STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155224	A. BUILDING 00 B. WING	08/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLUMBIA HEALTHCARE CENTER	621 W COLUMBIA ST EVANSVILLE, IN 47710

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 7, 8, 9, 10, 11, 14, 2023 Facility number: 000129 Provider number: 155224 AIM number: 100266780 Census Bed Type: SNF/NF: 116 Total: 116 Census Payor Type: Medicare: 1 Medicaid: 99 Other: 16 Total: 116 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Qualiuty review was completed on August 24, 2023.	F 0000	**Plan of Correction for Columbia Healthcare Center.** **F000 Initial Comments** The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation and interview the facility failed to accommodate each resident with the use	F 0558	**F558** **Reasonable Accommodations Needs/Preferences.**	09/14/2023

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

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	of call lights to summon help from staff for 4 of 4 residents reviewed for assistance. (Resident 26, Resident 117, Resident 29, Resident 114) Findings include: 1. On 8/8/23 at 9:43 A.M., Resident 26's call device was observed out of reach at the top of the bed. It was a push button type of device. During an interview at that time, the resident indicated she had to go to the bathroom and could not find the call device. The call device was activated for the resident at 9:44 A.M. On 8/14/23 at 8:55 A.M., the resident's clinical record was reviewed. Diagnoses included, but were not limited to, dementia and COPD. Admission MDS 6/20/23 indicated resident has severe cognitive impairment and requires extensive assist of 2 for toileting. The current care plan, dated 6/15/23, included resident is at risk for falls. Interventions included, but were not limited to, touch pad call light in reach. The resident was not provided a touch pad type call light for use. 2. On 8/8/23 during a tour of the 1400 and 1500 units, 3 additional residents were observed with call devices out of reach. At 10:40 A.M., Resident 117's call device was observed out of reach at the foot of the bed. At 2:04 P.M., Resident 114's call devices was observed out of reach at the foot of the bed. At 2:21 P.M., Resident 29's call device was observed out of reach on the floor under the bed. Policy for call lights was not provided. On 8/11/23 at 11:19 A.M., a current Resident		***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Residents 26,29,114, and 117 have been assessed and no adverse effects noted from the alleged deficient practice and have call lights in reach at all times. ***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 practice. Observational rounds were completed to ensure all call lights were in reach. Clinical staff educated by DNS/designee on ensuring call lights within reach. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** As a measure of ongoing compliance and systemic change, the DNS and/or designee will complete daily audits of resident rooms to ensure call lights are within reach. All staff were inserviced by DNS/designee related to ensuring call lights within reach at all times. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recure, IE: what quality***	

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	Rights policy dated as 7/23 was provided and reviewed. It indicated "all staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being and proper delivery of care." 3.1-3(v)(1) 3.1-19(u)		***assurance program will be put into place?*** The DNS/designee will be responsible for the completion of the Accommodation of Needs QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. ***By what date the systemic changes for each deficiency will be completed?*** September 14, 2023.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview, and record review, the facility failed to ensure that residents who are unable to carry out activities of daily living received the necessary services to maintain good grooming, and personal and oral hygiene for 3 of 4 residents reviewed. (Resident 26, Resident	F 0677	**F677** **ADL Care Provided for Dependent Residents** ***What corrective action(s) will be accomplished for those residents found to have been***	09/14/2023

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	72, Resident 88) Findings include: 1. During an interview and observation with Resident 26 on 8/8/23 at 9:43 A.M., her hair was observed to be very disheveled. She indicated the facility has staff but some of the people don't bother to work. Resident indicated she had to go to the bathroom now. She called for help at 9:44 A.M. No help arrived, no one was in the hall. At 9:55 A.M., the resident got to her feet and refused to sit back down. She begged to go to the bathroom. A clinical instructor, who indicated she was employed by the facility, came to the door to see what was going on. She left to get help. Resident continued to try and walk to the bathroom and cried out "I'm pooping on myself". At 9:58 A.M., QMA (Qualified Medication Aide) 9 and CNA (Certified Nursing Assistant) 6 arrived to assist resident. They helped her to sit on the toilet, and cleaned up the bowel movement. When finished, QMA 9 assisted the resident into her chair and put her oxygen tubing back on her and handed her the call device, wearing the same gloves she used to clean up the bowel movement. During an interview with Resident 26 on 8/8/23 at 10:11 A.M., her hair was observed to be very disheveled and greasy-looking. Resident indicated she needs help because it's long. She indicated she gets a shower once a week, and washes herself in between showers. On 8/9/23 at 11:12 A.M., the resident was observed sleeping in her wheelchair in the hallway. Her hair was still very disheveled and greasy-looking. On 8/14/23 at 8:55 A.M., the resident's clinical		***affected by the deficient practice?*** Residents 26, 72, and 88were reviewed for their preferences in bathing, and are receiving assistance necessary to maintain adequate grooming and hygiene. ***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. An audit of all residents to note current bathing preferences will be completed by Social Services and reviewed by nursing administration for implementation. All Residents will have their preferences met and offered bathing as requested; with refusals for care documented appropriately by staff. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** An in-service will be completed with all nursing staff by DNS and/or designee related to appropriate documentation of refusals and the systemic practice of returning to help/ask the resident more than once. Observational rounds will be completed daily to ensure that residents are receiving adequate	

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	record was reviewed. Diagnoses included, but were not limited to, chronic pulmonary obstructive disease (COPD), dementia, epilepsy, anxiety, depression, and heart failure. The Admission MDS (Minimum Data Set) Assessment, dated 6/20/23, indicated the resident had severe cognitive impairment and requires extensive assistance of 2 for bed mobility, transfers, and toileting, limited assistance of 1 for eating, and total dependence for bathing. Care plan date 6/15/23 Resident requires assistance with ADL's...provide ADL assistance, including oral care, to maintain comfort and dignity. Assist with bathing, as needed per resident preference. Offer showers two times per week. partial bath in between. Shower schedule reviewed at that time the resident was scheduled for showers on Monday and Thursday. No record of showers completed was available. 2. During an observation and interview with Resident 72 on 8/8/23 at 10:59 A.M., she was observed to have hair that was grossly disheveled and greasy-looking. The resident indicated she gets a bed bath about once a week. During observation and interview on 8/8/23 at 10:59 A.M., resident's hair was observed to be grossly disheveled and greasy-looking. Resident indicated she gets a bed bath about once a week. On 8/9/23 at 10:00 A.M., Resident 72 was observed asleep in bed with grossly disheveled and greasy-looking hair. During an interview with resident on 8/10/23 at 9:35 A.M., resident indicated she gets bed baths, not showers, because she can't get her surgical		assistance to maintain grooming and hygiene. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recure, IE: what quality assurance program will be put into place?*** The DNS/designee will be responsible for the completion of the ADL Care for Dependent Residents QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. ***By what date the systemic changes for each deficiency will be completed?*** **September 14, 2023.** **F689**	

