STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155390	A. BUILDING 00 B. WING	09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRICKYARD HEALTHCARE - WOODBRIDGE CARE CENTER	816 N FIRST AVE EVANSVILLE, IN 47710

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00385834 & IN00377528. Complaint IN00385834- Substantiated. Federal/State deficiencies related to the allegations are cited at F656, F921. Complaint IN00377528- Substantiated. Federal/State deficiencies related to the allegations are cited at F623, F625. Survey dates: August 29, 30, 31, September 1, 2, 2022. Facility number: 000438 Provider number: 155390 AIM number: 100274170 Census Bed Type: SNF/NF: 62 Total: 62 Census Payor Type: Medicare: 7 Medicaid: 47 Other: 8 Total: 62 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 15, 2022.	F 0000	This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied. The facility respectfully requests consideration of paper compliance for this plan of correction.	

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

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F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility,			

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	the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on interview and record review, the facility failed to provide necessary documentation to ensure a resident or responsible party was issued a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) before the proposed end of services for 1 of 3 beneficiary notices reviewed. (Resident 15) Finding includes: On 8/30/22 at 1:45 P.M., during review of three randomly chosen resident Medicare Part A discharge notices, Resident 15's notice stated, "The facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted," and a SNF ABN notification form was not provided, and a written note was provided from the facility that stated "employee turnover new employee inserviced on process." On 9/1/22 at 1:16 P.M., the Business Office Manager (BOM) indicated an ABN should have been completed.	F 0582	It is the practice of this facility to ensure required notices are provided to residents being discharged from Medicare services. • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #15 was not harmed by the alleged deficient practice. BOM, SSD and MDS Coordinator educated on the proper notification forms to be issued to resident / resident representative. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;	10/18/2022

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	On 9/2/22 at 12:48 P.M., a current, undated Advance Beneficiary Notices policy was provided and indicated..."The current CMS-approved [Centers for Medicare and Medicaid Services] version of the forms shall be used at the time of issuance to the beneficiary (resident or resident representative). Contents of the form shall comply with related instructions and regulations regarding the use of the form. For Part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), Form CMS-10055. 3.1-4(i)		All residents have the potential to be affected by the alleged deficient practice. Proper notification forms will be issued to resident/ resident representative when a resident is being discharged from Medicare services. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; BOM, SSD and MDS Coordinator educated regarding required notifications for residents no longer receiving Medicare skilled servives. During weekly Medicare meeting, therapy/skilled nursing services discharge dates will be discussed. Proper notification forms and dates will be identified to be issued to resident/resident representative. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Administrator/designee will audit all residents discharged from Medicare services weekly for 4 weeks, then monthly for 5 months. Any concerns identified will be addressed if observed. Results on monitoring will be further reviewed in QAPI and if trends are identified	

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			then another action may be developed. Any action plan written by the QAPI Committee will be monitored by the ED weekly until resolution	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility			

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	would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and			

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	(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on interview and record review, the facility failed to ensure a notice of transfer or discharge was given to residents or resident representatives for 2 of 5 residents reviewed for hospitalizations. There was no documentation of a resident or representative receiving a notice of transfer or discharge at the time of hospitalization. (Resident K, Resident C) Findings include: 1. On 8/30/22 at 10:23 A.M., Resident K's clinical	F 0623	It is the practice of this facility to provide notice prior to a resident transfer/discharge • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents that discharged on 5/6/22 to 6/13/22, Resident K and C, reviewed and provided a	10/18/2022

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	record was reviewed. Resident K had been sent to the hospital on the following dates: From 5/6/22 through 5/12/22 - Resident K's clinical record lacked documentation of a transfer or discharge form being given to the resident or resident's representative. On 9/1/22 at 10:52 A.M., a notice of transfer or discharge form was provided for Resident K's hospital visit on 5/6/22, but the form was not filled out or dated. From 6/11/22 through 6/13/22 - Resident K's clinical record lacked documentation of a transfer or discharge form being given to the resident or resident's representative. During an interview on 9/1/22 at 10:52 A.M., the Regional Consultant indicated the transfer or discharge form was not found for that hospitalization, and should have been provided. 2. On 9/1/22 at 1:26 P.M., Resident C's clinical record was reviewed. Resident C had been sent to the hospital on 7/16/22. On 9/1/22 at 2:00 P.M., a notice of transfer or discharge form was provided that indicated it was issued on 7/16/22. The form lacked the name and address of the facility being transferred to, or the transfer or discharge effective date. During an interview on 9/2/22 at 9:14 A.M., RN (Registered Nurse) 3 indicated the nurse on duty at the time of a resident transfer was responsible for filling out the appropriate paperwork, including the notice of transfer or discharge to include the name, date, and name and address of where they are going. On 9/2/22 at 1:17 P.M., a current non-dated		transfer/discharge in writing by social services and understanding documented. The resident's representative was also notified and given a copy of the notice. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that have been transferred or discharged had the potential to be affected by the deficiency. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In service will be conducted to educate nursing staff on the required transfer/discharge notices. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Social Services will conduct a audit daily x 4 weeks then weekly x 5 months of residents who have been transferred/discharged from the facility to ensure a record included copy of	

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	Transfer and Discharge policy indicated "The facility's transfer/discharge notice will be provided to the resident and the resident's representative ... The notice will include all of the following at the time it is provided ... The effective date of transfer or discharge ... the specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged" This Federal tag relates to Complaint IN00377528. 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii)		transfer/discharge. Audits will be reviewed in QAPI to review the need for additional education and or audits.	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.			

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	§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on interview and record review, the facility failed to ensure a bed hold policy was given to residents or resident representatives for 2 of 5 residents reviewed for hospitalizations. There was no documentation of a resident or representative receiving a bed hold policy at the time of hospitalization. (Resident K, Resident C) Findings include: 1. On 8/30/22 at 10:23 A.M., Resident K's clinical record was reviewed. Resident K had been sent to the hospital on the following dates: From 5/6/22 through 5/12/22 - Resident K's clinical record lacked documentation of a bed hold policy being given to the resident or resident's representative. From 6/11/22 through 6/13/22 - Resident K's clinical record lacked documentation of a transfer or discharge form being given to the resident or resident's representative. During an interview on 9/1/22 at 10:52 A.M., the Regional Consultant indicated the transfer forms, including the bed hold policy, was not found for that hospitalization, and should have been provided. 2. On 9/1/22 at 1:26 P.M., Resident C's clinical record was reviewed. Resident C had been sent to the hospital on 7/16/22.	F 0625	It is this facilities practice to ensure a notice of bed hold is given before transfer /discharge • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents that were discharged between 5/6/22 to 6/13/22 reviewed and notified of the facility bed hold policy. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that are transferred from the facility have the potential to be affected by the deficiency. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff will e educated on the required bed hold policy upon transfer	10/18/2022

