be stored properly, drugs and biologicals shall be stored in packaging, containers or other dispensing systems in which they are received to include loose pills are to be removed from cart and disposed of when identified. Additionally, reeducation included carts are to be cleaned at the end of each shift. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine visual observations of medication carts to ensure medication is stored appropriately with no loose pills in the bottom of the medication carts. Observations to occur: All medication carts wkly x's 4 wks, then 4 random residents monthly x's 5 months for a total of 6	

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	they are received". 3.1-25(j)		months of monitoring. Any findings will be addressed as noted below. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the review process	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview, and record review, the facility failed to ensure that food was served at palatable temperatures and taste for 1 of 1 tray tested for temperature. Findings include: On 11/06/24 10:38 A.M., Resident 6 indicated food is not appetizing, often very similar or the same over and over. On 11/06/24 at 12:16 P.M., Resident 15 indicated they get a lot of sandwiches. On 11/8/24 at 12:39 P.M., a test tray was obtained from 200 Hall: Grilled Cheese 117 Degrees Fahrenheit Fruit Cocktail 60.2 Degrees Fahrenheit The grilled cheese was cool to taste The fruit cocktail was cool to taste	F 0804	**It is the practice of this facility to assure that residents are provided with food that is served at palatable temperatures and taste.** **The corrective action taken for those residents found to be affected by the deficient practice include:** On (Date) Administrator checked the temperature of the last tray on each food cart to ensure that food was the proper temperature. No issues noted. **Other residents that have the potential to be affected have been identified by:**	12/13/2024

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	On 11/8/24 at 2:30 P.M., the Ombudsman indicated after the resident council there were several anonymous complaints about food and meals. During an interview on 11/08/24 at 11:58 A.M., the Interim Dietary Manager indicated hot food temperatures should be served at a minimum of 155 Degrees Fahrenheit and cold food is served at minimum of 41 Degrees Fahrenheit. On 11/14/24 at 8:15 A.M., the DON (Director of Nursing) provided a current policy "Temperatures" dated 7/2023. The policy indicated "...foods sent to the units for distribution will be transported and delivered to maintain temperatures at or below 41 Degrees F for cold and at or above 135 Degrees F..." 3.1-21(a)(2)		All residents have the potential to be affected by the deficient practice. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** Dietary and Nursing staff were re-educated on proper temperatures of food items and process for serving meals to ensure proper temperatures. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews temperatures of food to ensure that it is served at the proper temperature. The Administrator, or designee, will complete this tool 3x Weekly x 4 weeks, 2 x week x 8 weeks, and 1 x week x 3 months. Any issues identified will be immediately corrected. The Quality Assurance	

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			Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure food was stored, labeled, and dated properly in accordance with professional standards for food service and refrigerator temperature were recorded for 3 of 3 kitchen observations. Findings include: 1. On 11/6/24 at 8:47 A.M., an initial tour of the kitchen was conducted. The following items were located In the Dry Storage area at 8:50 A.M., 1 Box of onion dated 8/2/24 that had an onion sprouted 2. Drink Refrigerator at 9:05 A.M., 3 bags of lettuce not dated 12 pitchers of tea not dated 1 box of thick and easy open date of 1/4/23 with best by dated 1/26/23 1 box of thick and easy open date 4/9 best by 3/29/24 1 pitcher of orange juice not dated 1 jar of chicken base not dated 1 open bag of lettuce wilted open dated of 10/25/24 1 container of cottage cheese with no open date Temperature Log for the Drink Refrigerator lacked	F 0812	**It is the practice of this facility to assure that food is stored, prepared, distributed, and served in accordance with professional standards. The corrective action taken for those residents found to be affected by the deficient practice include:** All identified food items were Thrown away. **Other residents that have the potential to be affected have been identified by:** An Audit was completed on all refrigerators in the kitchen and resident nutrition areas to ensure that temperatures were recorded and food was dated properly. Any issues identified were corrected immediately.	12/13/2024