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	incisions wet. Her hair was disheveled and greasy-looking. Resident indicated that today the CNA just "put water on it and called it a day". Resident's friend who was on the speaker phone at the time indicated the last hair wash was 2 weeks ago. During an interview on 8/11/23 at 9:41 A.M. with CNA 7, she indicated that CNA's wash under the resident's arms, back, and genital area. She added that they offer toothpaste and mouthwash, but the resident doesn't like the mouthwash and won't let them brush her teeth. She indicated they do wash resident's hair every time they give her a bath. Resident has never refused a bed bath or shower. During an observation and interview with resident on 8/11/23 at 1:40 P.M., her hair was observed to again be grossly disheveled and greasy-looking. She indicated she had no bath today because she is tired and has been sleeping all day. On 8/11/23 at 2:07 P.M., the resident's clinical record was reviewed. The record indicated the resident received partial bed baths on 8/10/23, 8/8/23, 8/7/23, 8/3/23, 8/2/23, 7/28/23, 7/26/23, 7/25/23. During interview on 8/14/23 at 10:00 A.M. with QMA 9, she indicated a partial bed bath includes washing the resident's face, hands, arm pits, under the breasts for women, and genital area. On 8/14/23 at 10:01 A.M., the resident was observed asleep in bed. Hair was observed to be disheveled and greasy-looking. On 8/14/23 at 8:27 A.M., the resident's clinical record was reviewed. Diagnoses included, but			

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	were not limited to, cerebral palsy, neuromuscular dysfunction of bladder, urostomy, colostomy, anxiety, and depression. The Admission MDS (Minimum Data Set) Assessment, dated 7/11/23, indicated resident is cognitively intact and requires extensive assistance of 2 for bed mobility, complete dependence for transfers, extensive assistance of 1 for eating, total assistance of 1 for toileting, and total dependence for bathing. Current physician orders included, but were not limited to: Up Ad Lib Wheel Chair Assist 2 with mechanical lift 7/5/23. Care Plan included: resident requires assistance with activities of daily living (ADL's), including bed mobility, transfers, eating, and toileting related to diagnoses of neurogenic bladder, cerebral palsy, iron deficiency anemia, depression, mood disorder, insomnia, anxiety, gastroesophageal reflux (GERD), allergies. Has urostomy and colostomy. Interventions included: a. assist with ambulation as needed b. assist with bathing as needed per resident preference. Offer showers 2 times per week, partial bath in between c. assist with bed mobility as needed d. assist with dressing/grooming/hygiene as needed. Encourage resident to do as much for self as possible e. assist with eating and drinking as needed f. assist with hearing appliance as needed g. assist with oral care at least 2 times daily h. assist with toileting and/or incontinent care as needed 3. On 8/8/23 at 9:39 A.M., Resident 88 indicated she was not sure when she last had a shower, and that she does not get showers as often as she			

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	would like. On 8/10/23 at 10:28 A.M., Resident 88 indicated she preferred showers because her hair gets washed in the shower. She further indicated that staff does not wash her hair during a bed bath. On 8/10/23 at 8:53 A.M, shower report sheets for the past 6 months were requested and only one shower report sheet, dated 8/3/23, was provided. At that time, the ADON (Assistant Director of Nursing) indicated she was unable to find any others. She further indicated that if Resident 88 refused her shower it would be charted in the progress notes or in the Point of Care response. On 8/10/23 at 8:44 A.M., Resident 88's clinical record was reviewed. Resident 88's diagnosis included, but was not limited to, end stage renal disease. The most recent quarterly MDS (Minimum Data Set) Assessment, dated 7/6/23, indicated Resident 88 had no cognitive impairment, no behaviors, and required total assistance of 1 staff for bathing, extensive assistance of 2 staff for toileting, and total assistance of 2 staff for transferring. A current care plan, dated 4/18/22, indicted that Resident 88 required assistance with ADLs (Activities of Daily Living) with an intervention to offer showers two times per week and a partial bath in between. A current shower schedule, provided 8/10/23 at 10:28 A.M., indicated Resident 88 was to receive showers on Mondays and Thursdays. The Point of Care History indicated that in the past 6 months, Resident 88 received showers on			

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	5/4/23, 5/5/23, 6/10/23, 7/8/23, and 8/3/23. The Point of Care History lacked documentation of a refusal. On 8/11/23 at 11:19 A.M., a current Resident Rights policy dated as 7/23 was provided and reviewed. It indicated "all staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being and proper delivery of care." 3.1-38(a)(3)(B) 3.1-38(b)(2) 3.1-38(b)(3)			
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 interview, record review, and observation, the facility failed to provide adequate supervision, assistance devices, or interventions to reduce the risk of fall for 2 of 3 residents reviewed for falls with major injuries. (Resident 94 and Resident 39) Findings include: 1. Resident 94's clinical record was reviewed on 8/9/23 at 9:32 A.M. Diagnoses included, but were not limited to, type 2 diabetes mellitus, dysphagia, and invertebral disc degeneration.	F 0689	**F689** **Free of Accident Hazards/Supervision Devices** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** It is the practice of this facility to implement interventions to prevent accidents. Resident 94 and resident 39 fall care plans were reviewed and updated as	09/14/2023

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	Resident 94's most recent Annual Minimum Data Set (MDS) Assessment, dated 7/7/23, indicated the resident was severely cognitively impaired, required extensive assistance of two people for mobility and transfers, and required extensive assistance of one person for toileting and bathing. Resident 94's care plan included, but were not limited to, Assist with toileting and/or incontinent care and Assist of one with transfers, dated 08/24/2021. A fall event report was created on 7/20/23 at 2:43 P.M. The fall event indicated an unwitnessed fall occurred in the shower room bathroom, and the resident was found lying on the floor with severe pain in the left hand/wrist accompanied by swelling. The fall note indicated a Nurse Practitioner was called regarding the fall, and an order for an x-ray was placed. The x-ray indicated a fracture of the lower left radius and required a cast placement to the left wrist. The fall event indicated the intervention put in place related to this fall was "staff educated on staying with the patient when using the restroom". During an interview on 8/11/23 at 8:20 A.M., the Director of Nursing (DON) indicated staff had wheeled Resident 94 in to the shower room bathroom, transferred Resident 94 to the toilet, and left Resident 94 unattended in the bathroom. When staff returned to the bathroom, Resident 94 was found on the floor. The DON confirmed the resident was to be assisted with transfers and toileting, and indicated the intervention put in place related to this fall was to educate staff to stay with resident while toileting. 2. On 8/10/23 at 11:01 A.M., Resident 39's clinical record was reviewed. Resident 39 was admitted on		appropriately needed. ***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. Residents with fall interventions were reviewed to ensure appropriateness of interventions. ***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 be educated in implementing care planned fall interventions. The Clinical Education nurse and/or Designee will train/teach the implementation process starting during specific orientation and on-going learning. DNS/designee will review all fall documentation to determine root cause of fall and develop appropriate intervention to add to care plan. Observational rounds will be completed daily to ensure that fall interventions are in place per the plan of care for interventions added to fall care plans. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recure, IE: what quality assurance program will be put into place?*** The DNS/designee will be	