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	On 9/1/22 at 2:00 P.M., a notice of transfer or discharge form was provided that indicated it was issued on 7/16/22. On the back page, there was a blank bed hold policy with a space reserved for the resident's name. At that time, the Regional Consultant indicated the name of the resident should have been filled in. During an interview on 9/2/22 at 9:14 A.M., RN (Registered Nurse) 3 indicated the nurse on duty at the time of a resident transfer was responsible for filling out the appropriate paperwork, including a bed hold policy, to include the name of the resident. On 9/2/22 at 12:48 P.M., a current nondated Bed Hold policy was provided, and indicated "It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold policies prior to transferring a resident to the hospital ..." This Federal tag relates to Complaint IN00377528. 3.1-12(a)(6)(A)(i) 3.1-12(a)(6)(A)(ii)		• how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Social Services will conduct a audit daily x 4 weeks then weekly x 5 months of residents who have been transferred from the facility to ensure a record includes a copy of the Bed Hold. Audits will be reviewed in QAPI to review the need for additional education and or audits.	
F 0656 SS=E Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the			

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	following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.			
	Based on observation, interview, and record review, the facility failed to ensure physician orders were followed and care plans were implemented for 6 of 6 residents reviewed for medications and treatments. Residents did not receive medications, side effects were not monitored, skin treatments not performed, labs not obtained, oxygen not applied/worn, care plan	F 0656	It is the practice of this facility to develop and implement a comprehensive care plan. • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	10/18/2022

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	interventions not implemented. (Resident B, Resident M, Resident L, Resident K, Resident O, Resident P) Findings include: 1. On 8/29/22 at 8:22 a.m., Resident B indicated they did not always receive their insulin shot. On 8/31/22 at 1:58 p.m., Resident B's clinical record was reviewed. Diagnoses included, not limited to, Diabetes Mellitus with stable proliferative diabetic retinopathy, hyphema, left eye, atelectasis unspecified. A quarterly MDS (Minimum Data Set) assessment dated 7/13/22, indicated Resident B's cognition was moderately impaired. Care plans were reviewed and included, not limited to: Alteration in blood glucose due to: hyperglycemic episodes, hypoglycemic episodes, insulin dependent Diabetes Mellitus. Interventions included, not limited to: Administer medications as ordered, initiated 5/10/22. August 2022 physician orders were reviewed and included, not limited to: Basaglar KwikPen 100 unit/ml (milliliters) solution pen-injector - inject 24 unit subcutaneously at bedtime related to Type 2 Diabetes Mellitus without complications, order date 7/15/22. Insulin Lispro (1 unit dial) solution pen injector 100 unit/ml inject as per sliding scale: 150-189 =1 190-229 = 2 230-269 = 3 270-299 = 4 300+ = 5		Resident B, M, L and O had care plans reviewed and updated. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents that receive insulin. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff were educated on physician orders, care plans, lab orders, and side effect monitoring. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and DNS or designee will audit new orders and care plans, and labs. 10 times a week Monday thru Friday for 4 weeks then 5 times a week Monday thru Friday for 5 months then review in QAPI to needs for further education and audits.	

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	155390	A. BUILDING 00 B. WING	09/02/2022

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	If blood glucose > 300 give 5 units and recheck BS at next ordered time. If remains > 300 contact MD, subcutaneously before meals for hyperglycemia related to Type 2 Diabetes Mellitus without complications, order date 5/11/22. The August 2022 EMAR (Electronic Medication Administration Record) was reviewed and included, not limited to: Basaglar KwikPen 100 unit/ml solution pen-injector inject 24 unit subcutaneously at bedtime related to Type 2 Diabetes Mellitus without complications. The following dates on the EMAR were blank: 8/5/22 8/16/22 8/18/22 8/20/22 8/28/22 Progress notes for August 2022 were reviewed and did not contain refusals for the above dates. Insulin Lispro (1 unit dial) solution pen injector 100 unit/ml inject as per sliding scale: 150-189 =1 units 190-229 = 2 units 230-269 = 3 units 270-299 = 4 units 300+ = 5 units If blood glucose > 300 give 5 units and recheck BS at next ordered time. If remains > 300 contact MD, subcutaneously before meals for hyperglycemia related to Type 2 Diabetes Mellitus without complications. The following date and times were blank on the EMAR: 8/5/22 11:00 a.m. 8/17/22 7:30 a.m., 11:00 a.m. 8/20/22 11:00 a.m. 8/21/22 11:00 a.m. 8/29/22 4:30 p.m.			

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	Progress notes were reviewed and contained the following: A progress note dated 8/21/22 at 10:15 a.m., indicated that Resident B's blood sugar was 109, the nurse did not feel comfortable giving the insulin dose. 8/22/22 9:20 a.m.,...Insulin held. BS 148 at present. No concerns at this time... No documentation was seen in the progress notes of refusals, or the physician was notified of the insulin being held. On 9/1/22 at 12:44 p.m., RN 3 indicated if a resident refuses insulin, the physician should be notified, document refusal on the EMAR and progress notes, a code of 3 should be documented for insulin held. 2. On 9/2/22 at 8:11 a.m., Resident M indicated they sometimes do not receive their insulin. On 8/31/22 at 2:53 p.m., Resident M's clinical record was reviewed. Diagnoses included, not limited to, Type 2 Diabetes Mellitus with unspecified complications, Bipolar disorder, Type 1 Diabetes Mellitus with diabetic neuropathy, Type 1 Diabetes Mellitus with unspecified diabetic retinopathy with macular edema. A quarterly MDS (Minimum Data Set) assessment dated 7/14/22 indicated Resident M's cognition was intact. Care plans were reviewed and included, not limited to: Alteration in blood glucose due to: hyperglycemic episodes, hypoglycemic episodes, insulin dependent diabetes, initiated 5/17/22. Interventions included, not limited to, Administer			

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	medications as ordered. August 2022 physician orders were reviewed and included, not limited to: Insulin Glargine Solution inject 36 unit subcutaneously at bedtime related to Diabetes Mellitus due to hyperglycemia, order date 5/16/22. Insulin Lispro solution 100 unit/ml inject 8 unit subcutaneously before meals related to Diabetes Mellitus due to underlying condition with hyperglycemia, order date 5/17/22. Insulin Lispro solution 100 unit/ml inject as per sliding scale: 151-200 = 4 units 201-250 = 6 units 251-300 = 8 units 301-350 = 10 units 400 = 20 units 4-1-450 = 24 units over 450 call MD, subcutaneously before meals related to Diabetes Mellitus due to underlying condition with hyperglycemia, order date 5/17/22. The August 2022 EMAR (Electronic Medication Administration Record) was reviewed and included, not limited to: Insulin Glargine solution inject 36 unit subcutaneously at bedtime related to Diabetes Mellitus due to underlying condition with hyperglycemia. The following dates were blank on the EMAR: 8/5/22 8/16/22 8/18/22 8/20/22 8/28/22 Progress notes were reviewed and not observed to contain any refusal of the bedtime dose of			

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	insulin. Insulin Lispro solution 100 unit/ml inject 8 unit subcutaneously before meals related to Diabetes Mellitus due to underlying condition with hyperglycemia. The following date and times were blank on the EMAR: 8/2/22 at 11:00 a.m. 8/5/22 at 11:00 a.m. 8/7/22 at 4:30 p.m. 8/21/22 at 11:00 a.m. 8/29/22 at 4:30 p.m. 8/31/22 at 7:30 a.m. Progress notes were reviewed and not observed to contain a refusal for the above date and times. On 9/2/22 at 9:05 a.m., the DON indicated if a resident refuses insulin it should be documented and the physician notified. 3. On 8/31/22 at 8:52 A.M., Resident K's clinical record was reviewed. Diagnosis included, but were not limited to, schizoaffective disorder, bipolar, and anxiety disorder. The most recent quarterly MDS (minimum data set) Assessment, dated 7/7/22 indicated Resident K was cognitively intact. Resident K's care plans were reviewed and included, not limited to: Mood/Behavior: I have a diagnoses of Schizoaffective DO (disorder) and Bipolar. I do not always understand my my situation/circumstances and will make statements that I feel like I am being "neglected/abused" because I think I should have been able to leave the facility after I finished therapy. I sometimes have behaviors which include loud disruptive yelling/screaming. false beliefs/delusions, such as my dad has taken over my body. I sometimes am			

