STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155459	A. BUILDING 00 B. WING	03/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HICKORY CREEK AT NEW CASTLE	901 N 16TH STREET NEW CASTLE, IN 47362

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: March 20, 21, 22, 23, and 24, 2023. Facility Number: 000341 Provider Number: 155459 AIM Number: 100286550 Census Bed Type: SNF/NF: 27 Total: 27 Census Payor Type: Medicare: 1 Medicaid: 22 Other: 4 Total: 27 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 3, 2023.	F 0000	Hickory Creek at New Castle survey exit date 3-24-23 plan of correction due 4/15/23. This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at New Castle desires this Plan of Correction to be considered the facility's Allegation of Compliance is effective 4/24/23. We respectfully request paper compliance.	
F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. Based on interview and record review the facility	F 0557	(1) What corrective action will be	04/24/2023

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

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	failed to maintain a dignified environment for a resident requested assistance with care for 1 of 2 residents reviewed for abuse (Resident 4). Finding include: During an interview with Resident 4 on 3/21/23 at 1:45 p.m., indicated CNA 1 yelled at her the other day on 3/17/23. The resident indicated she wanted to go to bed and CNA 1 yelled and told her that she had to wait her turn. The resident indicated she told her she wasn't going to treat her like a dog. The nurse heard CNA 1 yelling at me. The resident indicated it made her mad and she told CNA 1 she paid to live at the facility and she was not allowed to yell at me. Review of the record of Resident 4 on 3/23/23 at 1:05 p.m., Cerebral palsy, respiratory failure, cerebral infarction, personal history of transient ischemic attack, hypertensive heart disease, obstructive sleep apnea, diabetes, anxiety disorder, major depressive disorder and muscle weakness. The Quarterly Minimum Data Set (MDS) for Resident 4, dated 2/14/23, indicated the resident was moderately impaired for daily decision making. The resident had no behaviors. The resident required extensive assistance of two people for transfers and toileting. The resident utilized a wheelchair for mobility. The resident did not ambulate. The plan of care for Resident 4, dated 1/24/23, indicated the resident was at risk for signs and symptoms such as withdrawal, decreased appetite, tearfulness and insomnia. The interventions included, but were not limited allow resident to express feelings and frustrations; offer		accomplished for those residents found to have been affected by deficient practice? Resident #4 was put to bed that evening. CNA was educated on 3/22/23 regarding incident and resident rights. (2) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Any resident has the potential to be affected. Administrator conducted resident interviews with residents regarding the care and services they receive. There were no other allegations as a result of the interviews. Staff in-serviced on 4-7-23 regarding Resident Rights and Abuse Policies. (3) What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Administrator will be immediately notified of any allegations of abuse. Investigation will begin immediately. Administrator or designee will conduct resident interviews monthly for 6 months and any identified issues will be handled immediately. Staff will be in-serviced on types of Abuse and Resident rights monthly for 6 months. (4) How corrective action will be monitored to ensure the deficient practice will not recur, i.e. what	

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	validation and support, emphasize and promote independence, encourage activities of interest. The plan of care for Resident 4, dated 1/24/23, indicated the resident was at risk for signs and symptoms of anxiety. The interventions included, but were not limited to, encourage the resident to verbalize fears and anxiety and offer validation and reassurance, maintain a calm environment and move to a quiet area. The witness statement for CNA 1, dated 3/21/23 (no time), indicated that on 3/17/23 Resident 4 and herself got into an argument regarding assisting the resident to bed. CNA 1 told the resident that she would get to her the first opportunity she could and then the resident indicated she needed to go to the bathroom, CNA 1 told the resident to go to the back hallway and she would come assist the resident. Resident 4 kept arguing with CNA 1, CNA 1 then told her there were 27 other residents besides her to take care of and the resident was not the "queen" of the building and she would have to learn to wait her turn. The resident began saying the staff were treating her like a dog and she was going to move to another facility. CNA 1 told the resident that was her choice if she wanted to go to another facility. LPN 2 then told CNA 1 to take a break and walk away from Resident 4. During an interview with the Administrator on 3/23/23 at 2:53 p.m., indicated the abuse allegations made by Resident 4 were not founded after the facility conducted an investigation. The facility suspended CNA 1 and brought her back after the investigation was completed. During an interview with CNA 1 on 3/23/23 at 3:09 p.m., indicated on 3/17/23 during the evening time Resident 4 was being demanding wanting to be		quality assurance program will be put into place. Administrator will report findings of interviews to the monthly QAPI meeting and follow QAPI recommendations until facility has gone 6 months with 100% compliance. (5) Date of completion 4/24/23	