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	8/31/22. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left nondominant side and maxillary fracture, left side. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 7/13/23, indicated Resident 39 had moderately impaired cognition, 1 fall with no injury since the prior assessment on 6/22/23, and required extensive assistance of 2 staff for transfers and toileting. A current care plan, revised 8/9/23, indicated Resident 39 was at risk for falls due to weakness, limited mobility, and impaired cognition with an intervention of "call light in reach" dated 9/1/22. The clinical record indicated that Resident 39 fell 13 (thirteen) times since admission. On 9/7/22 at 9:37 A.M., Resident 39 sustained an unwitnessed fall while attempting to transfer to the bedside commode unassisted. The intervention "encourage resident to use call light prior to transfers" was added to the care plan on 9/7/22. On 11/8/22 at 5:42 A.M., Resident 39 sustained an unwitnessed fall. An IDT note dated 11/8/22 indicated the resident rolled out of her bed onto the mat next to her bed and went to sleep. The care plan lacked an updated intervention. On 12/23/22 at 3:50 A.M., Resident 39 sustained an unwitnessed fall while attempting to pick up a piece of trash off the floor while sitting in her wheelchair. The intervention "remind resident to use call light for assistance retrieving objects from floor" was added to the care plan on 12/23/22.		responsible for the completion of the Fall Management QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. ***By what date the systemic changes for each deficiency will be completed?*** **September 14, 2023.**	

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	On 3/15/23 at 9:00 P.M., Resident 39 sustained an unwitnessed fall while attempting to transfer to the bedside commode unassisted. The intervention "visual cue to call light" was added to the care plan on 3/16/23. On 6/15/23 at 2:26 P.M., Resident 39 sustained an unwitnessed fall while attempting to transfer from the wheelchair to the bed unassisted. At that time, the resident was sent to the emergency room. An x-ray confirmed a non-displaced fracture lateral wall of the left antrum with dense opacification (fractured cheek bone). The intervention "offer to lay resident down after lunch" was added to the care plan on 6/16/23. The resident sustained three falls, 9/7/22, 3/15/23 and 8/9/23 all included the only intervention was to reword the use of the call light, no other intervention was added. On 8/11/23 at 8:20 A.M., the DON (Director of Nursing) indicated that the IDT (Interdisciplinary Team) should update the care plan with a new and relevant intervention after every fall. On 8/11/23 at 11:10 A.M., a current IDT Comprehensive Care Plan Policy, revised 10/2019, was provided and indicated "care plan problems, goals, and interventions will be updated based on changes in resident assessment/condition". On 8/14/23 at 11:34 A.M., the DON provided a current fall management policy with a most recent revision date of 8/2022. The policy indicated "ensure residents residing within the facility receive adequate supervision and or assistance to prevent injury related falls". 3.1-45(a)(2)			

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	155224	A. BUILDING 00 B. WING	08/14/2023

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure residents received appropriate treatment to prevent urinary	F 0690	**F690** **Bowl/Bladder Incontinence, Catheter**	09/14/2023

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	tract infections (UTIs) for 1 of 1 residents reviewed for catheter use and history of UTIs. A catheter bag was observed on the floor. (Resident 49) Finding includes: On 8/8/23 at 9:08 A.M., Resident 49's catheter bag was observed laying on the floor next to the resident's bed. On 8/9/23 at 8:57 A.M., Resident 49's catheter bag was observed laying on the floor next to the resident's bed. On 8/9/23 at 9:11 A.M., RN (Registered Nurse) 12 changed the dressing around Resident 49's supra pubic catheter. At that time, the catheter bag was on the floor and the tubing touched the floor. RN 12 exited the room and left the catheter bag on the floor. On 8/9/23 at 9:19 A.M., RN 12 indicated that Resident 49 had a history of throwing the catheter bag on the floor. She further indicated that staff should pay attention to where the catheter bag is when they are in the room and pick it up if it is on the floor. On 8/10/23 at 08:29 A.M., Resident 49 indicated no one has ever explained to him why the catheter bag shouldn't be on the floor. On 8/9/23 at 9:35 A.M., Resident 49's clinical record was reviewed. Resident was admitted on 6/13/22. Diagnoses included, but were not limited to, chronic kidney disease and obstructive and reflux uropathy. The most recent quarterly MDS (Minimum Data		***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident # 49 foley catheter tubing was secured to prevent it from touching the floor. ***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 have catheters have the potential to be affected. DNS/designee completed a facility wide audit to ensure no other tubing was on the floor. No findings noted. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The DNS/designee will provide re-education to nursing staff on ensuring bag and or tubing does not touch the floor. DNS/designee education to nursing staff will include how to use the plastic tubing attachment, leg adhesive securement device to ensure the tubing to prevent bag and/or tubing from touching the floor. Observational rounds will be completed daily to ensure that catheter equipment is maintained appropriately and not touching floor. ***How the corrective action(s) will***	

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	Set) Assessment, dated 6/20/23, indicated the resident had no cognitive impairment, no behaviors, had an indwelling catheter, and required supervision of 1 staff for transfers and bed mobility and extensive assistance of 1 staff for toileting. Current Physician Orders included, but were not limited to: Change dressing around supra pubic catheter QD (every day) et (and) PRN (as needed), dated 2/25/23. A current care plan, dated 2/25/19, indicated resident required a supra pubic urinary catheter with an intervention of "encourage tubing or any part of the drainage system not to touch the floor". Infection Control Event Reports indicated Resident 49 had UTIs with onset dates of 9/13/22, 10/1/22, 3/10/23, and 5/4/23. On 8/11/23 at 10:37 A.M., the Infection Preventionist indicated that the catheter bag should be hung on the frame of the bed or the side of the wheelchair and should not be touching the floor. On 8/14/23 at 12:00 P.M., a current Nursing policy, revised 6/2023, was provided and indicated that nursing staff should "prevent catheter bag or tubing from touching the ground". 3.1-41(a)(2)		***be monitored to ensure the deficient practice will not recure, IE: what quality assurance program will be put into place?*** The DNS/designee will be responsible for the completion of the Catheter QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. ***By what date the systemic changes for each deficiency will be completed?*** **September 14, 2023.**	
F 0691 SS=D Bldg. 00	483.25(f) Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care.			