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	non-compliant w/ my medication regime. I tend to pick and choose the medications I want to take and when I want to take them, refusing them at other times. I will attempt to to hide medications I do not want to take. I experience delusions with medications. I will state things like "the devil told me not to take this " "I am allergic" or thinking the medication will harm me in some way. I make false accusations towards staff. Interventions included, not limited to: Give my medications as my doctor has ordered, initiated 1/6/22. Current physician orders included, but were not limited to:..."Haloperidol [Haldol] Lactate Concentrate 2MG/ML [milligram/ milliliter] Give 0.25 ml by mouth two times a day for mix with drink of choice at meals related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE,..." started 7/28/22. On 8/31/22 at 7:35 A.M., Registered Nurse (RN) 15 removed an oatmeal from the meal cart and RN 15 pushed a liquid substance into Resident K's oatmeal and returned the oatmeal to the meal cart. During an interview at that time, RN 15 indicated the medication pushed into the oatmeal was Haldol. On 8/31/22 at 8:26 A.M., Resident K was observed lying in bed with a backpack on the bed and the meal tray sat on the bedside table next to the resident. On 8/31/22 at 8:37 A.M. Certified Nurse Aide (CNA) 17 removed Resident K's tray. At that time, the oatmeal was observed to have one-third of the oatmeal left in the bowl. During an interview on 9/1/22 at 1:14 P.M., Director of Nursing (DON) indicated Haldol			

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	should be given mixed with a drink of choice two times a day. 4. On 8/31/22 8:30 A.M., Resident L's clinical record was reviewed. Diagnoses included, but were not limited to paranoid schizophrenia,schizoaffective disorder, and dementia. The most recent quarterly MDS (Minimum Data Set), dated 8/18/22, indicated Resident L had a significant cognitive impairment and required extensive assistance of 2 (two) staff with dressing, transfers, eating, bed mobility, and toileting. The MDS also indicated Resident L received antipsychotics on a daily basis for the 7 (seven) day look-back period. Current physician orders included, but were not limited to: Monitor for side effects and report to physician: Antipsychotic medication, initiated 5/13/22 Iloperidone: Tablet 1 MG (milligram),Give 1 mg by mouth three times a day, initiated 5/12/22 Haloperidol Lactate Concentrate: Give 0.25 ml (milliliters) by mouth three times a day, initiated 7/7/22. A current psychotropic medication use care plan, initiated 1/25/22, included, but were not limited to, the following interventions: "Monitored for side effects and reported to physician: Antipsychotic medication-sedation, drowsiness, dry mouth, constipation, blurred vision, EPS [extrapyramidal symptoms], weight gain, edema, postural hypotension, sweating, loss of appetite, urinary retention....", initiated 1/25/22. Resident L's MAR (medication administration record) for June through August 2022 included the following dates that Haldol failed to be administered: 6/20/22 at 5:30 P.M.			

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	7/10/22 at 8:30 A.M. and 12:30 P.M. 7/13/22 at 5:30 P.M. 8/13/22 at 12:30 P.M. Resident L's MAR indicated from June through August 2022, side effects from Haldol were not monitored on the following dates: 7/10/22 day shift 7/27/22 night shift 7/30/22 evening and night shift 8/1/22 evening shift 8/9/22 night shift 8/10/22 night shift Resident L's MAR indicated from June through August 2022, Illoperidone was not administered on the following dates: 6/20/22 at 5:00 P.M. 7/10/22 at 8:30 A.M. and 12:30 P.M. 7/13/22 at 5:00 PM 7/20/22 at 8:30 AM, 12:30 PM, and 5:30 PM 7/30/22 at 5:00 PM 8/13/22 at 12:30 PM Resident L's MAR indicated from June through August 2022, side effects from Illoperidone were not monitored on the following dates: 7/10/22 day shift 7/27/22 night shift 7/30/22 evening and night shift 8/1/22 evening shift 8/9/22 night shift 8/10/22 night shift During an interview on 9/2/22 at 9:29 A.M., the DON (Director of Nursing), indicated nurses were supposed to document on Resident L's MAR the administration of medication and side effects of Haldol and Illoperidone and was unsure why Resident L's MAR lacked documentation in June,			

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	July, and August for these areas. 5. On 8/29/22 at 12:24 A.M., Resident O was observed lying in bed. The resident's feet were observed uncovered and the right foot third toe was black. On the left foot, all toes were black except the second toe. All toes were stained orange. The resident indicated that he does not wear his oxygen continuously, he was observed to not have oxygen on . On 8/30/22 at 9:24 A.M., Resident O was observed laying in his bed without oxygen on. On 8/31/22 at 12:58 P.M., Resident O was observed laying in his bed without oxygen on. On 9/1/22 at 10:10 A.M., the resident was observed lying in his bed awake with oxygen tubing on the floor beside his bed. On 09/01/22 at 8:20 A.M., Resident O's clinical record was reviewed. Diagnoses included, but were not limited to, atherosclerosis of native arteries of right leg with ulceration of other part of foot, atherosclerosis of native arteries of extremities of left leg with ulceration of other part of foot, atherosclerosis of native arteries of extremities with gangrene, bilateral legs, and COPD (chronic obstructive pulmonary disease). The most recent significant change MDS (minimum data set) Assessment, dated 7/11/22 indicated Resident O required extensive assistance of 1 (one) staff with bed mobility, and had a moderate cognitive impairment. A current care plan titled "Impaired Gas Exchange..." initiated 6/3/22, indicated but not limited to the following interventions: "Administer oxygen as prescribed or per standing order".			

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	A current physician's order, dated 6/29/22, was reviewed and included Betadine solution 10% (Povidone-Iodine) apply to feet toes topically every day shift. Resident O's TAR (treatment administration record) was reviewed for 8/1/22 through 8/31/22. The following dates of Betadine solution treatments were not completed: 8/5/22, 8/12/22, 8/13/22, 8/14/22, 8/15/22, 8/18/22, 8/22/22, 8/26/22. A current physician's order, dated 7/20/22, was reviewed and included continuous oxygen @ 2 lpm (liters per minute) via NC (nasal cannula). Call MD if O2 sats are below 90% every shift. Vital signs were reviewed for 8/1/22 through 8/31/22. The Residents oxygen was not monitored as ordered on the following shifts: 8/1/22 evening shift 8/2/22 evening and night shift 8/3/22 evening shift 8/4/22 evening shift 8/5/22 day shift 8/6/22 night shift 8/7/22 evening shift 8/9/22 evening and night shift 8/10/22 evening and night shift 8/11/22 evening shift 8/12/22 evening shift 8/13/22 day and evening shift 8/14/22 day and evening shift 8/15/22 day and evening shift 8/19/22 day, evening, night shift 8/20/22 evening and night shift 8/21/22 night shift 8/22/22 day and evening shift 8/23/22 evening shift			