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	temperatures for the following shifts" Nights 3/4/24 Days 3/5/24 Nights 3/5/24 3. Walk in freezer at 9:25 A.M. 1 bag of biscuits opened but no open date 4. Spice Rack above sink at 9:33 A.M. spices above sink 1 open bottle of rosemary not dated 1 open bottle of black pepper not dated 1 open bottle of Worcestershire sauce no dated 1 open bottle of caramel sauce no dated During an interview on 11/6/24 at 9:06 A.M., the Interim Dietary Manager indicated that they will usually keep open lettuce should be dated and is usually good for only 3 days after opened. She also indicated that the temperatures should be taken 2 times a day and recorded. 5. On 11/08/24 at 10:14 A.M., the second walk through was conducted and the following was discovered: 1 bottle of Worcestershire sauce not dated not marked 1 open container of cottage cheese with no open date 6. On 11/13/24 at 11:22 A.M., the kitchenette nutrition refrigerator on the first floor was observed with the following: No temperature log 1 open container of pumpkin spice cream cheese for [Resident Name] with no open date 1 container of iced tea with no name with date of 11/8/24 1 open container of lunch meat with no name dated 11/7/24		**The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** All staff were re-educated on the safe storage of food and drink, including documentation of temperatures of the refrigerators and freezers. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews all refrigerators and freezers to ensure that food is dated properly, disposed of properly, and temps are logged properly. The Administrator, or designee, will complete this tool 3x Weekly x 4 weeks, 2 x week x 8 weeks, and 1 x week x 3 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as	

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	1 open container of Neapolitan ice cream with no name or open date 2 containers of fried chicken with no name or date 1 open container of Ben and Jerry Pumpkin Cheesecake Ice Cream with no name or open date 1 container of food for [Resident Name] with open date 11/10/24 On 11/13/24 at 3:15 P.M., the Human Resources Director provided a current temperature sheet for the kitchenette refrigerator for the Month of November with the same initials for the entire month. On 11/13/24 at 4:10 P.M., the administrator indicated that housekeeping did the temperatures and kept the log in a binder in housekeeping. The Administrator indicated that [initials] was not on the schedule every day. On 11/14/24 at 8:15 A.M., the DON (Director of Nursing) provided a current policy "Storage Areas" revised 11/2024. The policy indicated "...all containers must be legible and accurately labeled and dated...temperatures should be checked two times each day using the Refrigerator/Freezer Temperature Log...all frozen foods should be covered, labeled, and dated..." On 11/14/24 at 8:15 A.M., the DON provided a current policy "Food from Outside Sources" dated 7/2023. The policy indicated "...visitor/family members will label food with the resident's name, room number, and date with a suitable container...perishable foods with a use by date is 3 days from the date it was brought into the facility...food or beverages without a manufactures expiration date will be thrown away 3 days after the day marked..."		needed based on the outcomes of the tools.	

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	On 11/14/24 at 11:15 A.M., the DON indicated the temperature logs were kept in binder in housekeeping. The housekeepers check the temperatures in the kitchenette daily. She was going to check and see if there was a policy for kitchenette refrigerator. None was every produced. 3.1-21(i)(3) 3.1-21(i)(2)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interview, the facility failed to ensure consistent documentation for wound care treatments on 1 of 3 residents reviewed for pressure injury. (Resident 47) Findings include: On 11/8/2024 at 10:19 A.M., Resident 47's clinical record was reviewed, the diagnoses included, but were not limited to, pressure ulcer of right buttock- stage two (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister), and pressure ulcer of right heel- stage three (Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.), hemiplegia (one-sided muscle paralysis) from cerebral vascular event, hemiparesis (one-sided muscles weakness), cancer of the prostate, diabetes mellitus type 2, coronary artery disease, and peripheral vascular disease.	F 0842	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** A licensed nurse completed wound treatments to resident #47 right heel on 11/9/2024. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents with wound treatments have the potential to be affected. The DON/designee conducted visual observation audits of all resident treatment records of residents with wounds to determine ordered treatments were completed and documented on the treatment administration record. **What measures will be put into**	12/13/2024