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	The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, interview, and record review, the facility failed to provide a resident with a urostomy care consistent with professional standards of practice and the comprehensive person-centered care plan for 1 of 1 residents with a urostomy. (Resident 72) Finding includes: On 8/10/23 at 9:07 A.M., LPN (Licensed Practical Nurse) 5 was observed changing the urostomy dressing for Resident 72. The resident had been on contact precautions beginning 8/9/23 at 10:30 A.M. due to the presence of an antibiotic-resistant urinary tract infection (UTI). LPN 11, who identified herself as the wound nurse, observed the procedure but did not assist. Approximately 200 cc's of rust-colored urine were observed in the catheter bag. When disconnecting the catheter bag, LPN 5 placed it in the waste basket next to resident's bed. She removed the old urostomy bag and deposited it in a plastic bag on the bed. There were 2 stents, about 8" long, protruding from the stoma. They were filled with a dark red substance that was not draining. When applying the new urostomy bag, LPN 5 discussed with the resident how the paste they had been using to adhere the urostomy bag had been burning the resident's skin. LPN 11 then indicated there were other things they could use and would check into it. When leaving, both nurses removed their personal protective equipment (PPE) and used	F 0691	**F691** **Colostomy, Urostomy, or Ileostomy Care** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident # 72 urostomy care has been completed and will be continued with professional standards of practice and with comprehensive person-centered care plan completed- including the measuring of urine output. ***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 have urostomy's have the potential to be affected. DNS/designee completed a facility wide audit to ensure no other issues. No findings noted. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The DNS/designee will provide re-education to nursing staff on ensuring professional standards of	09/14/2023

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	hand sanitizer, then started towards the door. When asked about the catheter bag in the waste basket, LPN 5 indicated it needed to be thrown away. LPN 5 put on gloves and bagged all the trash in the room, including the catheter bag, and took 3 bags to the soiled utility room. Neither nurse measured the urine output. During an interview on 8/10/23 at 10:45 A.M. with the Director of Nursing (DON) and LPN 5, LPN 5 indicated she did not know anything about the stents because the resident was supposed to have a follow-up appointment with her surgeon in Indianapolis. The discharge instructions from the surgeon indicated the resident had an appointment in Indianapolis on 7/20/23. The DON indicated the doctor in Indianapolis had given permission and made arrangements for the resident to be seen by a urologist in Evansville because she was too weak to tolerate the 6-hour round trip to Indianapolis and back. On 7/27/23, the urologist in Evansville refused to see the resident. That same day, the facility sent the resident to the emergency room at 9:48 A.M., where the resident's surgical staples were removed, but not the stents. The DON indicated the facility was supposed to follow up with the surgeon in Indianapolis and had failed to do so. On 8/14/23 at 8:27 A.M., the facility in-services were reviewed, and indicated a urostomy care in-services had been conducted on 5/9/23. Attendees included LPN 5 and LPN 11. On 8/14/23 at 9:30 A.M., the resident's clinical record was reviewed. Diagnoses included, but were not limited to, cerebral palsy and urostomy. The Minimum Date Set (MDS) Assessment, dated 7/11/23, indicated the resident was cognitively		practice, comprehensive person-centered care plans, and resident's goals and preferences- to include measuring of urine output. Observational rounds will be completed daily to ensure professional standards are met for ostomy care. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recure, IE: what quality assurance program will be put into place?*** The DNS/designee will be responsible for the completion of an Ostomy QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. ***By what date the systemic changes for each deficiency will be completed?*** **September 14, 2023.**	

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	intact and was totally dependent for toileting and bathing. Current Physician Orders included, were not limited to, change urostomy bag once a day on Wednesdays, change urostomy bag as needed, nurse to record urostomy output every shift every 8 hours, contact isolation for ESBL urinary tract infection (UTI). The Physician Orders lacked an order for stent care. The resident discharge instructions from the surgeon were reviewed. The instructions indicated the ureteral stents were to have been removed at the post-operative visit with the surgeon, which was scheduled on 7/20/23 and did not occur. The resident's care plan, dated 7/6/23, included the resident has a urostomy. Interventions included: a. assist resident with stoma changes as needed. b. keep site clean and dry. c. observe stoma site for excretions and irritations. Document abnormal findings and notify MD. d. treatments as ordered/indicated. Policy was not available. 3.1-47(a)(3)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the			

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	comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care consistent with professional standards of practice for 1 of 1 residents reviewed for respiratory care (Resident 26). Findings include: During an interview with Resident 26 on 8/8/23 at 9:43 A.M., she indicated how she needed her oxygen. During an observation on 8/8/23 at 9:34 A.M., the tubing on Resident 26's oxygen concentrator was not dated. There was a 2-inch strip of brown sticky substance on top of concentrator. The oxygen was on at 1.5 liters per minute (lpm) per nasal cannula (nc). During an observation on 8/9/23 at 11:00 A.M., the resident was observed in the hallway, asleep in her wheelchair, with a portable oxygen tank hanging from the wheelchair. The tubing was not dated, and was connected to the portable oxygen tank which was empty, as indicated by the contents indicator being in the red and the arrow resting at zero (0). The oxygen concentrator in the resident's room was observed to be on at 1.5 lpm. The brown sticky substance on top of the concentrator was still there. On 8/11/23 at 1:34 P.M., the resident was observed in the hallway, asleep in her wheelchair with oxygen tubing that was not dated. The tubing was attached to a portable oxygen tank, which was empty as indicated by the contents indicator	F 0695	**F695** **Respiratory/Tracheostomy Care and Suctioning** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident # 26 was not affected by the alleged deficient practice. Resident # 26 tubing dated correctly, portable tank functioning and adjusted to reflect use of 2 liters per nasal cannula as ordered. ***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 on oxygen have the potential to be affected by the alleged deficient practice. An audit was completed by DNS/designee to identify all residents with oxygen orders and accuracy and all equipment functioning properly. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** DNS/designee will re-educate nursing staff related to oxygen therapy and the application and	09/14/2023

