STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00426488. Complaint IN00426488 - No deficiencies related to the allegations are cited. Survey dates: February 7, 8, 9, 12, and 13, 2024 Facility number: 000222 Provider number: 155329 AIM number: 100274950 Census bed type: SNF: 7 SNF/NF: 99 Total: 106 Census payor type: Medicare: 7 Medicaid: 83 Other: 16 Total: 106 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 19, 2024	F 0000	**The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents. The Facility formally requests a desk review of the following plans of correction.**	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Omar Johnson	3/4/2024	03/04/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on observation, interview, and record review, the facility failed to provide showers, as preferred, for 1 of 4 residents reviewed for ADL (Activities of Daily Living) care (Resident 45). Findings include: The clinical record for Resident 45 was reviewed on 2/7/24 at 11:22 a.m. The Resident's diagnosis included, but were not limited to, dermatitis and diabetes. A physician's order, dated 9/21/23, indicated to encourage showers 2 times weekly on Tuesday and Friday and to document any refusals.	F 0561	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 45 has been provided with a shower per choice, and as often as needed. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**	03/04/2024

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	A Preferences for Customary Routine and Activities Observation, dated 1/15/24, indicated that it was very important to Resident 45 to choose between a tub bath, shower and bed bath. The type of bathing he was used to were showers. A Quarterly MDS (Minimum Data Set) Assessment, completed 1/16/24, indicated that he was cognitively intact and dependent on staff for bathing. A care plan, last reviewed on 1/29/24, indicated that Resident 45 had a self-care deficit related to weakness and decreased mobility. He needed assist with ADLs including bathing, dressing, grooming, personal hygiene, toileting, transfers, bed mobility, and eating. His ability fluctuated from morning to evening and day to day. The goal was for him to have his basic needs met daily with staff assist as evidenced by being neat, clean, well-groomed and dressed appropriately. The interventions included, but were not limited to, encourage showers biweekly, initiated 9/22/23, he preferred to wear hospital gown at times, initiated 10/4/22, and offer showers two times per week with partial bath in between, initiated 10/10/2019. On 2/7/24 at 11:22 a.m., Resident 45 was observed laying in bed in his room. He was wearing a hospital gown and had scattered small, scabbed areas on his forehead and around his nose and chin. His hair appeared greasy and unwashed. His skin was flakey and dry. He was scratching his face and arms. Resident 45 indicated his skin was itching and that he needed a shower. He could not remember the last time he had a shower. The staff gave him bed baths instead and he didn't feel like they got all of the soap off, which		All residents have the potential to be affected by the alleged deficient practice. 1x resident interviews will be completed by Customer Care Representatives by 3/4/2024 to ensure resident choices are being met for bathing. Resident choice for bathing will be documented on resident profile. DNS/Designee will in-service all Nursing staff on resident choice including right to choose between shower and bed bath. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·The DNS/designee will be responsible for monitoring or auditing the completion of resident bathing per resident choice by reviewing shower sheets daily for completion. **How will the corrective action (s) 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 DNS/designee will complete a POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 6 months by a nurse manager or designee. The	

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	caused him to itch. He had taken a shower every day while he was at home. He had told the staff that he would like to have showers. On 2/8/24 at 2:47 p.m., Resident 45 was observed laying in his bed with his eyes closed. He was in a hospital gown and his hair appeared unwashed. During an interview on 2/09/24 at 10:40 a.m., Resident 45 indicated that he had not had a shower. He was observed laying in his bed. His hair looked greasy, and his face had flakey skin. During an interview on 2/09/24 at 10:41 a.m., CNA (Certified Nursing Assistant) 2 indicated Resident 45 received partial baths each morning and he received his showers on the evening shift. He did not normally refuse any care. On 2/12/24 at 8:59 a.m., the Nurse Consultant provided Resident 45's bathing documentation for January and February 2024, which indicated he had received complete bed baths instead of showers. The documentation did not indicate he had refused to be showered. 3.1-3(u)(1)		Resident POC CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. **By What date will the systematic changes be completed** Compliance date 3/4/2024	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to assess vision status, as instructed in the RAI (Resident Assessment Instrument) manual, while completing the MDS (Minimal Data Set) Assessments for 1 of 3 residents reviewed for vision (Resident 24).	F 0641	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 24 MDS has been updated to indicate accurate vision	03/04/2024