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	An Annual Minimum Data Set (MDS) Assessment, dated 10/26/2024, indicated the resident was mild to moderately cognitively impaired, had no behaviors regarding rejection of care, required extensive assistance by 2 staff members in bed mobility, transferring, and toileting. The MDS indicated the resident was at risk for the development of pressure ulcers and had pressure injury that was not present upon admission. The MDS did not specifically indicate the location of the pressure injury. Current orders included, but were not limited to: Cleanse wound to right heel with wound wash, apply collagen, followed by calcium alginate, cover with ABD (type of gauze) pad, wrap with Kerlix. Change daily and PRN (as needed), dated 11/8/2024. Cleanse wound to right buttock with wound wash, apply hydrocolloid and change 3 times a week. Every day-shift on Tuesday, Thursday, and Sunday for wound care and as needed for soilage or dislodgement, dated 11/10/2024. The Medication Administration Record/Treatment Administration Record for the month of October 2024 indicated the following: Administration of treatment: cleanse wound to right buttock with wound wash, apply Medi-honey and border dressing, change daily every dayshift, order active from 9/24/2024 through 11/8/2024. The following dates treatments were incomplete: 10/4/2024, 10/9/2024, 10/16/2024, 10/18/2024, and 10/22/2024. Administration of treatment: right heel, clean with wound cleanser, pat dry, apply dry collagen to the		**place or what systemic changes will be made to ensure that the deficient practice does not recur?** The DON/designee provided reeducation to licensed nurses. The reeducation included the licensed nurse was to receive and transcribe written, verbal, and telephone orders to chart, MAR, TAR, etc and assures execution of same. As well as, the nurse is responsible for competent administration of care and treatments according to physician orders to include wound treatments are completed and documented on the treatment administration record. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine visual observations of treatment administration records to ensure treatments are completed and documented on the treatment administration record 3 times a week for 4 wks, then 4 random residents monthly x's 5 months for a total of 6 months of monitoring. Any findings will be addressed as noted below. The results of these reviews will be immediately reported if concerns exist and will be discussed at the	

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	wound bed, apply calcium alginate, wrap with Kerlix, secure with tape. Change daily. Order was active 9/24/2024 through 11/8/2024. The following dates treatments were incomplete: 10/4/2024,10/9/2024, 10/16/2024, 10/18/2024, and 10/22/2024. The Medication Administration Record/Treatment Administration Record for the month of November 2024 indicated the following: Administration documentation for order of: Cleanse wound to right buttock with wound wash, apply Medi-honey, and a border dressing, change once daily on day shift. The following dates, treatments were incomplete: 11/1/2024, 11/5/2024, and 11/8/2024. Administration documentation for order of: right heel, clean with wound cleanser, pat dry, apply dry collagen to the wound bed, apply calcium alginate, wrap with Kerlix, secure with tape, change daily on day shift. The following dates, treatments were in complete: 11/1/2024, 11/2/2024, 11/5/2024, and 11/8/2024. On 11/13/2024 at 11:25 A.M. the DON (Director of Nursing) was not able to provide an explanation as to why documentation for treatments were inconsistent. An undated staff nurse (RN) job description provided by the Administrator on 11/14/2024, at 10:00 A.M., indicated the nurse was to "receive and transcribe written, verbal, and telephone orders to the chart, MAR, TAR, etc, and assures execution of same". As well as, the nurse is "responsible for competent administration of care and treatments according to physician orders and facility policy and procedure including at minimum".		monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the review process.	

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview the facility failed to follow proper infection prevention and control practices for 1 of 1 resident reviewed for urinary tract infection and urinary catheter care, 1 of 1 resident reviewed for pressure injury, and 1 of 1 resident reviewed for a urinary catheter. (Resident 47, Resident 8, and Resident 29) Findings include: 1. On 11/7/2024 at 2:38 P.M., CNA (Certified Nurses Aide) 15 and CNA 21 were observed to be putting Resident 47, whom had multiple open wounds and an indwelling suprapubic catheter, back to bed from wheel chair. A mechanical lift was used to assist the resident's transfer. The mechanical lift sling that was used, was previously used on Resident 47's room mate and not washed between use. Both CNAs caring for Resident 47 did not wear a gown for enhanced barrier precautions during care. 2. On 11/12/24 at 9:20 A.M., CNA (Certified Nurse Aide) 25 and CNA 21 were observed providing incontinence care for Resident 8. Both CNA's sanitized hands and donned plastic gowns and gloves prior to placing Resident 8 on right side. CNA 21 used 3 cleaning wipes to clean Resident 21 going from front to back. Rolled the dirty brief under resident and helped position the resident onto left side. CNA 25 removed dirty brief and placed new brief. Neither CNA removed gloves nor sanitized before placed new brief. LPN (Licensed Practical Nurse) 3 sanitized hands and donned plastic gown before LPN changing	F 0880	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** A licensed nurse provided resident #47 with a clean lift sling. The Director of Nursing/Designee reeducated all licensed and certified nursing staff on Enhanced Barrier Precaution. Resident #8 experience no negative outcome as a result and is receiving incontinent care and wound care in accordance with infection control guidance. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Potentially all residents could be affected as a result of improper infection control practices. The Director of Nursing/Designee conducted visual observation audits of care provided to include wound care and incontinent care to determine infection control practices were followed to include removing gloves and sanitizing hands from dirty to clean areas. **What measures will be put into place or what systemic changes will be made to**	12/13/2024