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	being in the red and the arrow resting at zero (0). On 8/14/23 at 8:55 A.M., the resident's clinical record was reviewed. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), dementia, epilepsy, anxiety, depression, and heart failure. The Admission Minimum Data set (MDS) Assessment, dated 6/20/23, indicated the resident had severe cognitive impairment and required extensive assist of 2 for bed mobility, transfers, and toileting, limited assist of 1 for eating, and total dependence for bathing, oxygen was identified in use. Current Physician Orders included, but were not limited to: Oxygen at 2 liters per nasal cannula, head elevated while in bed to alleviate shortness of breath while lying flat related to diagnosis of COPD every shift. Care plan included: Resident has symptoms of decreased oxygenation. Utilizes 2L nasal cannula. Interventions included: 1. Elevate had of bed as tolerated 2. Labs/x rays as ordered 3. Observe for continued or worsening symptoms of decreased oxygenation 4. Monitor oxygen saturations as ordered 5. Administer oxygen as ordered On 8/14/23 at 8:55 A.M. a current facility oxygen therapy and devices policy was reviewed. The undated policy, lacked guidelines for labeling tubing and humidifier bottles, cleaning oxygen concentrators, administering oxygen according to physician orders, or maintaining/filling portable oxygen tanks.		care of this therapy. Observation rounds will be completed daily by DNS/designee to ensure oxygen use is appropriate for identified residents and that physician orders are followed. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recure, IE: what quality assurance program will be put into place?*** The DNS/designee will be responsible for the completion of an Oxygen Therapy QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. ***By what date the systemic changes for each deficiency will be completed?*** **September 14, 2023.**	

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	3.1-47(a)(6)			
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 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			

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	minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to post accurate total number of staff and actual hours worked for licensed and unlicensed nursing staff directly responsible for resident care per shift daily for 6 of 6 days during the annual survey period. Finding includes: During an observation on 8/7/23 at 9:30 A.M. a posted nursing staffing data sheet was observed on the side of the reception desk, dated 8/7/23 and indicated the census was 116. The sheet included, but was not limited to, the following information: Shift hours, total number of staff for each shift, and total hours of each shift for RN (Registered Nurse), LPN (Licensed Practical Nurse), and CNA (Certified Nurse Aide). The sheet indicated there were 11.5 members of unlicensed nursing staff working during the evening shift. The sheet did not specify which actual hours were worked by each discipline during the specified shift when the total hours were not equal to the number of staff. During an observation on 8/11/23, a posted nursing staffing data sheet was observed on the side of the reception desk, dated 8/11/23 and indicated the census was 115. The sheet included, but was not limited to, the following information: Shift hours, total number of staff for each shift, and total hours of each shift for RN, LPN, and CNA. The sheet indicated there were 13.5 members of unlicensed nursing staff working during the	F 0732	**F732** **Posted Nurse Staffing Information** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** No residents were affected 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 practice. Daily staffing hours are correct and will be updated as needed. Scheduler, Clinical Education Nurse, and nursing administration will be in-service concerning scheduled posted form by DNS/designee. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** Scheduler/Staffing coordinator will be re-educated on daily staffing sheets by DNS/designee. Observation rounds will be completed daily by DNS/designee daily to ensure that the nursing hours are posted and correct with	09/14/2023

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	evening shift. The sheet did not specify which actual hours were worked by each discipline during the specified shift when the total hours were not equal to the number of staff. During an interview on 8/14/23 at 10:25 A.M., the Director of Nursing (DON) reviewed the posted nurse staffing sheets and indicated the staffing sheets did not reflect the exact times of staff on the floor for partial shifts, and would find a place to add that in to the sheet. On 8/14/23 at 11:34 A.M., the DON provided a copy of posted nurse staffing sheets for dates 8/7/23, 8/8/23, 8/9/23, 8/10/23, 8/11/23, and 8/14/23, each of these dates did not reflect actual hours worked. A copy of posted nurse staffing policy dated 7/2019 was also provided at this time. The posted nurse staffing policy indicated "total hours should include the total actual hours worked on each shift including partial shifts" and "the nurse staffing data should be in a clear and readable format".		any changes made. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recure, IE: what quality assurance program will be put into place?*** The DNS/designee will be responsible for the completion of a Daily Staffing Therapy QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. ***By what date the systemic changes for each deficiency will be completed?*** **September 14, 2023.**	
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			

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	percent or greater; Based on observation, record review, and interview, the facility failed to ensure it was free of a medication error greater than 5 percent for 1 of 4 residents observed during medication pass. Three medication errors were observed during 35 opportunities for error in medication administration. This resulted in an 8.57% error rate. (Resident 1) Findings include: During a random medication administration, on 8/9/23 at 8:51 A.M., QMA (Qualified Medication Aide)10 administered 13 pills and 2 nasal sprays to Resident 1: Clonidine 0.1 mg 1 po (by mouth) bid (twice a day). Amlodipine 5 mg 1 po daily. Baby Asa (aspirin) 81 mg 1 po daily. CertaVite 1 tablet 1 po daily. Docusate 100 mg (milligrams) 2 po bid. Depakote delayed release 125 mg 1 po bid. Epinaster 0.05% 1 qtt (drop) both eyes BID. Azelstaine 137 mcg (microgram) (0.1%) 1 spray each nostril bid. Atrovent 0.06% 2 sprays bid each nostril. Lisinopril 10 mg 1 po bid. Vitamin D3 1000 units 2 tabs po daily. Protonix 40 mg 1 po daily. Propranolol 40 mg 1 po bid. Senokot-S 8.6mg/50 mg (sennosides/docusate) 1 po bid. Optimal D3 (cholecalciferol) capsule 1,250 mcg (micrograms)1 orally every Wednesday. Tizadine 2 mg 1 po bid. MS Contin 100 MG 1 po bid. During an interview on 8/9/23 at 8:51 A.M., QMA 10 indicated the pills were not available because	F 0759	**F759** **Free of Medication Error Rates 5 percent or more** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Resident #1 was assessed, no adverse effects noted from 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 deficiency. QMA 10 educated on medication administration policy with focus on medication refusals and crushing medications. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** All nursing staff educated on medication administration policy by DNS/designee with focus on medication refusals and crushing medications. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recure, IE: what quality assurance program will be put into place.*** The DNS/designee will be	09/14/2023

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	the resident used a different pharmacy from the facility and were not ordered timely. QMA 10 did not administer Alfuzosin, Naloxegol, and Tradjenta, also indicated the drugs will be ordered that day. Resident 1's record was reviewed on 8/11/23 at 11:56 A.M. Diagnoses included, but were not limited to, Type 2 diabetes mellitus and Chronic Obstructive Pulmonary Disease. Resident 1's quarterly MDS (Minimum Data Set) Assessment, dated 7/31/23, indicated the resident was cognitively intact. Resident 1's physician orders include Tradjenta (linagliptin), 5 mg (milligrams), once a day for Type 2 diabetes mellitus without complications, Alfuzosin 10 mg, once a day for retention of urine, Movantik(naloxegol) 25 mg, once a day for constipation. On 8/14/23 at 11:32 A.M. a current "Reordering, Changing and Discontinuing Orders" policy, revised 1/1/22, was provided by the DON (Director of Nursing) and indicated this "policy sets forth procedures for communications of any medication reorders, change or discontinuations to the pharmacy...reorders/refills are encouraged to reorder medications electronically or by fax whenever possible...". 3.1-48(c)(1)		responsible for the completion of a medication administration QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. ***By what date the systemic changes for each deficiency will be completed?*** **September 14, 2023.**	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include			