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	put to bed. The resident "stalks" staff in her wheelchair and wants us to stop everything we are doing and take care of her. The resident started getting "mouthy" and "back talking" the CNA. The CNA told her she had to wait her turn. The nurse came and told me to take a break and not to provide care for the resident the rest of the night. The Director Of Nursing (DON) and the Assistant Director Of Nursing (ADON) did provide education to the CNA on 3/22/23 that if a resident starts an argument to walk away. During an interview with the DON on 3/23/23 at 3:26 p.m., indicated she did provide education to CNA 1 to be careful how she reacted to residents with behaviors and to get the charge nurse if a resident was making her feel uncomfortable. During an interview with LPN 2 on 3/23/23 at 3:40 p.m., indicated she was the nurse on 3/17/23 when CNA 1 and Resident 4 had the incident. LPN 2 indicated she intervened and told CNA 1 to walk away and take care of other residents. CNA 1 was being firm with Resident 4 but LPN 2 could tell it was going to escalate into an argument. The resident rights policy provided by the Administrator on 3/24/23 at 11:10 a.m., indicated "All staff members recognize the rights of the residents at all times and residents assume responsibilities to enable personal dignity, well being, and proper delivery of care." 3.1-3(a)(1)(t)			
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			

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	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, interview and record review the facility failed to provide fresh ice water daily for 1 of 1 resident's reviewed for hydration (Resident 20). Finding include: During an observation on 3/21/23 at 11:05 a.m., Resident 20 had no water available in his room. During an observation on 3/22/23 at 11:50 a.m., Resident 20 was laying in bed, the resident had a small medication cup of water on his bedside table. Review of the record of Resident 20 on 3/22/23 at 11:03 a.m., indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), Alzheimer's disease, hypertensive heart disease, diabetes, muscle weakness and pneumonia. The Quarterly Minimum Data Set (MDS) assessment for Resident 20, dated 3/14/23, indicated the resident was severely impaired for daily decision making. The resident required set up with drinking. During an observation on 3/22/23 at 2:00 p.m., Resident 20 was sitting on the side of his bed, the resident had no water available. During an observation on 3/23/23 at 10:50 a.m., Resident 20 had a small medicine cup of water on his bedside table.	F 0558	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice? Res 20 was given fresh ice water. 2. How other residents having the potential to be affected by the same deficient practice will be identified and wat corrective action will be taken? No residents were affected by this deficiency. All residents have potential to be affected. Staff passed water to all residents and hydration management policy reviewed no changes needed at this time. 3. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur? DON/Designee to round daily each shift to ensure residents received fresh ice water. 4. How corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?DON/Designee will complete Annual POC QAPI tool weekly x4 weeks and monthly times 6 weeks. If 100% compliance is not achieved an action plan will be developed. 5. Date of completion 4-24-23	04/24/2023

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	During an observation on 3/23/23 at 11:20 a.m., Resident 20 had a small medicine cup of water on his bedside table. During an interview with the Director Of Nursing (DON) on 3/23/23 at 2:30 p.m., indicated nursing was responsible to ensure Resident 20 had fresh ice water available and it should be passed during medication administration. 3.1-3(v)(1)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the			

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	interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to complete care plan meetings for 2 of 21 residents reviewed. (Residents 9 and 4) Findings include: 1. During an interview, on 3/21/23 at 11:42 a.m., Resident 9 indicated she has only been to one care plan meeting when she first came to the facility. Resident 9's record was reviewed on 3/22/23 at 11:30 a.m. The record indicated Resident 9 had diagnoses that included, but were not limited to, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, high blood pressure, heart disease with heart failure, paranoid schizophrenia, bipolar disorder, depression, anxiety, epilepsy, type 2 diabetes mellitus, osteoarthritis, difficulty swallowing, sleep terrors, and difficulty in walking, A Significant Change Minimum Data Set assessment, dated 1/24/23 indicated Resident 9 was cognitively intact. No documentation could be located in the electronic record that Resident 9 had had a quarterly care plan meeting. During an interview, on 3/23/23 at 2:24 p.m., the Social Service Director indicated they had a care plan meeting on 2/15/23 and he is looking for the notes of the meeting. He could not find documentation of the meeting and is still looking.	F 0657	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice. Resident #9 and #4 Had care plan conferences held on 3-29-23 and 4-19-23 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? No residents were affected by this deficiency. All residents have the potential to be affected. SSD completed an audit of all resident care plan conferences and is scheduling care plan conferences with all families. SSD was re-educated on the IDT comprehensive care plan policy on 4-13-23. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? ED and SSD will review MDS schedule weekly and SSD will inform resident and families of upcoming care conference meetings following the IDT comprehensive care plan policy. Any identified issues will be addressed immediately. 4. How corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be	04/24/2023