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	dressing on Resident 8's right shoulder. LPN 3 removed dirty dressing and did not change gloves or sanitized hand before opened clean bandage. LPN 3 cleaned shoulder wound with saline. LPN 3 placed clean dressing. LPN 3, CNA 21, and CNA 25 removed gowns, gloves, and then sanitized hands. During an interview on 11/12/24 at 9:40 A.M., LPN 3 indicated she should have changed gloves before placed clean dressing to open area. 3. During an observation of catheter care on 11/13/24 at 10:31 A.M., Resident 29 stated she felt like a science experiment that day because staff were wearing gowns and face masks during care and that staff never wear those. On 11/12/24 at 4:15 P.M., the DON (Director of Nursing) provided a current policy "Infection Control Guidelines for All Nursing Procedures" revised August 2012. The policy indicated "...if hands are not visibly soiled, use of an alcohol-based hand rub... before and after direct contact with residents ... and after handling used dressing..." An Enhanced Barrier Precautions policy was provided by the Administrator on 11/14/2024 at 11:53 A.M., it indicated "EBP's employ targeted gown and glove used during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity. Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include (but not limited to) transferring. EBP's are indicated for resident's with wounds, and or indwelling medical devices regardless of Multidrug Resistant Organism colonization".		**ensure that the deficient practice does not recur?** The DON/designee provided reeducation to licensed nurses medication assistants, and certified nursing assistant regarding infection control practices. The reeducation included proper PPE for resident in precautions to include wearing gowns when direct care is provided to any resident in Enhanced Barrier Precautions, equipment is not shared to include lift slings, gloves are changed, and hand hygiene is performed when going from a dirty to clean area to include during incontinent care. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The DON/designee will complete routine visual observations of the prevision of care of 5 staff members to determine proper PPE for resident in precautions to include wearing gowns when direct care is provided to any resident in Enhanced Barrier Precautions, equipment is not shared to include lift slings, gloves are changed and hand hygiene is performed when going from a dirty to clean area to include during incontinent care weekly x 3 weeks, monthly x 3	

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	3.1-18(b)(1)		months then quarterly x 3 months. Any findings will be addressed as noted below. The results of these reviews will be immediately reported if concerns exist and will be discussed at the monthly facility Quality Assurance Committee meeting monthly for three months and then quarterly thereafter once full compliance has been achieved for a total of 6 months of monitoring. Re-education, frequency and/or duration of reviews will be increased as needed, if areas of noncompliance are identified through the review process.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to provide a safe and sanitary environment for residents, staff, and the public for 9 random observations on 6 of 6 days. Urine smells in unit hallways and conference room, pests flying in resident room and nurses' station, and condition of resident air conditioners. (Resident Room 203, Resident Room 400, Resident Room 403, Resident 308, Conference Room, Hallway 400 Unit, 200 Unit Nurses Station) Findings include: 1. On 11/6/24 at 8:47 A.M., a strong smell of urine was observed in the conference room and the 400 Unit Nurse's Station Hallway. 2. On 11/7/24 at 8:47 A.M., a strong smell of urine was observed in the 400 Unit Nurse's Station and	F 0921	**It is the practice of this facility to assure that the facility will provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The corrective action taken for those residents found to be affected by the deficient practice include:** New heating and air units have Been ordered and will be installed Upon their arrival. The urine smell On the 400 unit was caused by Urine in the tile of a residents Bathroom. The tile has been pulled Up and replaced. The trash was	12/13/2024