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	the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview, and record review, the facility failed to provide proper storage of medications in 4 of 6 medication/treatment carts. Loose pills and unlabeled biologicals/medications were found in drawers of treatment cart and medication carts. (1400 Hall medication cart, First floor treatment cart, 2200 Hall medication cart, 2400 Hall medication cart) Findings include: 1. On 8/9/23 at 9:05 A.M., the medication cart on the 2400 Hall was observed to have the following medications laying loose in the cart: 1 large white oblong pill with numbers 1104 30 1 large white pill	F 0761	**F761** **Label/Store Drugs and biologicals** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** No residents were affected by this 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	09/14/2023

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	2 bottles of multivitamin with the initial [resident initial] 1 bottle of opened Activa (protein supplement) no label or name 1 bottle of Melatonin no label with the [resident initial] 1 large bottle of Tums with Resident 1 name but no label 2. On 8/10/23 at 7:50 A.M., the medication cart on 1400 Hall was observed to have the following medications unlabeled in the cart: 1 Tresiba insulin pen not labeled. 1 Victoza insulin with no name or prescription label 3. On 8/10/23 at 7:54 A.M., the treatment cart on the first floor was noted to have the following biological unlabeled in the cart: 1 tube of zinc paste with the [resident name] no label or date. 4. On 8/10/23 at 8:09 A.M., the medication cart on the 2200 Hall was observed to have the following loose pills and unlabeled medications in the cart: 1 small yellow pill 2 insulin pens, glargine, and Humalog, for [resident name] in the same bag for prescription label for one on the bag. 3 insulin pens: basaglar, NovoLog, other, for [resident name] in the same bag with the prescription label for basaglar. During an interview on 8/9/23 at 9:05 A.M., QMA (Qualified Medication Aide) 10 indicated that there should be no loose medications and when found should be placed in a Drug Buster solution.		practice. All areas of medication storage have been audited and all outdated medications were destroyed. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** Observational rounds will be completed daily by DNS/designee and when needed pharmacy consultant to audit medication dates and storage areas to ensure compliance. License staff will be re-educated by DNS/Designee related to medication storage. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recure, IE: what quality assurance program will be put into place.*** The DNS/designee will be responsible for the completion of a Medication Storage QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible	

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	During an interview on 8/10/23 at 7:43 A.M., the DON (Director of Nursing) indicated that once the liquid protein was opened, she would label the bottle with the name of the resident and dated opened. She indicated that it was a prescription from the dietician ordered. She also indicated she would have to check about the prescription label that needed to be added to the bottle. During an interview on 8/10/23 at 8:18 A.M., Registered Nurse 12 indicated the insulin was placed in the bags for convenience and safety of the resident based on the color of the insulin pens. On 8/14/23 at 11:32 A.M., a current policy "Storage and Expiration Dating of Medications, Biological", revised 8/7/23, was presented by the DON. The policy indicated "The policy sets the procedures relating to the storage and expiration dates of medications, biologicals...facility should destroy...biological... with incomplete or missing labels...should ensure that medications ...for each resident are stored in the containers in which they were originally received...". 3.1-25(m)		employee. ***By what date the systemic changes for each deficiency will be completed?*** **September 14, 2023.**	
F 0802 SS=E Bldg. 00	483.60(a)(3)(b) Sufficient Dietary Support Personnel §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			

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	required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). Based on observation and interview, the facility failed to employ staff with the appropriate competencies and skills sets to carry out the function of preparing pureed diets for 8 resident meals during 1 of 1 food processing reviewed. Findings include: On 8/9/23 at 11:35 A.M., the puree process for the noon meal was observed. The Dietary Manager oversaw the process while Kitchen Staff 17 prepared the pureed food. Kitchen Staff 17 indicated she was preparing 10 servings for 8 residents who required pureed food. When measuring the dry potato pearls, Kitchen Staff 17 misread the amount to measure, and held the measuring cup sideways so both the amount and the measurement were incorrect. They were out of the butter blend listed in the recipe, so Kitchen Staff 17 added regular butter from 7 individual 5-gram packets. Neither Kitchen Staff 17 nor the Dietary Manager knew the conversion from grams to ounces and did not check to make sure they were meeting the nutritional requirements outlined by the Dietician. The recipe for the puree menu that was prepared for lunch on 8/9/23 was requested twice and not	F 0802	**F802** **Sufficient Dietary Support Personnel** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Residents on pureed had no negative effects from 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 on a pureed diet have the potential to be affected by the alleged deficient practice. Culinary staff have been in-serviced on following recipe for a pureed diet RD, ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** Daily observations utilizing Pureed prep tool will be completed by	09/14/2023

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	provided. 3.1-20(h)		Culinary Supervisor, RD or designee ***How the corrective action(s) will be monitored to ensure the deficient practice will not recure, IE: what quality assurance program will be put into place.*** The Culinary Manager/designee will be responsible for the completion of a Puree Food Preparation QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. ***By what date the systemic changes for each deficiency will be completed?*** **September 14, 2023.**	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp			

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	§483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review and interview, the facility failed to provide food and drink that are palatable, attractive, and at a safe and appetizing temperature for 1 of 1 meal test trays and resident interviewed for palatable food served at a palatable temperature. Findings include: 1. The following resident interviews were obtained: On 8/8/23 at 9:07 A.M. Resident 5 complained of the food being cold. On 8/8/23 at 10:04 A.M., Resident 26 complained on cold food. On 8/8/23 at 10:56 A.M., Resident 72 complained of lukewarm food. 2. During Resident Council meeting on 8/9/23 at 9:30 A.M., residents complained about food portions, some were not getting the double portions they ordered, the poor quality of food, and the food being cold. Residents complained about getting spoiled milk and watered-down juice. One resident produced multiple pictures of a meal they had recently been served, which was listed on the menu as chicken stir fry over rice with egg roll. On the plate, the rice covered over 3/4 of the plate, the chicken stir fry was about 1/2	F 0804	**F 804** **Nutritive Value/Appear, Palatable/Prefer Temp** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Residents 5, 26, and 72 suffered no adverse effects from this 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 alleged practice. Residents have been interviewed about food concerns. Food Service Director/Registered Dietician will audit food temperatures during mealtimes to ensure food is served at an appetizing temperature and food is palatable ***What measures will be put into place and what systemic changes will be made to ensure***	09/14/2023