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	8/24/22 evening shift 8/25/22 evening and night shift 8/26/22 day and evening shift 8/27/22 evening and night shift 8/28/22 evening and night shift 8/29/22 evening shift 8/30/22 evening shift 8/31/22 evening shift During an interview on 09/01/22 10:20 A.M., CNA 12 indicated that resident did not wear oxygen continuously. 6. On 08/29/22 at 9:27 A.M., Resident P was observed laying in his bed. On 08/31/22 07:56 A.M., Resident P's clinical record was reviewed. Diagnoses included, but were not limited to, Type II Diabetes Mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolarity coma, localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus, and hypokalemia. The most recent quarterly MDS Assessment, dated 7/22/22, indicated Resident P required total dependence of 2(two) staff with bed mobility, and had severe cognitive impairment. A current care plan titled "Nutrition.." initiated on 6/30/10 included not limited to the following interventions: Monitor lab values as ordered", initiated 2/10/20. A list of physician orders included but was not limited to the following: Levetiracetam solution 100MG/ML give 10 ml via PEG-tube four times a day related to			

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	localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus active 3/16/22. Potassium Chloride Solution 20 MEQ/15ML (10%) give 10 mEq via PEG-Tube three times a day related to hypokalemia active 1/12/21. CBC, Lipid, BMP, and Keppra level every 4 months every night shift...active 3/5/22. During an interview on 8/31/22 at 1:08 P.M., RN (Registered Nurse) 15 indicated the labs drawn on 3/10/22 were the last labs the resident completed. During an interview on 9/2/22 at 12:48 P.M., the DON (Director of Nursing) indicated there was not a specific policy related to care plan interventions, but the facility policy was to implement care plan interventions. On 9/2/22 at 9/2/22 at 1:06 p.m., the DON provided the current undated policy on Medication Administration. The policy included, not limited to: medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician, administer medication as ordered in accordance with manufacturer specifications, sign MAR after administered, report and document any adverse side effects or refusals. This Federal tag relates to Complaint IN00385834. 3.1-35(a)			

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	3.1-35(g)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to implement interventions to prevent accidents for 1 of 2 residents reviewed for falls. Resident 62 had 16 falls April through August, care plan interventions were not followed. (Resident 62) Finding includes: During record review on 08/31/22 10:27 A.M., Resident 62's most recent quarterly MDS (Minimal Data Set) Assessment, dated 8/20/22, indicated the Resident was an extensive assist with 2 (two) staff members for transfers. Resident 62's diagnoses include, but were not limited to, Parkinson's disease, repeated falls, traumatic subdural hemorrhage with loss of consciousness of unspecified duration, fracture of unspecified part of right clavicle, with routine healing, unspecified displaced fracture of seventh cervical vertebra, with routine healing, multiple fractures of ribs, right side, with routine healing, unspecified fracture of the first thoracic vertebra, with routine healing, orthostatic hypotension,	F 0689	It is the practice of this facility to implement interventions to prevent accidents. • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Review of resident 62 fall care plan. Updated care plan. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the deficiency • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;	10/18/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cerebral infarct, and syncope and collapse. Resident 62's care plan included, but was not limited to, at risk for injury from falls. The fall risk care plan included the interventions, bed in lowest position (initiated 4/18/22), footwear or gripper socks to prevent slipping (initiated 4/5/22), mat beside bed (initiated 4/5/22), use activity box to stimulate and occupy resident while in wheelchair (initiated 4/18/22), use weighted blanket for comfort while in bed (initiated 4/18/22). A review of Resident 62's falls included the following: 04/04/2022 7:15 P.M.-Fall was not witnessed. Resident was found on floor of their room sitting on floor next to bathroom with head under chair sitting next to door. No injury noted. Neurological checks initiated. New intervention: Resident's bed placed in low position. 4/5/2022 8:30 A.M.-Fall was not witnessed. Resident attempted to get dressed independently and missed the chair when he tried to sit down. Resident found lying on the floor of their room. He was not wearing any non-skid socks or shoes at the time of fall. Floor mat was not on floor. No injury noted. New interventions: Neurological checks initiated, fall mat at bedside and resident to be moved to room closer to nurse's station with increased supervision. 04/09/2022 8:40 A.M.-Fall was witnessed. Fall occurred in the hallway as Resident was trying to ambulate and fell out of wheelchair. The wheelchair was unlocked. No injury noted. New intervention: added anti-roll back brakes to his wheelchair.		Nursing staff will be educated on implementing care planned fall interventions. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and DNS or designee will audit fall interventions 10 times per week for 4 weeks then 5 times per week for 5 months then review in QAPI for need for further audits or education.	

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	04/12/2022 6:40 P.M.- Fall was witnessed. Fall occurred in dining room as Resident was sitting in a straight back chair in the dining room and attempted to stand up but slid out of the chair onto the floor onto his buttock. No injury noted. The care plan was not updated with a new intervention. 4/13/2022 12:20 A.M.-Fall was unwitnessed. Resident found in their room off their bed on the mat. Resident denied hitting head. No injury noted. Resident assisted in broda chair and put by nursing station. Neurological checks initiated. The care plan was not updated with a new intervention. 04/13/2022 12:10 P.M.-Fall was unwitnessed. Resident was sitting up in bed and staff brought in his lunch tray. While staff returned to hallway to continue passing out trays, they turned around and noted that resident was on floor, partly on mat near bed . No injury noted. Resident continued neurological checks from previous fall. New intervention: do not leave him in his wheelchair in his room. 04/14/2022 6:42 P.M.-Fall was unwitnessed. Fall occurred in the Resident's room and it was clear that resident hit head. Found with knot and bleeding on left side of temple. Left eyebrow also had a small cut and was bleeding as well. Once resident was in chair, resident began to vomit. Resident sent to ER. No acute findings with CT of head and spine. New intervention: use weighted blanket to reduce anxiety/promote calmness and more restful sleep. A record of neurological checks was asked for but not provided and was not recorded in clinical record. 4/16/2022 12:45 A.M.-Fall was witnessed. Resident			

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	stood up from gerichair in front of nurses station without assistance and fell to his knees onto the floor striking left elbow on the chair. Resident had abrasions to left knee and left elbow. New intervention: provide activity box when up in Broda chair at nurses station. 4/17/22 11:58 A.M.-Fall was unwitnessed. Resident found on floor of room with 4 cm laceration to above left eyebrow. Resident sent to ER and returned to facility with 7 (seven) sutures. Bed was at normal height and a mattress was on the floor instead of a beveled fall mat. New intervention: put bed in low position and remove mattress. A record of neurological checks was asked for but not provided and was not recorded in clinical record. 04/20/2022 6:30 A.M.-Fall was witnessed. Resident was food on floor lying between the bedroom and bathroom. Resident was wearing regular socks. Resident had laceration on their left eyebrow measuring 2.5 cm and an egg size knot above previous stitches. Resident transferred to ER. No acute findings on CT of head. 5 (five) sutures were placed to laceration of left temple. A record of neurological checks was asked for but not provided. New intervention: resident be placed on toileting program. 4/25/2022 4:40 P.M.-Fall was witnessed. Resident was in dining room after activity resident attempted to stand from wheelchair and slid to floor. No injury noted. New intervention: staff to keep eyes on Resident if awake and in chair and also keep Resident near nurse's station if not in activity. 4/26/2022 6:07 P.M.-Fall was witnessed. Resident was in activity room after participating in activity			