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	Findings include: The clinical record for Resident 24 was reviewed on 2/7/24 at 3:38 p.m. The Resident's diagnosis included, but were not limited to, diabetes and hypertension. An Admission MDS (Minimum Data Set) Assessment, completed 6/16/23, indicated that Resident 24 was cognitively intact, had adequate vision, and did not wear glasses. A Consultation Note from an eye surgeon, dated 8/7/23, was provided on 2/12/24 at 4:18 p.m., by the Nurse Consultant. The consultation note indicated that Resident 24 had Combined Senile Cataracts in the right and left eyes. Resident 24 had experienced blurred vision for years and it was bothersome to Resident 24, affecting his ability to watch television and recognize faces from across the room. The plan was that the Cataract on his right eye was causing his decreased vision, but Resident 24 needed to have medical clearance prior to having the surgery. The cataract on the left eye was not to be removed due to corneal scaring on the left eye. Quarterly MDS Assessments, completed 9/5/23 and 11/29/23, indicated that he was cognitively intact, adequate vision, and did not wear glasses. During an interview on 2/7/24 at 3:38 p.m., Resident 24 indicated that he needed to see the eye doctor. He had cataracts and needed to have them checked. He was supposed to see the eye surgeon for a follow-up, but the appointment had been canceled. During an interview on 2/12/24 at 3:04 p.m.,		assessment. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. An audit will be completed by DNS/designee by 3/4/2024 of all residents to determine accuracy of vison charting on MDS. An in-service will be completed by DNS/designee with all MDS staff by 3/4/2024 on following accurate coding MDS. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** An in-service will be completed by DNS/designee with all MDS staff by 3/4/2024 on accurately coding MDS. Any new admit will be reviewed by IDT to ensure accuracy of vision assessment and MDS. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	Resident 24 indicated that he did not wear glasses, but could not see the television very well because of the cataracts in his eye. He didn't turn the television on often, and when it was on, he normally was just listening to it. He couldn't always see fine details. During an interview on 2/13/24 at 10:35 a.m., the SSD (Social Services Director) indicated she completed the vision portion of the MDS Assessment. To complete the vision portion she would look at the residents' diagnosis in the chart and see if they wore glasses. If the resident did not have a diagnosis that would indicate visual impairment and did not wear glasses, then she would code vision as adequate. The SSD indicated she did not have the residents read anything while completing the vision portion of the MDS Assessment, that would be what an optometrist would do. During an interview on 2/13/24 at 10:45 a.m., the MDSC (Minimum Data Set Coordinator) indicated that she was unsure why Resident 24's vision had been coded as adequate and that the facility used the RAI Manual as the policy for completing the MDS. Current RAI Manual guidelines from October 2023 for completing vision read "...Steps for Assessment 1. Ask family, caregivers, and/or direct care staff over all shifts, if possible, about the resident's usual vision patterns during the 7-day look-back period [e.g.[sic], if the resident is able to see newsprint, menus, greeting cards?]. 2. Then ask the resident about their visual abilities. 3. Test the accuracy of your findings: Ensure that the resident's customary visual appliance for close vision is in place...Ensure adequate lighting. Ask the resident to look at regular-size print in a book		·To ensure compliance, the POC CQI audit tool will be completed for six months with audits being completed once weekly for one month, and then monthly for 6 months by a nurse manager or designee. The POC CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. **By What date will the systematic changes be completed** Compliance date 3/4/2024	

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	or newspaper. The ask the resident to read aloud, starting with larger headlines and ending with the finest, smallest print. If the resident is unable to read a newspaper, provide material with larger print, such as a flyer or large textbook...Code 0, adequate: if the resident sees fine detail, including regular print in newspapers/ books..."			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the			

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	resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	Based on interview and record review, the facility failed to ensure a resident had a care plan to address his insomnia and create a vision careplan for a resident with visual difficulties for 1 of 5 residents reviewed for unnecessary medications and 1 of 4 residents reviewed for vision or hearing services. (Residents 24 and 66) Findings include: 1. The clinical record for Resident 66 was reviewed on 2/8/24 at 10:30 p.m. His diagnoses included, but were not limited to, dementia. The physician's orders indicated to administer one 5 mg tablet of melatonin at bedtime, starting 6/6/22, and half of a 50 mg tablet of trazodone at bedtime, starting 12/20/23. The 1/24/24 psychiatry note indicated to continue the Melatonin 5 mg every evening and the Trazodone 25 mg every evening, both for	F 0656	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 66 to have accurate care plan to address his insomnia. Resident 24 to have accurate care plan to address his vision. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected. —- DNS/Designee will review all care plans related to insomnia and	03/04/2024