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	On 3/23/23, at 4:40 p.m., the Social Service Director provided an Interdisciplinary Team Care Plan Pathway, dated 1/24/23 that had the components of care plan goals, but failed to provide documentation a care plan meeting had been held, who was invited, who attended, or any notes from the meeting. 2.) During an interview with Resident 4 on 3/21/23 at 1:55 p.m., indicated the facility did not have care plan meetings with her and her family. Review of the record of Resident 4 on 3/23/23 at 1:05 p.m., Cerebral palsy, respiratory failure, cerebral infarction, personal history of transient ischemic attack, hypertensive heart disease, obstructive sleep apnea, diabetes, anxiety disorder, major depressive disorder and muscle weakness. The care plan meeting for Resident 4, dated 5/18/22, indicated the resident and her sister attended. During an interview with the Social Service Director (S.S.D.) on 3/23/23 at 1:50 p.m., indicated Resident 4 had no documentation of a care plan meeting since May 2022. During an interview with the S.S.D. on 3/23/23 at 1:16 p.m., indicated care plan meetings were suppose to be completed every three months. The care plan policy provided by the Administrator on 3/23/23 at 3:45 p.m., indicated all Interdisciplinary Team (IDT) should promptly meet with the resident and resident representative. The facility would go over advanced directives, discharge goals, vision, dental, hearing, podiatry needs, medications, treatments, Activities Of Daily (ADL) status, update preferences, pain,		put into place? SSD/Designee will complete the Annual POC QAPI tool weekly x4 weeks and monthly x6 weeks to ensure compliance has occurred. If 100% compliance is not achieved an action plan will be completed. 5. Date of completion 4-24-23	

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	adaptive devices, interventions, diet orders, weight, activity preferences and any complaints or concerns. 3.1-35(B)			
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 assist dependent residents with removal of facial hair for 2 of 2 residents reviewed for Activities Of Daily Living (ADL) (Resident 20 and Resident 2). Findings include: 1.) During an observation on 3/21/23 at 10:59 a.m., Resident 20 was laying in bed with his eyes closed the resident had a moderate amount of facial hair. During an observation on 3/22/23 at 11:50 a.m., Resident 20 laying in bed, unshaven with a moderate amount of facial hair. Review of the record of Resident 20 on 3/22/23 at 11:03 a.m., indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), Alzheimer's disease, hypertensive heart disease, diabetes, muscle weakness and pneumonia. The Quarterly Minimum Data Set (MDS) assessment for Resident 20, dated 3/14/23, indicated the resident was severely impaired for	F 0677	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #20 and #2 were shaved immediately. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? No residents were affected by this deficiency. All dependent residents have the potential to be affected by this alleged deficiency. DON/ADON completed rounds focusing on facial hair with no other identified concerns. 3. 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 re-educated on CNA To Do List and providing ADL care on 4-14-23 A daily rounding tool including resident shaving to be utilized by Care	04/24/2023

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	daily decision making. The resident required extensive assistance of one person for personal hygiene. During an observation on 3/22/23 at 2:00 p.m., Resident 20 was sitting on the side of his bed, unshaven with a moderate amount of facial hair. During an observation on 3/23/23 at 11:20 a.m., Resident 20 was laying in bed with his eyes closed, the resident had a moderate amount of facial hair. During an observation and interview with Resident 20 on 3/23/23 at 2:10 p.m., the resident indicated he did not like having a beard and would like to be shaved every day, but not right now because he had to use the bathroom. The clinical record for Resident 2 was reviewed on 3/23/2023 at 12:08 p.m. The medical diagnoses included intracranial injury and convulsions. An Annual Minimum Data Set Assessment, dated 2/7/2023, indicated Resident 2 was severely cognitively impaired, did not reject care, and required extensive assistant for personal hygiene tasks, including shaving. An activities of daily living care plan, dated 12/2/2015, indicated an intervention to assist Resident 2 with activities of daily living as needed. An observation of Resident 2 on 3/21/2023 at 1:39 p.m., indicated long facial hair on the chin. An observation of Resident 2 on 3/22/2023 at 1:30 p.m., indicated long facial hair on the chin. An interview with CNA 1 on 3/24/2023 at 2:02		Companions/Department managers to ensure residents are shaved per preference. 4. How corrective action will be monitored to ensure the deficient practice will not recur. What quality assurance program will be put into place? DON/designee will complete the Annual POC QAPI tool weekly x4 and monthly x6 to ensure compliance. If 100% compliance is not achieved an action plan will be completed. 5. Date of completion 4-24-23	