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	in their reclining chair. Resident attempted to stand up and ambulate without assist of staff. Resident slid from chair onto his bottom. No injury noted. The care plan was not updated with a new intervention. 5/29/22 5:56 P.M.-Fall was witnessed. Staff was assisting resident to restroom from broda chair with use of gait belt. While transferring resident into the hallway restroom, Resident lost balance. Staff was unable to maintain balance due to Resident's height. Staff assisted to the floor and Resident landed on top of staff in a sitting position. No injury noted. New intervention: Resident on hospice services. 07/09/2022 1:05 P.M.-Fall was witnessed. Fall occurred in dining room while Resident was attempting to transfer from gerichair alone while foot rests were lowered. Resident had a laceration measuring 0.4 cm across bridge of nose. Resident sent to ER. No acute findings and wound care completed. Neurological checks were initiated. New intervention: will offer and encourage rest period after lunch, place with staff member to keep resident within line of sight at all times while out of bed, and up with assist only using appropriate assistive equipment. 07/20/2022 3:50 P.M.-Fall was unwitnessed. Fall occurred in the hallway while Resident was ambulating without assistance. Staff found Resident lying on the floor in the hallway on his right side. Resident had a skin tear to left elbow measuring 1.5 x 0.5 cm and one to right elbow measuring 0.5 x 0.2 cm. A record of neurological checks was asked for but not provided and not recorded in clinical record.			

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	7/29/2022 4:09 P.M.-Fall was unwitnessed. Resident attempted to transfer self from bed and fell in the process. No injury noted. Post fall evaluation was provided but was blank. A record of neurological checks was asked for but not provided. 8/31/2022 6:20 P.M.-Fall was unwitnessed. Staff found Resident on the floor by their bed with blood everywhere. Before the fall, the resident had been saying repeatedly they wanted their shoes on. Resident sent to the ER. No acute findings found. Wound care to abrasion on head. Neurological checks initiated and placed on 15 (fifteen) minute checks for 24 (twenty-four) hours. New intervention: staff to place shoes in closet when not in use so that the resident doesn't worry about his shoes. During an observation on 8/31/22 at 11:15 A.M., Resident 62 was in the dining room eating in Broda chair not interacting with staff. The resident did not have shoes on, there was not an activity box present. During an interview on 9/2/22 at 10:50 A.M. CNA (Certified Nursing Assistant) 14 indicated that she was unaware of an activity box or weighted blanket use for the Resident. During an interview on 9/2/22 at 10:40 LPN (Licensed Practical Nurse) 8, indicated that staff could not provide constant supervision to him. She further indicated that she was unaware of an activity box or weighted blanket to use for the Resident. On 9/2/22 at 12:48 P.M., the DON (Director of Nursing) provided an undated facility policy titled, Fall Prevention Policy. The policy stated,			

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	"Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk... implement interventions...If a fall should occur...review the resident's care plan and update as indicated. 3.1-45(a)(2)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data			

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	available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to provide staffing information on 2 of 3 units (100 unit, 200 unit) and failed to ensure the correct date was posted for staffing forms for 5 of 5 days during the survey. Posted nurse staffing was only able to be viewed in the front lobby. Resident units 100, 200, and 300 all failed to have staffing information posted in resident areas. Findings include: On 8/29/22 at 6:53 A.M., a staffing form, dated 8/25/22 was observed to be posted in the front lobby. On 8/30/22 at 2:33 P.M., a staffing form, dated 8/29/22 was observed in the front lobby. On 8/31/22 at 11:10 A.M., a staffing form, dated 8/30/22 was observed in the front lobby. On 9/1/22 at 8:06 A.M., a staffing form, dated 8/31/22 was observed in the front lobby. On 9/2/22 at 7:55 A.M., a staffing form, dated 9/1/22 was observed in the front lobby. During an interview on 9/2/22 at 8:33 A.M., the Director of Nursing (DON) indicated the staffing forms were posted by the time clock and front door and was unsure if the staffing forms should	F 0732	It is the practice of this facility to ensure the correct date is posted for staffing forms. • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Corrected posted staffing form. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; There are no specific residents identified • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In service will be provided to scheduler and other management staff on posting. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur,	10/18/2022

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	be posted on the other units. At that time, the DON indicated the staffing forms should be posted for the previous day. On 9/2/22 at 12:48 P.M., a current, undated Nurse Staffing Posting Information policy was provided and indicated..."The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information:...The current date..."		i.e., what quality assurance program will be put into place; and DNS or designee will audit staff posting daily for 4 weeks then weekly for 5 months	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to ensure it was free from a medication error rate greater than 5% for 2 of 26 opportunities observed to administer medications correctly, resulting in an error rate of 7.69%. This affected 2 of 5 residents observed during medication administration. (Resident K, Resident 40) Findings include: 1. On 8/30/22 at 9:55 A.M., Licensed Practical Nurse (LPN 8) was observed to administer 2 (two) 110 mg (milligram) tablets of Zinc sulfate (A total of 220 mg) to Resident 40. The physician's orders included, but were not limited to, " Zinc Tablet 50 MG Give 2 tablet by mouth one time a day for supplement." 2. On 8/31/22 at 7:35 A.M., Registered Nurse (RN) 15 removed an oatmeal from the meal cart and RN 15 pushed a liquid substance into Resident K's	F 0759	It is the practice of this facility to ensure it is free from a medication error rate of greater than 5%. • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The facility ensured that the correct dose of Zinc was available for order. Doctor and Family notified. Educated nurse on medication administration. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents receiving care have the potential to be affected.	10/18/2022

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	oatmeal and returned the oatmeal to the meal cart. During an interview at that time, RN 15 indicated the medication pushed into the oatmeal was Haldol. On 8/31/22 at 8:52 A.M., Resident K's clinical record was reviewed. Current physician orders included, but were not limited to:..."Haloperidol [Haldol] Lactate Concentrate 2MG/ML [milligram/ milliliter] Give 0.25 ml by mouth two times a day for mix with drink of choice at meals related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE,..." started 7/28/22. During an interview on 9/1/22 at 1:14 P.M., Director of Nursing (DON) indicated Haldol should be given mixed with a drink of choice two times a day. On 9/2/22 at 1:06 P.M., a current, undated Medication Administration policy was provided and indicated..."Administer medications as ordered...observe resident consumption of medication..." 3.1-48(c)(1)		• what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; In Service to nursing staff on medication administration. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and DNS or designee will audit medication administration 10 times a week for 4 weeks then 5 times a week for 5 months then review in QAPI to needs for further education and audits.	
F 0800 SS=E Bldg. 00	483.60 Provided Diet Meets Needs of Each Resident §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure the temperature of food items were taken before food was served to residents for 1 of 1 meal observations.	F 0800	It is the practice of this facility to provide each resident with a nourishing, palatable, well balanced diet that meets his or her daily nutritional and special	10/18/2022