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	cup on the side of the rice, and the single egg roll was about 2" long and 3/4" wide. The resident produced pictures of several egg rolls that were burnt. Residents also complained about not getting bed time snacks. 3. On 8/9/23 at 2:10 P.M. a meal tray was received form the room cart. The food temperatures as follows: French fries-106 degrees F (Fahrenheit) Hamburger 116 degrees F Bacon 106 degrees F Fruit salad 55.5 degrees F Iced tea no ice 58.3 degrees F The french fries were cold and mushy, no taste. The burger on bun with cheese lukewarm and tasteless. Bacon sour tasting. Fruit salad room temperature not chilled. During an interview on 8/14/23 at 9:50 A.M. with a resident on the 1100 hallway, he indicated the food was hot on Friday and Monday, and was cold all weekend. Another resident indicated that he was glad state was here because the food has been better this week. On 8/9/23 at 3:30 P.M. the facility food temperature policy was received and reviewed. The policy was last reviewed by facility on 6/21/23, indicated that all hot and cold food items will be served to the resident at a temperature that is considered palatable at the time the resident receives the food. 3.1-21(a) 3.1-21(e)		***that the deficient practice does not recur?*** Dietary staff and nursing staff will be reeducated on food temperatures and delivering the food carts, and food trays timely to residents. Daily observational wounds will be completed for food temps & taste of food. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recure, IE: what quality assurance program will be put into place.*** The Culinary Manager/designee will be responsible for the completion of an Food Temperature Monitoring QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. ***By what date the systemic changes for each deficiency will be completed?*** **September 14, 2023.**	

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F 0809 SS=E Bldg. 00	483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. Based on interview, observation, and record review, the facility failed to provide a nourishing snack at bed time for 5 of 5 residents interviewed for bedtime snacks, and to provide meals at times comparable to normal mealtimes in the community for 1 of 1 meals observed. Findings include: 1. During Resident Council meeting on 8/9/23 at 9:30 A.M., residents complained about not getting bed time snacks. Resident 10 indicated they all	F 0809	**F 809** **Frequency of Meals/Snacks at Bedtime** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** Residents 24, 57, 112, 113 had no negative effects by the alleged deficient practice.	09/14/2023

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	keep their own stash of snacks that they buy when they go to Wal-Mart. They also complained about meals being late. The following interviews were obtained: On 8/10/23 at 10:30 A.M., Resident 24 complained about not getting bed time snacks. On 8/10/23 at 10:35 A.M., Resident 57 complained about not getting bed time snacks. On 8/10/23 at 10:40 A.M., Resident 113 complained about not getting bed time snacks. On 8/10/23 at 10:45 A.M., Resident 112 complained about not getting bed time snacks. He indicated he buys extra snacks at Wal-Mart for himself and other residents. During an interview on 8/11/23 at 11:07 A.M. with the dietary manager, he indicated the residents do not get a menu with meal choices on it to select their preferences. If they want something other than what's on the menu, they have to call the kitchen. He indicated resident preferences such as likes/dislikes are stored on a computer program in his office, and that these are printed on the tickets the staff use to plate the food. The dietary manager indicated the alternative meal choices are always the same and include grilled cheese, hamburger, cheeseburger, and leftovers. During an interview with the Dietary Manager on 8/9/23 at 11:50 A.M., he indicated that snacks were just "whatever they can get in". He indicated they have maybe 1 person on diabetic (controlled carbohydrate) diet. At the same time, the white board on his office wall listed the special diets on each hall, including controlled carbohydrate diets, of which there were approximately 10. The Spring/Summer 2023 monthly meal menu for		***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 practice. Residents were interviewed in for desire for snacks Staff was educated on snack delivery and meal times ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** Staff was educated on mealtimes and providing snacks. Observational rounds will be completed daily for snack pass & compliance on meal times ***How the corrective action(s) will be monitored to ensure the deficient practice will not recure, IE: what quality assurance program will be put into place.*** The Food Service Director/designee will monitor/audit nourishing bedtime snacks. The ED/designee will be responsible for the completion of a Meal Time/Snack Provision QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2	

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	155224	A. BUILDING 00 B. WING	08/14/2023

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	meals beginning 4/16/23 lacked alternative meal choices or snack choices of any type. The Dietary Manager indicated they had no snack policy or snack menu. 2. On 8/11/23 at 9:00 A.M., the Dining schedule was reviewed. Meal times listed were: Breakfast: cottage (locked unit) 7:15 A.M., first floor 7:35 A.M., second floor 8:05 A.M. Lunch: cottage 12:15 P.M., dining room 12:20 P.M., first floor 12:35 P.M., second floor 1:05 P.M. Dinner: cottage 6:15 P.M., first floor 5:35 P.M., second floor 6:05 P.M. During observation of meal service on 8/9/23 at 1:24 P.M., lunch was delivered to the dining room at 1:50 P.M. After serving the residents in the dining room, the staff began delivering trays to the residents on the 2200, 2300, 2400, and 2500 hallways. The trays on the 2 carts were mixed up, so the staff had to hunt through the carts to find the trays for the hallway they were on. Then they went to the next hall and hunted through the rest of the trays to find the meals for the residents on that hall. At 2:10 P.M., the last tray that was to be delivered on the 2500 hallway was received from the cart. No policy for timely delivery of meals was provided. 3.1-21(c) 3.1-21(e)		consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. ***By what date the systemic changes for each deficiency will be completed?*** **September 14, 2023.**	
F 0812 SS=E	483.60(i)(1)(2) Food			

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Bldg. 00	Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchens reviewed. Findings include: On 8/7/23 at 9:54 A.M. the kitchen tour began. 1. The kitchen floor was sticky, with food crumbs and scattered pieces of debris observed throughout. 2. There was a dirty towel on the floor behind the coffee machine. 3. The tops of 4 storage bins were sticky, the flour was not labeled or dated. 4. There was a fist-sized hole in the drywall above the faucet of the 3-sink, all the way through. 5. There were 3 ceiling lights burned out in	F 0812	**F 812** **Food Procurement, Store/Prepare/Serve-Sanitary** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** No residents were affected by this alleged deficient practice. Kitchen floor has been cleaned, Storage bins have been cleaned, Drywall has been repaired above the 3 well sink, ceiling lights in the kitchen have been replaced, lights in the dishroom have been	09/14/2023