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	p.m., indicated that Resident 2 is not able to provide shaving by herself. A policy entitled, "A.M. Care", was provided on 3/23/2023 at 3:45 p.m. by the Administrator. The policy indicated, " ...Shave resident, is needed ..." [sic] 3.1-38(a)(3)(D)			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review the facility failed to maintain respiratory equipment in a bag for good infection control practices and failed to change oxygen tubing as ordered by the physician for 4 of 5 residents reviewed for respiratory care (Resident 20, Resident 23, Resident 12, and Resident 26). Finding include: 1.) During an observation on 3/21/23 at 10:53 a.m., Resident 20 a respiratory mask sitting on bedside table not in a bag and a nebulizer mouth piece laying on the edge of the raised floor not in a bag. During an observation on 3/22/23 at 11:50 a.m., Resident 20 laying in bed with oxygen on, a respiratory mask on nightstand not in a bag and	F 0695	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice? Residents 20, 23, 12 and 26 had their respiratory equipment placed in a bag and dated. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? DON/ADON completed audit of other residents using respiratory equipment with no other identified concerns. Nursing staff re-educated on Oxygen Therapy and Devices Policy on 4-14-23.	04/24/2023

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	nebulizer mouth piece laying on the edge of the raised floor not in a bag. Review of the record of Resident 20 on 3/22/23 at 11:03 a.m., indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), Alzheimer's disease, hypertensive heart disease, diabetes, muscle weakness and pneumonia. The physician recapitulation (recap) for Resident 7, dated March 2023, indicated the resident was order albuterol sulfate aerosol inhaler 90 micrograms (mcg), 2 puffs every four hours as needed for wheezing and shortness of breath. Albuterol sulfate solution for nebulization: 2.5 milligram (mg)/ 3 milliliter (ml) inhalation every 6 hours as needed for shortness of breath or wheezing. Ipratropium bromide solution: 0.02% for shortness of breath or wheezing. The resident was ordered a Trelegy Elipta (fluticasone-umeclidin-vilanter) (respiratory tract agent/anti-inflammatory agent) one puff one time a day COPD. During an observation on 3/22/23 at 2:00 p.m., Resident 20 was sitting on the side of his bed, oxygen on 3 liters, respiratory mask and nebulizer mouth piece was not in a bag laying on the raised floor. During an observation on 3/23/23 at 10:50 a.m., Resident 20 had a respiratory mask was laying on his nightstand not in a bag and his nebulizer mouthpiece laying on the edge of the raised floor not in a bag. During an observation on 3/23/23 at 11:20 a.m., Resident 20's respiratory mask was laying on his nightstand not in a bag, his nebulizer mouthpiece		3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?DON/Designee will round on Mondays to ensure respiratory equipment/tubing were changed per standard order on Sundays. Corrective action will be taken as needed. 4. How corrective action will be monitored to ensure the deficient practice will not recur. What quality assurance program will be put into place? DON/designee will complete the Annual POC QAPI tool weekly x4 and monthly x6 to ensure compliance. If 100% compliance is not achieved an action plan will be completed. 5. Date of completion 4-24-23	

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	155459	A. BUILDING 00 B. WING	03/24/2023

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	laying on the edge of the raised floor not in a bag. 2. The clinical record for Resident 23 was reviewed on 3/22/2023 at 2:34 p.m. The medical diagnoses included dementia and chronic obstructive pulmonary disease. A Significant Change of Condition Assessment, dated 2/21/2023, indicated that Resident 23 was cognitively impaired, utilized oxygen therapy, and needed assistance with activities of daily living. A physician ordered for Resident 23, dated 7/17/2022, indicated to change oxygen tubing and humidification weekly. An observation on 3/20/2023 at 6:53 p.m. indicated oxygen tubing on the in-room concentrator was dated for 2/27/2023. An observation on 3/20/2023 at 7:10 p.m. with LPN 4 indicated the tubing was dated for 2/27/2023. 3. The clinical record for Resident 12 was reviewed on 3/23/2023 at 1:55 p.m. The medical diagnoses included pulmonary hypertension and muscle weakness. A Significant Change of Condition Assessment, dated 1/31/2023, indicated that Resident 12 was cognitively intact, used oxygen therapy, and needed assistance for activities of daily living. A physician order, dated 1/25/2023, indicated to change Resident 12's oxygen tubing and humidification every week. An observation on 3/20/2023 at 6:55 p.m. indicated oxygen tubing on the in-room concentrator was dated for 2/1/2023.			