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	Findings include: On 8/31/22 at 7:16 A.M., Cook 49 was observed placing food items on trays to be delivered to residents. On 8/31/22 at 7:27 A.M., Cook 49 pushed the meal cart out of the kitchen to be delivered to the 200 hall residents. At that time, Cook 49 indicated temperatures were not taken for any of the following food items: oatmeal, waffles, sausage links, puree sausage, puree waffles, scrambled eggs, and gravy. During an interview on 9/1/22 at 10:17 A.M., the Dietician indicated all food items should have the temperature taken when the food items are on the steam table and right before being put on the plate from the steam table. On 9/2/22 at 12:48 P.M., a current undated Food Safety Requirements policy was provided and indicated "...Cooking--foods shall be prepared as directed until recommended temperatures for the specific foods are reached..." 3.1-21(a)(2)		dietary needs, taking into consideration the preferences of each resident. • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A. There are no specific residents identified. B. Cook 49 was in-serviced on taking temperatures on all food that are placed on the steam table and taking temperatures right before serving. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; A. Dietary cook will be record temperature when items are placed in steam table and temperature will be recorded prior to serving from the steam table. B. Dietary staff will be in-serviced on the procedure of recording temperatures when items are	

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			placed on the steam table and record temperatures prior to serving from steam table. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Dietary Manager and or designee will audit 5 randomly picked trays at various meals weekly x 4 weeks then 3 trays weekly x 4 weeks then 2 trays weekly x 4 months to assure meals are served at an appropriate temperature The results for the audit will be reviewed by the QAPI committee to determine the need for further audits.	
F 0801 SS=F Bldg. 00	483.60(a)(1)(2) Qualified Dietary Staff §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either			

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	full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28,			

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	2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. Based on interview and record review, the facility failed to employ sufficient staff with the appropriate competencies to carry out the functions of food and nutrition services. The dietary manager lacked appropriate certification for 1 of 1 kitchen. Finding includes: On 8/31/22 at 10:00 A.M., employee records were reviewed. The current dietary manager lacked a state approved dietary certification. During an interview on 9/2/22 at 9:08 A.M., the Director of Nursing (DON) indicated the current dietary manager obtained that position on 2/2/18, and was currently working on becoming certified. On 9/2/22 at 10:21 A.M., a current manager of dining services job description, dated 9/27/15, was	F 0801	It is the practice of this facility to have a Certified Dietary Manager to oversee the operations of our dietary department. • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No specific Resident was identified as being affected. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents who receive meals in the facility have the potential to be affected.	10/18/2022

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	provided and indicated qualifications must include "State approved dietary manager certificate or become certified within one year from hire date." 3.1-20(h)		• what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The current dietary manager has enrolled in a state approved course to obtain her Certified Dietary Manager • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Administrator/Designee will monitor progress in course monthly for 6 months or until completion to ensure that the course is completed and the required certification is obtained. Any concerns identified will be addressed if observed. Results on monitoring will be further reviewed in QAPI and if trends are identified then another action may be developed. Any action plan written by the QAPI Committee will be monitored by the ED weekly until resolution	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by			

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	federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was served in a sanitary manner in accordance with professional standards for food service safety in 1 of 2 observations of the kitchen. The dishwasher was not tested with chemical strips, and the rinse solution container was empty. (Kitchen) Finding includes: During an initial kitchen observation on 8/29/22 at 7:27 A.M., a strip was placed in the dishwasher after a load was ran, and did not change color. At that time, the Kitchen Manager indicated she was unaware until recently that chemical strips were needed to test the dishwasher, and have had that dishwasher for about a year. At that time, the sanitizer container under the dishwasher was observed to be empty. On 8/29/22 at 7:56 A.M., the Kitchen Manager indicated the sanitizer, rinse, and detergent containers for the dishwasher were supposed to	F 0812	It is the practice of this facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety. • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No specific residents were identified by the alleged deficient practice. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the alleged deficient	10/18/2022

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	be changed when the solutions get to the bottom of the containers, and could be done by whoever was doing the dishes at that time. She indicated all staff were aware of when and how to change the containers. At that time, Cook 41 indicated staff did not test the dishwasher with strips, and only checked that it was 120 degrees while running. During an interview on 8/29/22 at 9:15 A.M., Cook 47 indicated staff was supposed to use a strip with the dishwasher, but had not done so the previous night when she had worked. She further indicated the only thing staff logged for the dishwasher was the temperature, and not the results of the strips. She also indicated she was unaware who was responsible for changing the solution containers for the dishwasher, and did not look at them during her shift. On 8/29/22 at 10:00 A.M., a dish machine temperature log was provided for August 2022. The log was filled out daily with the wash and final rinse for breakfast, noon meal, and evening meal. The form included a space to log PPM (parts per million), but all days were left blank. On 8/29/22 at 12:15 P.M., a current installation and operation manual for the dishwasher, dated December 5, 2007, indicated "... titration should be between 50 and 100 ppm ..." 3.1-21(i)(2) 3.1-21(i)(3)		practice. No residents were identified as being affected. Once the alleged violation was identified, a call was placed to Ecolab to replace the empty sanitizer. An in-service was provided to staff on the proper use and frequency of test strips that test the level of sanitizer in the dish machine. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Dietary staff will be educated on the proper use and frequency of using test strips to ensure the proper level of sanitizer in the dish machine. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Dietary Manager/designee will audit recorded dish machine temperatures and sanitizer level Three times a week for four weeks and then monthly for five months. Any concerns identified will be addressed if observed. Results on monitoring will be further reviewed in QAPI and if trends are identified then another action may be developed. Any action plan written by the QAPI Committee will be monitored	

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			by the ED weekly until resolution.	
F 0882 SS=F Bldg. 00	483.80(b)(1)-(4)(c) Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. Based on interview and record review, the facility failed to designate a qualified individual(s) as the Infection Preventionist with qualifying training or certification. The facility did not have a current certified Infection Preventionist for 1 of 1 employee file reviewed.	F 0882	It is the practice of this facility to have a certified infection preventionist. • what corrective action(s) will be	10/18/2022

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	Finding includes: During an interview on 8/29/22 at 10:21 A.M., the Director of Nursing (DON) indicated she was the Infection Preventionist, but was not yet certified. At that time, the DON indicated no other staff was acting as Infection Preventionist . The DON's hire date was 5/3/22. On 9/2/22 at 12:48 P.M., a current, undated Infection Preventionist policy was provided and indicated "The facility will ensure the Infection Preventionist is qualified by education, training, experience or certification"		accomplished for those residents found to have been affected by the deficient practice; The facility has designated an infection preventionist and certification will be scheduled. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents receiving care have the potential to be affected. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The facility will have the Infection Preventionist educated via CDC Infection Preventionist training. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and DNS or designee will review the completion of the certification to verify completion and review in QAPI	

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F 0886 SS=D Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing:			

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	(i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. Based on interview and record review, the facility failed to test symptomatic residents for COVID-19 for 1 of 1 residents with signs and symptoms. A resident was not tested for COVID-19 until 7 days after symptoms started. (Resident 46) Finding includes: On 8/31/22 at 1:04 P.M., Resident 46's clinical record was reviewed. On 8/26/22 Resident 46 was	F 0886	It is the practice of this facility to ensure proper testing of residents for Covid 19. • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident was tested on day 7. Reviewed all residents for any	10/18/2022