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	the conference room. 3. On 11/08/24 at 3:11 P.M. heating and air window until in room 308 observed to have had paint flaking off and moderate amounts of rust. 4. On 11/12/24 9:08 A.M., a strong smell of urine was observed outside of the conference room. 5. On 11/13/24 8:05 A.M., a strong smell of urine was observed in 400 Unit Hallway. 6. On 11/14/24 at 11:17 A.M. resident rooms 403, 400, and 308 observed to have had heating and air window units with paint flaking off and moderate amounts of rust. During an interview on 11/14/24 at 8:25 A.M., LPN (Licensed Practical Nurse) 3 indicated she had noticed an occasional smell of urine when she entered the second floor. During an interview on 11/14/24 at 8:32 A.M., the Administrator the facility should be clean and odor free and the urine smell on the first floor was due to a resident urinating on the floor. On 11/14/24 at 12:15 P.M.,the DON provided a current policy "Maintenance Administration" dated 3/2015. The policy indicated that "...maintenance maintains documentation of functionally/compliance for...heating and cooling systems..." 3.1-19(f)(4) 3.1-19(f)(5)		Removed from the second floor. **Other residents that have the potential to be affected have been identified by:** All residents living in the facility have the potential to be affected. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** All staff were re-educated that Facility must provide a safe, Functional, sanitary, and comfortable Environment for residents, staff, and The public. Nursing staff was Re-educated on the importance Of bagging dirty incontinence Items and placing them in a Barrel with a lid. **The corrective action taken to monitor performance to assure compliance through quality assurance is:**	

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			A Performance Improvement Tool has been initiated that reviews the facility to assure the facility provides a safe, Functional, sanitary, and comfortable Environment for residents, staff, and The public. The Administrator, or designee, will complete this tool Weekly x 6 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	
F 0925 SS=D Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program Based on observation, record review, and interview, the facility failed to provide a safe environment free of pests based on 3 of 3 random observations of flies and gnats during the survey. (Resident Room 15, Second Floor Nurses Station) Findings include: 1. On 11/6/24, at 12:11 P.M., during a random observation 2 flies and a gnat were observed flying in Resident's 15 room. During an interview on 11/6/24 at 12:12 P.M., Resident 15 complained of having other incidences gnats and flies flying around in the room.	F 0925	**It is the practice of this facility to maintain an effective pest control program so that the facility is free of pests and rodents.** **The corrective action taken for those residents found to be affected by the deficient practice include:** Pest control company was called And they serviced the facility. **Other residents that have the potential to be affected have**	12/13/2024

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	2. On 11/08/24 at 8:47 A.M., during a random observation a fly was observed flying around the Second Floor Nurse's Station flying around. 3. On 11/12/24 at 10:02 A.M., during a random observation a fly was observed flying around in Resident 15 room while a dressing change was performed. During an interview on 11/12/24 at 10:30, A.M., the Administrator indicated that he was not aware of bugs in the resident room. On 11/13/24 at 4:15 P.M., the DON (Director of Nursing) provided a current policy "Pest Control" dated 8/2011. The policy indicated "... the facility shall provide a clean sanitary environment free from pests...the facility will ensure that an appropriate pest control contract is in operation" 3.1-19(f)(4)		**been identified by:** All residents living in the facility Have the potential to be Affected. The pest control Company was notified and they Completed a service call. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** All staff were re-educated on the Importance of keeping food stored Properly, maintaining a clean environment, And ensuring meal trays are removed from The units as quickly as possible. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated to assure the facility remains free of pests and rodents. The Administrator, or designee, will complete this tool Weekly x 6 months. Any issues identified will be immediately corrected.	

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			The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	
F 9999 Bldg. 00		F 9999	**It is the practice of this facility to assure that there is an ongoing Inservice education and training program planned in advance for all personnel and the facility shall provide a program for developmentally disabled individuals. The corrective action taken for those residents found to be affected by the deficient practice include:**	12/13/2024
	1. 3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to maintain personnel records with documentation of staff completing an inservice related to residents' rights annually for 4 of 4 staff employed greater than 1 year reviewed. (Dietary Assistant 11, CNA 15, QMA 17, CNA 8) Finding includes: On 11/8/24 at 1:31 P.M., employee files were reviewed. The employee files for Dietary Assistant 11, Certified Nursing Aide (CNA) 15, Qualified Medication Aide (QMA) 17, and CNA 8 lacked documentation of a completed inservice related to residents' rights after the employee start date.		All staff who were identified As not having annual dementia And resident rights training Received the training. Residents 3, 23, 2, and 267 have been Reviewed for services needed.	