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	An interview and observation on 3/20/2023 at 7:15 p.m. with LPN 4 indicated the tubing was dated for 2/1/2023. LPN 4 indicated she was not sure how often oxygen tubing should be changed. 4. The clinical record for Resident 26 was reviewed on 3/23/2023 at 1:55 p.m. The medical diagnoses included tremor and weakness. A Quarterly Minimum Data Set Assessment, dated 2/21/2023, indicated that Resident 26 was cognitively confused and needed assistance with activities of daily living. An observation on 3/21/2023 at 2:25 p.m., indicated Resident 26's nebulizer was in the top drawer of the bedside table with no storage bag. An observation on 3/22/2023 at 2:45 p.m. indicated Resident 26's nebulizer was in the top drawer of the bedside table with no storage bag. A policy entitled, "Oxygen Therapy and Devices", was provided by the Administrator on 3/23/2023 at 3:45 p.m. The policy indicated to change oxygen tubing out weekly or as needed and to place in a labeled bag when not in use. A policy entitled, "Aerosolized Medication Therapy", was provided by the Administrator on 3/23/2023 at 3:45 p.m. The policy indicated to change the nebulizer equipment weekly and to place in a labeled bag with patient's name when finished with nebulizer treatments. 3.1-47(a)(6)			
F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse			

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	§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to provide eight hours of consecutive registered nurse (RN) coverage for 5 of 30 days reviewed for RN coverage. Findings include: As worked nursing scheduled for dates 2/25/2023, 2/26/2023, 3/5/2023, 3/18/2023, and 3/19/2023 indicated that no RN provided direct care to residents on those days. An interview with the Assistant Director of Nursing on 3/23/2023 at 3:40 p.m. indicated that they did not have RN coverage on those aforementioned days due to staffing. An interview with the Administrator on 3/24/2023 at 11:30 a.m., indicated there is no policy for 8 hours of RN coverage but they follow the CMS regulation and guidelines.	F 0727	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility has obtained RN coverage for 8 consecutive hours a day/7days a week. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No residents were affected by this deficiency. All residents have the potential to be affected by the alleged deficient practice. The daily staffing is reviewed by the Executive Director and the Director of Nursing to ensure that RN coverage is in place. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The daily staffing is	04/24/2023

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			reviewed by the Executive Director and the Director of Nursing to ensure that RN coverage is in place. If RN coverage is needed, the facility will contact staffing agencies and the in-company staffing group to obtain an RN. The executive Director and Director of Nursing are continuing to recruit and hire RN's full and part time. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e.: what quality assurance program will be put into place? To ensure compliance the ED/DNS will review the staffing schedule showing RN coverage monthly for 6 months and report on any identified issues during monthly QAPI meetings and follow QAPI recommendations. If RN coverage has not been achieved as required, an action plan will be developed and review will continue until RN coverage has been achieved 7 days a week for 8 consecutive hours. 5. Date of compliance 4-24-23	
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 federal, state or local authorities.			

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	(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 interview and record review the facility failed to maintain refrigerator/freezer temperature logs to ensure food was stored at a appropriate temperature and failed to maintain temperature logs for the dish machine to ensure dishes were sanitized for 7 out of 7 days, this had to potential effect 27 residents residing in the facility. Finding include: During initial tour of the kitchen on 3/20/23 at 6:55 p.m., Dietary Aide 3 provided the low temperature dish machine log, dated March 2023, the log was blank for lunch and supper from 3/13/23 to 3/19/23. The log indicated the facility was to check the water temperature and sanitation level of the dish machine when preparing to wash dishes for each meal; breakfast, lunch and supper. If the water temperature is below 120 "STOP" and notify the dietary manager. "Any items washed when minimum standards are not met are to be held and re-washed when issue resolved." During initial tour of the kitchen on 3/20/23 at 6:55	F 0812	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice? Temperatures were on a separate piece of paper that staff member had and they were added to the temperature logs for the refrigerator/freezer and dish machine. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? No residents were affected by this deficiency. All residents have the potential to be affected. All dietary staff were re-educated on the food storage policy and recording dish machine temperature/sanitizer policy. All other refrigerators/freezers temp logs were reviewed 3. What measures will be put	04/24/2023