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	insomnia. It indicated a dose reduction for either medication was contraindicated due to high risk of symptom escalation. The February, 2024 MAR (medication administration record) indicated the Melatonin was not administered on 2/6/24 and 2/7/24 due to the medication being unavailable. It indicated the Trazodone was not administered on 2/5/24, 2/6/24, and 2/7/24 due to the medication being unavailable. An interview was conducted with the DNS (Director of Nursing Services) on 2/12/24 at 12:25 p.m. She indicated their process for ensuring medications were available for administration was to reorder them on time. She was unsure why the Melatonin and Trazodone was not administered on the above dates, as both medications were available in their emergency drug kit, so the nurse could have administered them. There was no care plan in Resident 66's clinical record to address his insomnia. An interview was conducted with the DNS on 2/12/23 at 2:20 p.m. She indicated the only care plan that referenced Resident 66's insomnia was an at risk for adverse side effects care plan related to the use of psychotropic medication which included the Trazodone for insomnia. The 11/11/22 at risk for adverse side effects related to use of psychotropic medication care plan, last revised 2/6/24, indicated an antidepressant medication for insomnia was added on 12/5/23. It did not include specific approaches to address Resident 66's insomnia. 2. The clinical record for Resident 24 was reviewed on 2/7/24 at 3:38 p.m. The Resident's		vision to ensure accuracy. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·An in-service will be completed by ED/Designee by 3/4/24 for Social Services personnel to ensure knowledge of care plans getting completed accurately. Care plans will be reviewed by the IDT for all new admits and for residents who have a change in condition related to vision and insomnia. **How will the corrective action (s) 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 DNS/Designee will complete POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 6 months by a nurse manager or designee. The POC CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed.	

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	diagnosis included, but were not limited to, diabetes and hypertension. A Quarterly MDS (Minimum Data Set) Assessment, completed 11/29/23, indicated that he was cognitively intact. During an interview on 2/7/24 at 3:38 p.m., Resident 24 indicated that he needed to see the eye doctor. He had cataracts and needed to have them checked. He was supposed to see the eye surgeon for a follow-up, but the appointment had been canceled. During an interview on 2/12/24 at 11:11 a.m., the DNS (Director of Nursing Services) indicated that Resident 45 had been scheduled for an eye consult recently, but it had to be canceled because of transportation difficulties. On 2/12/24 at 4:18 p.m., the Nurse Consultant provided a Consultation Note from an eye surgeon, dated 8/7/23. The consultation note indicated that Resident 24 had Combined Senile Cataracts in the right and left eyes. Resident 24 had experienced blurred vision for years and it was bothersome to Resident 24, affecting his ability to watch television and recognize faces from across the room. The plan was that the Cataract on his right eye was causing his decreased vision, but Resident 24 needed to have medical clearance prior to having the surgery. The cataract on the left eye was not to be removed due to corneal scaring on the left eye. During an interview on 2/14/24 at 10:20 a.m., the DNS indicated there was not a care plan related to vision present in Resident 24's medical record. On 2/13/24 at 1:00 p.m., the Regional Infection		**By What date will the systematic changes be completed** Compliance date 3/4/2024	

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	Preventionist provided the IDT (Interdisciplinary Team) Comprehensive Care Plan Policy, last reviewed August 2023, which read "...It is the policy of this facility that each resident will have an interdisciplinary comprehensive person-centered care plan developed and implemented based on Resident Assessment Instrument [RAI] process. The care plan must include measurable goals and resident specific interventions based on resident needs and preferences to promote the resident's highest well-being..." 3.1-35(b)(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			

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	disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to invite a resident's representative to her care plan meetings for 1 of 2 residents reviewed for care planning. (Resident 1) Findings include: The clinical record for Resident 1 was reviewed on 2/7/23 at 3:00 p.m. Her diagnoses included, but were not limited to: hypertension, seizures, neuropathy, congestive heart failure, osteoarthritis, and diabetes mellitus. The 11/20/23 Significant Change MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status) score of 1, indicating she was severely cognitively impaired. Resident 1's face sheet in her electronic clinical record indicated her emergency contact, durable POA (power of attorney,) and health care representative was Family Member 13. It did not indicate the specific family member relationship between Resident 1 and Family Member 13. An interview was conducted with Family Member 13 on 2/7/24 at 3:15 p.m. He indicated he was not invited to routine care plan meetings by the facility. He received phone calls sometimes from an outside nurse who provided services at the facility, but nothing routine and scheduled by the facility. Ideally, it would be great to have them, "so I know where things are at."	F 0657	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** — Resident 1 representative has been invited to the next care plan meeting. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Social Service Director (SSD)/Designee reviewed the last 3-months care plan meetings to ensure resident representatives were invited. If the resident representatives were not invited, a new care plan meeting will be held. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?**	03/04/2024