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	kitchen, 1 ceiling light burned out in dishwashing room, and 3 ceiling lights were without covers in the kitchen. During an observation of the walk-in refrigerator on 8/7/23 at 10:00 A.M., there was: 6. 1 gallon of milk open not labeled 7. 3 18-qt. containers of yellow-colored drink, 1 of 3 was labeled, all expired on 8/2/23 8. 1 metal container of sliced cheese was open not labeled 9. 1 plastic container of ham was expired 8/5/23 10. 1 plastic container sliced tomatoes not labeled, with a white slimy substance on them. 11. 1 large container BBQ chicken expired 8/5/23 12. 1 large container vegetables expired 8/5/23 13. 1 large container ketchup, unreadable expiration date In the walk-in freezer, there was 1 package of unidentified contents that was wrapped in brown paper and clear wrap, not labeled or dated. During an interview on 8/7/23 at 10:13 A.M. with the Assistant Dietary Manager (ADM), he indicated the spice containers were to be marked with the open date and the use-by date, and produced one spice container that was labeled correctly to illustrate how it was to be done. The rest of the 20 spices on the rack had only one date, and and he indicated he did not know whether it was the open date or the use-by date. He indicated he did not know how long spices were supposed to be kept after opening. After inspecting all the containers, he threw 3 of them in the trash. During an interview on 8/7/23 at 10:22 A.M. with the ADM, he indicated that once they open an item, the date they put on it is the use-by date.		replaced, 3 missing light covers have been replaced, all food that was not dated or expired was immediately discarded ***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 same alleged deficient practice. An audit of all storage areas has been conducted and all undated & expired food discarded. Kitchen & dish rooms have been audited for cleanliness & have been cleaned All food and beverages have been discarded that were not properly labeled/dated. Culinary staff will be educated on the procedures and expectations regarding storage and sanitation. ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** The Food Service Director/Culinary Manager/RD and/or designee will complete observations daily for sanitation, labeled and outdated food ***How the corrective action(s) will be monitored to ensure the deficient practice will not recure, IE: what quality assurance program will be put into place.***	

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	During an observation of the dry storage room on 8/7/23 at 10:24 A.M., there was 1 open box of cornbread stuffing mix that expired 4/12/23. There were food wrappers, a pack of animal crackers, and crumbs on floor under the shelves. During an observation of the 3 unit nourishment refrigerators on 8/10/23 at 9:52 A.M., the thermometer in the nourishment refrigerator in the 1100 hall pantry indicated 50 degrees F. At that time, a second thermometer placed in the refrigerator indicated 47.4 degrees F. The refrigerator contained perishable food such as milk, chocolate milk, and lunch meat sandwiches. On 8/9/23 at 3:30 P.M. the food storage policy was received and reviewed. The policy last reviewed by the facility on 5/23, indicated that refrigerated, ready-to-eat, potentially hazardous food...shall be clearly marked with the date the original container is opened and the date by which the food shall be consumed or discarded. The opened food can be held at 41 degrees F or less for no more than 7 days; food items that are not considered potentially hazardous such as salad dressing...BBQ sauce, pickles and relish will be labeled when opened and used or disposed of within 90 days of opening or the use-by-date, whichever comes first; temperatures for refrigerators should be <41 degrees F; food items considered to be shelf stable are to be used within 1 year of delivery; all foods shall be covered or wrapped tightly, labeled, and dated. 3.1-21(i)(2 3.1-21(i)(3)		The Food Service Director/designee will monitor/audit food storage and kitchen sanitation. Audits are to be done 5 times a week for four weeks and continue weekly for no less than two additional months. The results will be presented to the monthly Quality Assurance Performance Improvement IDT Committee. The facility will achieve a 100% compliance threshold prior to adjusting the frequency of audits. Plan to be updated as indicated by Committee. ***By what date the systemic changes for each deficiency will be completed?*** **September 14, 2023.**	
F 0921 SS=E	483.90(i) Safe/Functional/Sanitary/Comfortable Environ			

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Bldg. 00	§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, the facility failed to maintain a safe, clean, comfortable, and homelike environment for 1 of 1 locked dementia unit. (The Cottage) Findings include: During observation of the unit on 8/8/23 at 1:00 P.M.: 1. The bathroom between rooms 1303 and 1305, which was shared by 4 residents, was observed to have 2 nail holes and a 13" diameter area on the wall where the toilet paper holder had been replaced. The surface of the drywall was torn off. 2. In room 1305, there was a fist-sized patch of paint chipped off on the left side of the bathroom door frame about halfway up. 3. In the bathroom between rooms 1308 and 1310, which was shared by 4 residents, there was a 12" x 4" area behind the left side of the toilet that had not been painted and had 2 different colors (red and blue) showing through. 4. On 8/9/23 at 3:39, during an observation and interview with LPN (Licensed Practical Nurse) 14, Room 1312 was found to have a bathtub that was dirty on the bottom, with a crumpled plastic bag over the drain, an uncovered toilet plunger, and a broken toilet assist bar also in the tub. LPN 14 indicated no one ever uses the bathtub, though 2 dementia residents use the toilet and sink. 5. In room 1302, there was a bathtub that was	F 0921	**F 921** **Safe/Functional/Sanitary/comfo rtable Environment** ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?*** No residents were affected by this alleged deficient practice. The bathroom between 1303 and 1305 nail holes have been repaired, 1305 the paint chipped on the door frame has been painted, the bathroom between 1308 and 1310 has had the paint missing repainted, 1312 has had the bathtub cleaned, toilet plunger has been stored properly and the plastic bag was removed & discarded. The broken hand rail has been repaired. 1302 the bath tub has been cleaned, Bathroom between 1310 and 1312 has had the black crape above the hand rail removed and the hallway in 1300 hall has repainted to cover missing paint ***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 same alleged	09/14/2023

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	observed to be dirty on the bottom and a missing the plug. LPN 14 indicated no one ever uses the bathtub, though 2 dementia residents use the toilet and sink. 6. On 8/11/23 at 11:38 A.M., the hallway between rooms 1310 and 1312 was observed to have a 3 ft. long black scrape above the handrail. 7. There were 2 fist-sized areas of paint flaking off the wall next to room 1309. 8. There were numerous dime-sized places of peeled-off paint with blue paint showing through on both sides of the hall from room 1305 to the end of the hall. Policy for maintenance was not available for review. 3.1-19(f)		deficient practice. House wide audit was completed for any maintenance or environmental concerns Daily environmental observational rounds will be completed by ED/ Maintenance/HSK or designee ***What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?*** Housekeeping and maintenance have been in-service on environment cleanliness, repair and painting. Preventative Program 'TELS' is in place, with work orders available to all staff. The Administrator/designee will monitor/audit resident rooms daily to ensure cleanliness, safety, functionality, sanitary, and comfortable environment. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recure, IE: what quality assurance program will be put into place.*** The ED/designee will be responsible for the completion of an Food Temperature Monitoring QA Tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QAPI committee overseen by	

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			the ED. If threshold of 100% is not achieved, an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of responsible employee. ***By what date the systemic changes for each deficiency will be completed?*** **September 14, 2023.**	