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	p.m., Dietary Aide 3 provided the refrigerator/freezer temperature log, dated March 2023, the log was blank for evening from 3/13/23 to 3/19/23. During an interview with the Dietary Manager on 3/22/23 at 12:00 p.m., indicated it was the responsibility of cook to log refrigerator/freezer temperatures to ensure food was maintained at appropriate temperatures. The Dishwasher was responsible to log the dishwasher temperatures to ensure dishes were sanitized. The facility had not had any food borne illness outbreaks. The Dietary Manager was unsure why the refrigerator/freezer or dishwasher temperatures were not checked. During an interview with the Dietary Manager on 3/22/23 at 1:53 p.m., indicated all 27 residents residing in the facility ate meals from the facility kitchen. The dish machine temperature/sanitizer policy provided by the Dietary Manager on 3/22/23 at 1:50 p.m., indicated dishwashing staff would monitor and record dish machine temperatures to assure proper sanitizing of dishes. The food storage policy provided by the Dietary Manger on 3/22/23 at 1:50 p.m., indicated food would be stored at an appropriate temperature and by methods designed to prevent contamination. Refrigeration temperatures for refrigerators should be less than 41 degrees Fahrenheit and should be checked two times a day, if food is at above 41 degrees Fahrenheit, the food should be discarded. The freezer temperature should be at 0 degrees Fahrenheit and checked at least two times daily. 3.1-21(i)(3)		into place and what systemic changes will be made to ensure that the deficient practice does not recur? All dietary staff were re-educated on the food storage policy and recording dish machine temperature/sanitizer policy. Dietary Manager will check the temp logs for refrigerator and freezer and dish machine to ensure complete and appropriate. 4. How corrective action will be monitored to ensure the deficient practice will not recur. What quality assurance program will be put into place? Dietary manager/designee will complete the Annual POC QAPI tool weekly x4 and monthly x6 to ensure compliance. If 100% compliance is not achieved an action plan will be completed. 5. Date of completion 4-24-23	

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F 0851 SS=E Bldg. 00	483.70(q)(1)-(5) Payroll Based Journal §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day			

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	(including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. Based on record review and interview, the facility failed to ensure they accurately reported licensed nursing hours for 14 of 91 days of payroll based journal data reviewed. Findings include: Payroll Based Journal Staffing Data Report for Quarter 1 of Fiscal Year 2023 (10/1/22 to 12/31/22) indicated the facility did not report 24 hours of licensed nurse coverage on 10/1/22, 10/8/22, 10/9/22, 10/15/22, 10/23/22, 11/19/22, 11/20/22, 11/24/22, 12/3/22, 12/4/22, 12/18/22, 12/23/22, 12/25/22, and 12/29/22. Review of the as worked schedules indicated that agency or salary licensed staff was present on the aforementioned dates.	F 0851	1. What corrective action will be accomplished for those residents found to have been affected by deficient practice. No residents were affected by the alleged deficient practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? The alleged deficient practice does not have the potential to affect residents. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The BOM or designee will review employee and agency time	04/24/2023

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	An interview with Administrator on 3/23/2023 at 2:30 p.m. indicated she believed there was an issue with reporting agency staff members to the payroll-based journal. At the time agency and salaried staff would not clock in using the electronic time clock so the offsite reporter was not able to see those shifts as worked. Agency and salaried members would utilize paper time clocks for verification and payment. An interview with the Administrator on 3/24/2023 at 1:35 p.m. indicated there is no policy regarding payroll-based journal reporting but they would follow the CMS guideline.		sheets/logs once daily 5 times per week to verify that worked hours are reported through Kronos. 4. How corrective action will be monitored to ensure the deficient practice will not recur. What quality assurance program will be put into place? BOM or designee will report on any identified concerns during monthly QAPI meeting and follow QAPI recommendations until facility has gone 6 months with 100% compliance. 5. Date of completion 4-24-23 We respectfully disagree with determination that reporting was inaccurate. We contest that all hours worked were accurately reported to the Payroll Based Journal per CMS guidelines.	