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	The 7/5/23 IDT (Interdisciplinary Team) Care Plan Summary indicated the care plan meeting occurred on 7/5/23 at 11:29 a.m. and only the IDT was in attendance. It read, "Resident's son has no questions or concerns at this time and did not want to participate in care plan meeting." The notes section read, "Resident's son did not want to participate in care plan meeting." The 9/27/23 IDT Care Plan Summary indicated the care plan meeting occurred on 9/27/23 at 3:28 p.m. and only the IDT was in attendance. It read, "Residents POA was invited to care plan meeting, however did not want to participate and had no questions or concerns." The notes section read, "POA had no questions or concerns." There was no information in the electronic health record to indicate Family Member 13 was invited to the 7/5/23 and 9/27/23 care plan meetings prior to 7/5/23 and 9/27/23. An interview was conducted with the SSD (Social Services Director) on 2/8/24 at 2:51 p.m. She indicated care plan meetings were held whenever a resident wanted one, quarterly, and at significant change assessments. The SSA (Social Services Assistant) was in charge of care plan invitation to residents and families. A resident received a care plan invitation card and was verbally informed of the meeting. Family was called via telephone and if they indicated they wanted a meeting, they would give the resident a care plan card, but didn't actually mail a care plan invitation to the family. An interview was conducted with the SSA on 2/8/24 at 3:19 p.m. She indicated when she called family to invite them to care plan meetings, if they said they didn't have any questions or concerns		·SSD & Social Services Assistant (SSA) will keep a running list of residents that need care plan invitations. ·SSD will ensure both SSD and SSA have two care plan invitation cards, one for residents, one for family invites. SS will keep a copy of the care plan invitation in the Care Plan binder. ·SS will stamp and mail family invitations. SS will write out name, phone number, and relation to resident in the Care Plan observation when inviting family to the care plan meeting. ·The SSD/SSA will be responsible for monitoring Care Plan invites during morning meetings to ensure proper communication with families. Social Services staff will be educated on requirements relating to care plan attendance. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** SSD/SSA will be responsible for monitoring/auditing the POC	

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	and didn't want to participate, she completed the care plan summary observation in the electronic health record at that time. She did not recall speaking with Family Member 13 on 7/5/23 and 9/27/23. She was familiar with Resident 1, but not Family Member 13. Follow-up telephone interviews were conducted with Family Member 13 on 2/8/24 at 10:30 a.m. and 2/8/24 at 11:08 a.m. He indicated he was Resident 1's grandson, not Resident 1's son, and had tried to resolve that with the facility prior. He attended a meeting at the facility in the spring of 2023, when Resident 1's therapy was ending and in November, 2023 when Resident 1 moved to a different unit of the facility. He would be fine with doing the meetings over the phone, as he had to wait 20 to 30 minutes for both meetings for the staff to be ready. He was not invited to any meetings in between those times. He indicated he was reviewing his incoming call log for any missed or incoming calls on 9/27/23 and 7/5/23, and did not miss or receive any calls from the facility on either date. He had one missed call on 7/5/23 from his dentist, but no missed or incoming calls from the facility. He had no missed or incoming calls on 9/27/23 from the facility or anyone else. He had 3 different phone numbers for the facility saved into his phone, so he would know it was them calling. The IDT Comprehensive Care Plan policy was provided by the SSD on 2/8/24 at 3:24 p.m. It read, "Purpose: Create an organized, resident-centered review on a routine basis to improve communication with residents, resident families and/or representative regarding the resident goals, total health status, including functional status, nutritional status, rehabilitation and restorative potential, ability to participate in		QAPI tool Weekly times 4 weeks, monthly times 6, 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 a threshold of 100% is not achieved, an action plan will be developed. **By What date will the systematic changes be completed** Compliance date 3/4/2024	

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	activities, cognitive status, psychosocial status, sensory and physical impairments, as well as care and services provided to maintain or restore health and well-being, improve functional level or relieve symptoms. Improve relationships between resident, families and/or representative, and facility caregivers through understanding of resident's social history, culture and preferences to enhance the resident's life. Procedure: ...Resident, resident's representative, or others as designated by resident will be invited to care plan review." The IDT Care Plan Review Guidelines was provided by the RIP (Regional Infection Preventionist) on 2/13/24 at 10:00 a.m. It read, "Prior to the Meeting IDT members must ensure the following: ...Care plan invitation has been mailed to the resident representative." 3.1-35(d)(2)(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 provide shampooing, toenail care, shaving, and incontinence care for 3 of 5 residents reviewed for Activities of Daily Living (ADL)s. (Resident 78, 97, and 306) Findings include: 1. The clinical record for Resident 97 was reviewed on 2/7/24 at 2:18 p.m. The diagnosis for Resident 97 included, but was not limited to, acute	F 0677	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 97 routinely receives nail care, shaving, and shampooing per resident preference. Resident 78 routinely receives	03/04/2024