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	tested for COVID-19 and had a positive result. During an interview on, 8/31/22 at 1:16 P.M., the Director of Nursing (DON) indicated Resident 46 had COVID-19 symptoms starting on 8/19/22. The DON was unable to find a COVID-19 test result from 8/19/22 through 8/25/22. At that time, the DON indicated residents should currently be tested every Tuesday and Thursday of when symptoms start. On 9/2/22 at 12:48 P.M., a current Clinical Guidance for COVID-19 testing, dated 2/8/22, was provided and indicated when a symptomatic resident was identified, they should be tested for COVID-19 regardless of vaccination status. 3.1-18(b)		current signs and symptoms. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents receiving care have the potential to be affected by this practice. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All Staff in serviced on CDC guidelines, policy, and procedures for systemic residents. The DNS or designee will in- service all staff on signs and symptoms of Covid-19. Nursing staff will test anyone with COVID-19 signs and symptoms and notify DNS or designee of results. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and DNS or designee will review daily documentation of residents to observe for anyone with COVID-19 signs and symptoms. Will complete 10 times a week x 4 weeks, then 5 times a week x4	

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			weeks, then review in QAPI for need for further audits or education. DNS or designee will review daily documentation of residents to observe for anyone with COVID-19 signs and symptoms. Will complete 10 times a week Monday thru Friday x 4 weeks, then 5 times a week Monday thru Friday x 5 months, then review in QAPI for need for further audits or education	
F 0888 SS=D Bldg. 00	483.80(i)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment,			

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	or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and			

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	spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's			

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	COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; Based on interview and record review, the facility failed to follow their contingency plan for staff that are not fully vaccinated for 1 of 1 staff not fully vaccinated. (Staff 19) Finding includes: On 8/30/22 at 11:50 P.M., the COVID-19 staff vaccination status was reviewed. Staff 19 was documented as partially vaccinated. On 8/31/22 at 6:33 A.M., Staff 19 was observed wearing a surgical mask entering a room with 3	F 0888	It is the practice of this facility to ensure staff are properly vaccinated or that the proper PPE is being utilized. • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Staff 19 was vaccinated. Nurse management rounded to ensure that unvaccinated staff were	10/18/2022

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	residents and was within an arms length of one of those residents. During an interview on 8/31/22 at 6:35 A.M., Staff 19 indicated administrative staff had said "something" about wearing an n95 while in the facility due to being partially vaccinated. During an interview on 9/2/22 at 9:30 A.M., the Director of Nursing (DON) indicated she was unsure why Staff 19 was working due to facility policy that employees without exemption or approved delay are required to have unpaid leave until fully vaccinated. On 8/29/22 at 10:00 A.M., a current COVID-19 Vaccination and Testing policy, revised 4/18/22, indicated "...Any employee that has not provided...an approved delay in vaccination...will have their status changed to unpaid leave after February 14, 2022." 3.1-18(b)		wearing an N95 mask. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents receiving care have the potential to be affected by this practice. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; All staff in serviced on CDC guidelines, policy, and procedures for unvaccinated staff and PPE requirements. The DNS or designee will educate all unvaccinated staff individually on CDC guidelines, policy, and procedures for unvaccinated staff and PPE requirements, DNS will offer additional education on Covid-19 vaccination and offer to provide or assistant staff in receiving vaccination and offer to to provide or assist staff in receiving vaccination or assistance in completing an exemption form if not completed • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and	

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			DNS and or designees will review staffing and audit those staff that are not vaccinated to ensure proper use of N95mask. Will complete 10 times per week x 4 weeks and then 5 times per week x 5 months, then review in QAPI for need for further audits and education.	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, and record review, the facility failed to maintain a safe, sanitary, and homelike environment in resident spaces in 2 of 3 halls observed. Holes in door, broken footboard, SHARPS container full at bedside, personal care items uncovered and unlabeled.(100 Hall, 200 Hall) Findings include: 1. On 8/30/22 at 8:54 A.M., in the shared bathroom of room 108, there was a quarter size hole in the bathroom door, an unlabeled, used urinal on the sink, an uncovered plunger on the floor, uncovered wash basin with used rags on the floor, bucket on floor open with paper towels and an empty, unlabeled urinal in it. In the bedroom, there were 4 (four) used gloves and an empty medication cup on the floor. On 9/2/22 at 9:10 A.M., there was still a quarter size hole in the bathroom door and an uncovered plunger on the floor.	F 0921	• what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; a. Room 108-bathroom door was repaired, used urinal was removed, plunger was placed in a plastic bag, rags were removed, wash basin was removed, and bucket was removed. Room 108 bathroom and resident room were cleaned. b. Room 201 footboard of bed was repaired, bathroom urine hat was removed, and sharps container was replaced. Room 201 was cleaned. c. Room 211-bathroom plunger was placed in a plastic bag, liner placed in trash can, unlabeled toothpaste removed, and new glove box placed.	10/18/2022

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	2. On 8/29/22 at 9:03 A.M., in room 201, the footboard of bed closest to the bathroom was broken and hanging off the bed and there were multiple black footprints on the floor in the middle of the room. In the shared bathroom, the sharps container was very full, an uncovered and unlabeled urine hat was on the floor. On 9/2/22 at 9:10 A.M., the footboard was still broken. 3. On 8/29/22 at 8:04 A.M., in the shared bathroom of room 211, there was an uncovered plunger on the floor, no liner in the trash can, unlabeled toothpaste on sink shelf, and no gloves in the box. On 9/2/22 at 9:10 A.M., the plunger was still uncovered on the floor. During an interview on 9/2/22 at 10:54 A.M., QMA 16 indicated all items should be labeled with the resident's name. She further indicated that plungers should be stored with a plastic bag covering them. During an interview on 9/02/22 at 11:02 P.M., the Maintenance Supervisor indicated he was unaware of the broken footboard in room 201 and the hole in the bathroom door of room 108. He further indicated that the facility utilizes a computer program that the staff are supposed to use to notify maintenance of issues. During an interview on 09/01/22 at 8:00 A.M., housekeeping indicated that in the resident rooms they are supposed to wipe all surfaces, pull trash and put in new bags daily. In the resident bathrooms, they are supposed to wipe the sink, toilet, and paper towel holders daily along with sweep and mop floors daily. She further indicated sometimes they have to clean the bathrooms more		• how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; a. All residents have the potential to be affected by this alleged deficient practice. A house wide audit will be conducted of all residents rooms, bathrooms, and common areas to identify any sanitation concerns. All areas identified have been addressed/corrected. The facility will continue their on-going cleaning scheduled and preventative maintenance programs. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; a. A mandatory in-serviced has been provided for all staff on the facility's environmental services and preventative maintenance programs. All staff was reminded of their responsibilities in keeping the facility clean, safe, functional, and sanitary in an effort to provide a comfortable environment for all residents, staff, and visitors. The staff was also re-educated on the facility procedure in reporting any faulty of defective equipment, furniture, etc. to ensure a safe	