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	Dietary Assistant 11 started employment with the facility on 7/4/11. CNA 15 started employment with the facility on 3/1/16. QMA 17 started employment with the facility on 2/23/22. CNA 8 started employment with the facility on 7/27/20. On 11/12/24 at 9:24 A.M., the Administrator indicated that inservices related to resident rights could not be found for Dietary Assistant 11, CNA 15, QMA 17, and CNA 8. At that time, he indicated he was aware that staff had not received the required inservices and the facility was working on getting all staff caught up. On 11/12/24 at 1:47 P.M., the Administrator provided a current Staff Development Program policy, dated September 2023, that indicated "Training topics upon orientation and annually included but are not limited to: ... Resident Rights ...". 2. 3.1-14 PERSONNEL (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by:		**Other residents that have the potential to be affected have been identified by:** Residents 3,23,2, and 267 were The only residents in the facility With developmental Disabilities. **The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:** Newly hired Staff development Coordinator was educated on Ongoing Inservice requirements. Social Services director was Educated on the requirements Of providing services for residents With developmental disabilities. **The corrective action taken to monitor performance to assure compliance through quality assurance is:** A Performance Improvement Tool has been initiated that reviews all residents who have a developmental disability to assure that they are receiving needed services. A Performance Improvement Tool has been initiated that reviews all staff	

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	Based on interview and record review, the facility failed to provide documentation of staff completing a minimum of three hours of dementia-specific training annually for 4 of 4 staff employed greater than 1 year reviewed. (Dietary Assistant 11, CNA 15, QMA 17, CNA 8) Finding includes: On 11/8/24 at 1:31 P.M., employee files were reviewed. The employee files for Dietary Assistant 11, Certified Nursing Aide (CNA) 15, Qualified Medication Aide (QMA) 17, and CNA 8 lacked documentation of dementia-specific training. Dietary Assistant 11 started employment with the facility on 7/4/11. CNA 15 started employment with the facility on 3/1/16. QMA 17 started employment with the facility on 2/23/22. CNA 8 started employment with the facility on 7/27/20. Dietary Assistant 11 lacked 3 dementia inservice hours. CNA 15 lacked 3 dementia inservice hours. QMA 17 lacked 3 dementia inservice hours. CNA 8 lacked 3 dementia inservice hours. On 11/12/24 at 9:24 A.M., the Administrator indicated that he was aware that staff were behind on required dementia-specific inservices and the facility was working to get all staff caught up. On 11/12/24 at 1:47 P.M., the Administrator provided a current Staff Development Program policy, dated September 2023, that indicated "Training topics upon orientation and annually		to ensure that they are receiving all required ongoing inservicing. The Administrator, or designee, will complete this tool Weekly x 6 months. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools.	

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	included but are not limited to: ... Dementia Management (State Specific requirements) ...". 3. 7-4 RESIDENT PROGRAMS (a) The facility shall provide a program for developmentally disabled individuals This state rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure implementation of a program for specialized populations served in the facility (intellectual and/or developmental disability) for 4 of 4 residents reviewed for Intellectual Disability. (Resident 3, Resident 23, Resident 2, Resident 267) Finding includes: On 11/7/24 at 10:52 A.M., the Administrator provided a list of four residents (Resident 3, Resident 23, Resident 2, and Resident 267) with a diagnosis of intellectual and/or developmental disability. On 11/8/24 at 8:04 A.M., the Administrator indicated there was no special program dedicated to intellectually and/or developmentally disabled residents that he was aware of. On 11/8/24 at 9:30 A.M., the Social Service Director indicated that she was the Qualified Intellectual Disabilities Professional (QIDP). At that time, she indicated that no residents diagnosed with intellectual and/or developmental disabilities received specialized services. She further indicated that staff did not receive inservices related to those diagnoses.			

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	On 11/8/24 at 1:29 P.M., the Director of Nursing (DON) provided a current Behavior Intellectual Disabilities Management Policy and Procedure, dated 6/1/18, that indicated "For those residents with an Intellectual Disability, a QMRP will be available in accordance with the state regulation. If these residents exhibit behaviors, they will be included as part of behavior management". At that time, the DON indicated that was the only policy related to residents with intellectual and/or developmental disabilities. On 11/12/24 at 11:24 A.M., the Administrator indicated the company did not have a program statement or policy related to programming for intellectually and/or developmentally disabled resident, and the facility followed federal and state regulations.			