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	respiratory failure. The Admission 11/23/23 Minimum Data Set (MDS) assessment indicated Resident 97 was cognitively intact. An ADL care plan dated 11/19/23 indicated the resident required assistance with ADL's. The approaches included but was not limited to, "Assist with dressing/ grooming/hygiene as needed." The January 2024 shower sheets indicated the following days shampooing, nail care and shaving was not provided with bathing: 1/2/24, 1/5/24, 1/9/24, 1/12/24, 1/16/24, 1/19/24, 1/23/24, 1/27/24, and 1/30/24 The February 2024 shower sheets indicated on 2/2/24 and 2/6/24 a bed bath was provided. Shampooing, nail care and shaving was not provided with bathing: An observation was made of Resident 97 on 2/7/24 at 2:18 p.m. The resident was observed with inch in length gray chin hair, toe nails long in length and hair appeared to be greasy. The resident had indicated at that time, she was suppose to receive bathing twice a week. The staff had provided bathing, but had not been washing her hair nor shaving her chin. She would like her hair wash at least once a week and chin hair shaved as needed. She had been asking since December for her toenails to be trimmed. The resident had been told staff will not cut her toenails. She needed to see a podiatrist for her toe nails to be trimmed. She was told she was on the list. She had not seen anyone yet.		nail care and hair shampooing per resident preference. Resident 306 is receiving appropriate incontinence care. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All residents were observed to ensure residents were well groomed. Personal hygiene/incontinence care was provided including shaving, nail care, and shampoos during bed baths by each resident care companion. All nursing staff will be educated by CEN/Designee on ADL care, including shaving, nail care, oral care, and ensuring residents are provided hair shampoos during bed baths and that appropriate incontinence care is provided by 3/4/2024. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** An in-service will be completed by DNS/designee by 3/4/2024 for all staff regarding ADL	

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	An observation was made of Resident 97 on 2/12/24 at 12:20 p.m. The resident's toes were observed to be long in length and hair was greasy. An observation was made of Resident 97 with the Director of Nursing Services (DNS) on 2/12/24 at 2:37 p.m. The resident's toenails were long in length. The resident indicated she had been told recently by Social Services Director she had never been placed on the podiatrist list to receive toenail trimming. The DNS indicated staff are not suppose to cut toenails only the podiatrist. A "Resident Rights" policy was provided by the Regional Infection Preventionist (RIP) on 2/13/24 at 10:44 a.m. It indicated "...The resident has the right to be treated with respect and dignity, including the right to: resident and receive services in the facility with reasonable accommodations of resident needs and preferences except when to do would endanger the health or safety of the resident or other residents..."2. The clinical record for Resident 78 was reviewed on 2/12/24 at 2:14 p.m. Resident 78's diagnoses included, but not limited to, chronic respiratory failure, chronic kidney disease, major depressive disorder and psoriasis. An observation and interview with Resident 78 was conducted on 2/7/24 at 3:17 p.m. Resident 78 indicated, when she gets a bed bath or shower, the staff does not always offer to wash her hair or to trim her fingernails. She indicated, she had observed other residents getting a their hair washed by the shampoo cap method and would not mind having that done. She further indicated, because she has psoriasis on her scalp, it was important to have her hair washed. Resident 78 had long fingernails that appeared to have dark		care. A daily rounding tool including resident hygiene to be utilized by Care Companions/Department managers to ensure good grooming and personal hygiene. **How will the corrective action (s) 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 DNS/Designee will complete a POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 6 months by a nurse manager or designee. The POC CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. **By What date will the systematic changes be completed** Compliance date 3/4/2024	

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	material stuck underneath them. When asked if she wanted them trimmed, she indicated, she would but no one had offered to trim them for her. Resident 78's care plan dated 9/1/23 and last reviewed/revised on 2/1/24 indicated, she required assistance with ADLs. Interventions, included but not limited to, Resident 78 required assistance of one person for bathing and grooming. A physician's order dated 9/18/23 indicated, Resident 78 was to use 2 % ketoconazole shampoo (an antifungal shampoo used to treat scaly areas on scalp), and to wash hair on shower days with the shampoo. A review of Resident 78's December 2023, January 2024, and February 2024 MAR/TARs (medication/treatment administration record) on 2/12/24 at 3:14 p.m. indicated, no administrations of the 2% Ketoconazole shampoo were documented. A review of Resident 78's point of care (POC) task for bathing/showers for December 2023, January 2024, and February 2024 did not indicate if the resident was offered a hairwashing/shampoo when receiving shower/baths. Resident 78's shower sheets for November 2023, December 2023, January 2024 and February 2024 were received from Nurse Consultant (NC) on 2/12/24 at 10:13 a.m. Resident 78 received a shampoo/hairwashing on the following dates: 11/2/23 11/9/23 11/13/23 2/2/24 The shower sheets did not indicate if the resident was offered and refused a hairwashing/shampoo			