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	than once and they are still cleaning high touch surfaces (bed side tables, bed rails, remote controls) due to COVID with EPA approved cleaner. During an interview on 9/02/22 at 11:48 P.M.,the DON (Director of Nursing) indicated there is not a specific policy for labeling resident items, but she would assume that the facility policy would be to label items. On 9/2/22 at 11:48 P.M., the DON provided an undated Safe and Homelike Environment policy that indicates"...the facility will provide a safe, clean, comfortable, and homelike environment ..." This Federal tag relates to Complaint IN00385834. 3.1-19(f)(5)		environment. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and a. Quality Assurance tool has been developed and implemented to monitor the facility environment to ensure that a safe, functional, sanitary and comfortable environment is maintained at all times. This tool will be completed by the Environmental Supervisor weekly for four weeks, then monthly for five months. The outcome of this tool will be reviewed at the facility's QAPI meetings to determine if any additional action is warranted.	
F 9999 Bldg. 00	#1. 3.1-14 PERSONNEL (u) In addition to the required inservice hours in subsection (1), 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	F 9999	Part 1 It is the practice of this facility to ensure that employees have completed annual dementia training. • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	10/18/2022

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	residents and to gain understanding of the current standards of care for residents with dementia. This State rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that employees had completed annual dementia training for 4 of 10 employees reviewed. (LPN 1, Dietary Manager, Activity Director, CNA 1) Findings include: 1. During a review of the employee records on 8/31/22 at 10:00 a.m., records indicated LPN 1 had not completed annual dementia training. LPN 1's hire date was 9/25/14. 2. During a review of the employee records on 8/31/22 at 10:00 a.m., records indicated the Dietary Manager had not completed annual dementia training. Dietary Manager's hire date was 2/2/18. 3. During a review of the employee records on 8/31/22 at 10:00 a.m., records indicated the Activity Director had not completed annual dementia training. Activity Director's hire date was 8/3/18. 4. During a review of the employee records on 8/31/22 at 10:00 a.m., records indicated CNA 1 had not completed annual dementia training. CNA's hire date was 2/13/18. 5. During an interview with the Business Office Manager on 8/31/22 at 9:50 a.m., she indicated she knew the facility was not up to date on all the staff in-service training. On 9/2/22 at 1:18 p.m., the DON provided the		There were no specific residents identified. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Mandatory in-services for all staff regarding dementia education has been assigned through Health Care Academy. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Administrator / designee will audit completion of assigned course monthly for three months, then one time for one quarter. Results of monitoring will be further reviewed in QAPI. If trends are identified then, another action may be developed. Any action plan written by the QAPI Committee will be monitored by the ED weekly until resolution.	

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	current Dementia Care policy, the policy was undated. The policy included, not limited to: All staff will be trained on dementia and dementia care practices upon hire, annually, and as needed to ensure they have the appropriate competencies and skill sets to ensure resident's safety and help resident's attain or maintain the highest practicable physical, mental, and psychosocial well-being. #2. 7-3 Staff training and development programs (a) Each facility shall provide in service training and shall require all staff working with developmentally disabled residents to attend staff development programs concerning developmental disabilities. Written records of such training shall be kept in the facility. This State rule was not met as evidenced by: Based on interview and record review the facility failed to provide inservices to the staff who were working with developmentally disabled residents for 10 of 10 employee records reviewed. Findings include: On 8/30/22 at 1:30 p.m., a Resident Census and Conditions form was provided and indicated 5 residents with intellectual and/or developmental disability resided at the facility. 1. During an interview on 9/2/22 9:29 a.m., the DON indicated they had not found any staff training for the residents with intellectual and/or developmental disabilities.		Part 2 It is the practice of this facility to provide the proper training for all staff working with developmentally disabled residents. • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; There were no specific residents identified. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Mandatory in-service for all staff regarding working with developmentally disabled residents will be assigned through Healthcare Academy. • how the corrective action(s) will be monitored to ensure the	

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	2.. During an interview on 9/2/22 at 9:43 the Transitional Leader indicated the facility did not have any specific training for staff related to resident's with intellectual and/or developmental disabilities. #3. 7-4 Resident programs (a) The facility shall provide a program for developmentally disabled individuals, which assures the following: (1) There is a designated staff member qualified by a minimum of two (2) years experience with developmentally disabled individuals, or through completion of the council approved training program on developmental disabilities, responsible for the program. If the designated staff member does not qualify as a qualified mental retardation professional, as defined in 410 IAC 16.2-1-32, the designee must be supervised by a qualified mental retardation professional or the facility must have a consultant qualified mental retardation professional. This State rule was not met as evidenced by: Based on record review and interview the facility failed to employee a qualified mental retardation professional to oversee, and implement the program for the 5 of 5 intellectual and/or developmentally disabled residents currently residing in the facility. Findings include: On 8/30/22 at 1:30 p.m., a Resident Census and Conditions form was provided and indicated 5 residents with intellectual and/or developmental disability resided at the facility.		deficient practice will not recur, i.e., what quality assurance program will be put into place; and Administrator / designee will audit completion of assigned course monthly for three months, then one time for one quarter. Results of monitoring will be further reviewed in QAPI. If trends are identified then, another action may be developed. Any action plan written by the QAPI Committee will be monitored by the ED weekly until resolution. Part 3 It is the practice of this facility to employ a qualified mental retardation professional to oversee and implement the program. • what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The five residents identified during the survey with intellectual and/or developmental disability were reviewed. A QRMP reviewed level 2 completed screenings and wrote a plan based on the results of the evaluation • how other residents having the potential to be affected by the same deficient practice will be	

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	During an interview on 9/2/22 at 12:49 p.m., the DON indicated the facility did not have a certified staff member to oversee the QRMP (Qualified Mental Retardation Professional) program, the PASSAR'S (Preadmission Screening and Resident Review) were completed on the resident's and no additional services were required. On 9/2/22 at 11:30 a.m., the Transitional Leader provided the current policy on Mental Health and Rehabilitative Services with a last review date of 11/17/18. The policy included, not limited to: Health rehabilitative services will be provided for all residents with a primary mental health or intellectual disability diagnosis, by a qualified person, under the written order of a physician. Resident evaluation : The social services staff will identify developmental and/or specialized needs of residents related to MI or MR diagnoses. This may be obtained by a Level 2 PASSAR screening and the resident's comprehensive assessment. If necessary, further assessment may be obtained through a Qualified Mental Retardation Professional (QRMP), screening and/or psychological evaluation. Results of professional evaluations will be incorporated into the resident's comprehensive assessment. Services provided: A developed, integrated pan including programming approaches for a resident's unique, individual need designed to improve cognitive, emotional, and developmental functioning. Provision of a structured environment (e.g; structured socialization activities to diminish tendencies toward isolation and withdrawal). Implementation of programs designed to teach individuals daily living skills that they need to be more independent including, but not limited to, grooming, personal hygiene, mobility, nutrition, vocational skills, money management, and mental health education. Crisis intervention services,		identified and what corrective action(s) will be taken; No other residents were identified other than the five identified during survey. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Social Service Director will be in-serviced on the requirements of QRMP to put individual plans in place for MI/MR residents based on level two screening assessments. A binder will be kept with level 2's on all residents and new admits added as needed. QRMP will review upon their visit to ensure plans are written and up to date. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Social Service Director and or designee will complete an audit monthly for three months, then one time for one quarter. Results of monitoring will be further reviewed in QAPI. If trends are identified then, another action may be developed. Any action plan written by the QAPI Committee	

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	individual, group, family, and psychological services. Development of appropriate personal support networks. The social services staff will identify and coordinate community resources and maintain a relationship with those providers to assure the integration of care.		will be monitored by the ED weekly until resolution.	