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	on the dates in which she received a bed bath/shower. An interview with NC conducted on 2/9/24 at 4:09 p.m. indicated, residents were to offered hairwashing/shampoos and nail trimming with every complete bed bath/shower. 3. The clinical record for Resident 306 was reviewed on 2/12/24 at 12:16 p.m. Resident 306's diagnoses included, but not limited to, cellulitis of right lower limb, morbid obesity, lymphadema (localized swelling mostly in an arm or leg caused by a lymphatic system blockage), and unsteadiness on feet. An interview with Resident 306 conducted on 2/8/24 at 11:44 a.m. indicated, on the evening shift last night he had not received incontinence care and wasn't cleaned up until the next morning. He was unable to name the CNA as he could not see her name tag, but was familiar with her and could identify her if he saw her. An interview with Resident 306 conducted on 2/12/24 at 9:48 a.m. and 11:44 a.m. indicated, the CNA (Certified Nursing Assistant) on the evening shift of 2/7/24 had not performed incontinence care prior to leaving and he was left all night with feces in his depend brief. He indicated, he had placed his call light on prior to 8 p.m. because he wanted his cell phone plugged into the outlet to charge. The CNA came in and while in the room, has asked if he needed to be cleaned up to which he denied needing to be cleaned up at that time. Resident 306 stated this particular CNA usually will take her dinner break around 8 p.m. and when she returns from break, she would do her final rounds for the shift. He indicated, during the time his CNA was on break, he had placed his call light			

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	on again and a different CNA came in to answer the light. He stated to the CNA that he needed to be cleaned up. That CNA informed him that she was not 'in that area' but would let his CNA know about his need. Resident 306 indicated, he was waiting for his CNA to come back into his room after her break and didn't put his call light on because she would usually come in and do final rounds around 9 p.m., but on that evening, she never came back in. He stated, he would hear her walking down the hall with the linen can and even heard her in his next door neighbors room talking, but she never came back to his room that evening. "She had always been precise in doing a final round on me but that night she didn't and I thought that was weird." Resident 306 indicated, he must have fallen asleep because the next thing he knew, it was morning time. He placed his call light on to be cleaned up and that was when CNA 9 came in to assist him. He indicated, CNA 9 was so shocked to see the state he was in, that he went to get UM (Unit Manager) 32. Resident 306 stated, "you don't disrespect a resident like that. I was disappointed and disgusted". An interview with CNA 9 conducted on 2/12/24 at 11:27 a.m. indicated, he was Resident 306's CNA the morning after the the incident with the unnamed CNA. He was told the resident had a complaint about the lack of care he had received and that he needed to be changed. CNA 9 was doing his morning rounds but hadn't got down to Resident 306's room yet, but when he heard about the complaint, he went down to Resident 306's room to perform incontinence care. CNA 9 indicated, the care needed was more significant then what he thought and that was when he asked for UM 32 to come to the room (UM 32's office is right across the hall from his room). When asked what did it mean that the care needed was more			

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	significant, CNA 9 stated, the resident's bed was soaked with urine and the urine went up his back. Also, he had a large amount of feces in brief as well as up his back which indicated to him "he hadn't been changed in a numerous amount of hours". Resident 306's care plan dated 2/5/24 indicated, he required assistance with ADLs related to weakness and decreased mobility secondary to having cellulitis on his right lower extremity, chronic lymphedema in bilateral lower extremities, morbid obesity, debility, and chronic venous insufficiency. An intervention placed on 2/8/24 indicated, to "check every 2 hours, change as needed". The 2/5/24 care plan indicated, he was at risk for incontinence. One intervention was to "Check every 2 hours for incontinence." A Bladder Continence Review completed on 2/5/24 indicated, Resident 306 was not mentally and/or physically aware of the need to void and able to use a toilet, commode, urinal, or bedpan. Also, the resident was not able to resist or inhibit the sensation of urgency, postpone, or delay voiding and urinate according to a timetable rather than surrender to the urge to void. 3.1-38(a)(3) 3.1-38(b) 3.1-38(3)(B)(D)(E)			
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive			

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	treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to timely address and follow up on a resident's change of condition; administer a resident his medication for insomnia, as ordered; address a resident's skin condition, per policy; administer treatments, as ordered; and accurately monitor fluid consumption for a resident, as ordered, for 2 of 2 residents reviewed for hospitalization, 1 of 5 residents reviewed for unnecessary medications, 1 of 3 residents reviewed for abuse, and 1 of 4 residents reviewed for skin conditions. (Residents 1, 20, 45, 66, and 104) Findings include: 1. The clinical record for Resident 104 was reviewed on 2/8/24 at 2:42 p.m. The diagnosis for Resident 104 included, but was not limited to, acute kidney disease. A care plan dated 9/20/23 indicated "Resident is at risk for abnormal/excessive bleeding due to use of anticoagulant." The approaches included but was not limited to, observe for signs of bleeding: blood in urine/BM [bowel movement], dark tarry stools, blood tinged sputum, excessive bruising, bruise increasing in size, oozing from superficial injuries, bleeding gums." A physician order dated 9/19/23 indicated Resident 104 was to receive 2.5 milligrams of Eliquis twice a day. The November 2023 Medication Administration Record indicated the resident receive the	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 104- no longer resides in the facility Resident 66 is receiving his medication per physician's order Resident 1 received a skin assessment and MD was notified Resident 45 is receiving his medication per physician order and skin treatments as ordered Resident 20 to receive proper fluid restriction as ordered by the physician. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Audit of medication administration to be completed by DNS/Designee to check for medications marked as "Unavailable". Corrective action will be taken as needed. Audit of orders for residents on fluid restrictions was completed by DSN/Designee to ensure all	03/04/2024

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	scheduled 2.5 milligrams of Eliquis on 11/9/23 at 7:00 a.m. - 11:00 a.m., and 7:00 p.m. - 11:00 p.m. A nursing progress note dated 11/9/23 at 2:12 p.m., indicated "Resident examined by writer d/t [due to] reported rectal bleeding. Scant rectal bleeding noted. No obvious s/s [signs or symptoms] visible hemorrhoids. Call placed to on call MD [medical doctor]. Awaiting call back. Reported to oncoming Nurse." A nursing progress note dated 11/9/23 at 11:45 p.m., indicated "Writer was called to the patient room in regard to bleeding noticed by CNA [Certified Nursing Aide] while doing patient's care. After assessment, writer noticed bleeding coming out of patient rectum, call placed to MD, awaiting call back." A nursing progress note dated 11:55 p.m. "Call back received, new order to send patient to ER [emergency room] for evaluation via 911. 911 called, awaiting arrival. " A hospital transfer form for Resident 104 dated 11/10/23 at 12:00 a.m., indicated the resident was being transferred to hospital with black blood clot coming out of resident's rectum. A nursing progress note dated 11/10/23 at 12:17 a.m. Resident 104 had left the facility. An interview was conducted with the Director of Nursing Services (DNS) on 2/9/24 at 9:24 a.m. She indicated on 11/9/23, the staff had observed a scant of blood on Resident 104's brief at approximately 2:00 p.m. The CNA reported the observation to the nurse. The nurse notified the medical provider by leaving a message for a return call. It was at the end of her shift, so she left for		restrictions are followed. Audit of residents with skin conditions were reviewed by DNS/designee to ensure skin issues are identified and addressed. Audit of residents who have experienced a change in condition was completed by DNS/Designee to ensure MD is notified and appropriate action is taken. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·An in-service will be completed by DNS/designee by 3/4/24 for all staff to include ensuring orders and fluid restrictions are followed, skin is assessed timely, medications are provided per MD order, and change in conditions identified and reported to MD. ·DNS/designee will review daily orders during clinical meeting to verify and ensure all fluid restrictions, skin assessments, changes in condition and medication are according to orders. **How will the corrective action (s) 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	

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	the day. The nurse was not sure if the medical provider called back with orders. The DNS indicated there was no documentation by the nursing staff of follow up with the medical provider and/or orders received by the provider that afternoon. The next incident of observing blood was later that night at approximately 11:45 p.m., the nurse notified the medical provider and received orders to send the resident to the hospital. An interview was conducted with CNA 5 on 2/12/24 at 11:19 a.m. She indicated she had observed the blood on Resident 104's brief on the afternoon of 11/9/23, day shift. It was not a lot of blood just a little spot on her brief. She reported the observation to the nurse as she has been told to always report to the nurse if observe residents with blood. That was the first time she had noticed blood on Resident 104's brief. An interview was conducted with Physician 7 on 2/12/24 at 3:20 p.m. She indicated after reviewing her call report, she did not have any record a nurse staff person called her office about blood on Resident 104's brief on 11/9/23 approximately 2:00 p.m. She does not know the condition of the resident after 2:00 p.m., that day until she was sent to emergency room later that night. She would have held the scheduled evening dose of Eliquis medication. The resident was declining, and the end result would have been the same. It had been recommended on the last hospitalization, Resident 104 to be placed on palliative care. The family had declined the recommendation at that time. The resident's family agreed for the resident to be placed on palliative care on the 11/9/23 hospitalization. The resident at that time was made comfortable and past away at the hospital.		DNS/Designee will complete POC CQI tool once weekly for one month, and one time monthly for 6 months by a nurse manager or designee. The CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. **By What date will the systematic changes be completed** Compliance date 3/4/2024	

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	A "Resident Change of Condition Policy" was provided by the DNS on 2/12/24 at 12:13 p.m. It indicated "...d. If the physician has not returned the call by the end of the shift, the oncoming nurse will be notified for follow up. e. If unable to contact attending physician or alternate timely, the Medial Director will be notified for response and intervention for the resident change of condition. f. Document resident change of condition and response in the medical record. Documentation will include time and family/physician response. g. The licensed nurse responsible for the resident will continue assessment and documentation in the medical record every shift until the resident's condition has stabilized." 2. The clinical record for Resident 66 was reviewed on 2/8/24 at 10:30 p.m. His diagnoses included, but were not limited to, dementia. The physician's orders indicated to administer one 5 mg tablet of melatonin at bedtime, starting 6/6/22, and half of a 50 mg tablet (25 mg) of trazodone at bedtime, starting 12/20/23. The 1/24/24 psychiatry note indicated to continue the Melatonin 5 mg every evening and the Trazodone 25 mg every evening, both for insomnia. It indicated a dose reduction for either medication was contraindicated due to high risk of symptom escalation. The February, 2024 MAR (medication administration record) indicated the Melatonin was not administered on 2/6/24 and 2/7/24 due to the medication being unavailable. It indicated the Trazodone was not administered on 2/5/24, 2/6/24, and 2/7/24 due to the medication being unavailable.			

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	An interview was conducted with the DNS (Director of Nursing Services) on 2/12/24 at 12:25 p.m. She indicated their process for ensuring medications were available for administration was to reorder them on time. She was unsure why the Melatonin and Trazodone was not administered on the above dates, as both medications were available in their emergency drug kit, so the nurse could have administered them. The Medication Shortages/Unavailable Medications policy was provided by the DNS on 2/12/24 at 2:20 p.m. It read, "PROCEDURE...3. If a medication is unavailable is [sic] discovered after normal Pharmacy hours: 3.1 A Facility nurse should obtain the ordered medication from the Emergency Medication Supply." 3. The clinical record for Resident 1 was reviewed on 2/7/23 at 3:00 p.m. Her diagnoses included, but were not limited to: hypertension, seizures, neuropathy, congestive heart failure, osteoarthritis, and diabetes mellitus. The at risk for skin breakdown care plan, last reviewed/revised 12/25/23, indicated the goal was for her to be free from skin breakdown. An approach was to assess and document skin condition weekly and as needed and to notify the physician of abnormal findings, starting 3/1/23. The 12/6/23 weekly skin and vital sign assessment, completed by RN (Registered Nurse) 11, indicated she had scattered bruising to her bilateral arms. There was no description of the bruising to include size, color, or otherwise. There was no skin event or wound management entry in the electronic health record regarding the scattered bruising to Resident 1's bilateral arms.			

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	RN 11 was unavailable for interview. An interview was conducted with the DNS (Director of Nursing Services) on 2/9/24 at 12:37 p.m. She reviewed Resident 1's clinical record and indicated she did not see the scattered bruising was reported to Resident 1's physician or her representative. There was no skin event for further assessment of the bruising, but one should have been initiated. The wound nurse also should have been notified for further evaluation of the bruising and a wound management entry created. She was uncertain if the bruising would be considered suspicious for any reason, as they had no further information on it. An interview was conducted with CNA (Certified Nursing Assistant) 9 on 2/9/24 at 2:35 p.m. He indicated he didn't usually work on the unit where Resident 1 resided, but on 12/6/23, he did. What he saw was "kinda spotty, discoloration, like bluish, purple" on her right and left forearms. She wore geri-sleeves, but often refused them. He informed RN 11, who was caring for another resident at the time, of the spotty discoloration on Resident 1's arms. An observation of Resident 1's arms were made on 2/9/24 at 3:45 p.m. with the DNS. She was not wearing geri-sleeves. No bruising was observed. Resident 1 indicated during this observation that she did not like wearing her geri-sleeves. The Skin Management Program policy was provided by the DNS on 2/9/24 at 12:02 p.m. It read, "Any skin alterations noted by direct care givers during daily care and/or shower days must be reported to the licensed nurse for further assessment, to include but not limited to bruises,			

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	open areas, redness, skin tears, blisters, and rashes. The licensed nurse is responsible for assessing all skin alterations by the direct caregivers on the shift reported....1. Alterations in skin integrity will be reported to the MD/NP [Nurse Practitioner,] the resident and/or resident representative as well as to the direct care staff....4. All newly identified areas after admission will be documented on he New Skin Event. 5. The wound nurse/designee will be notified of alterations in skin integrity. a) The wound nurse/designee is responsible for communicating to IDT [interdisciplinary team] on a weekly basis for pressure and non-pressure wounds. b) The wound nurse/designee will complete further evaluation of the wounds identified and complete the appropriate skin evaluation on the next business day. The 'observed' date indicated on the Wound Management document is the date the wound was assessed, including but not limited to measurements, staging, condition of tissue, and drainage....ii) Wound management entries will be completed for non-ulcers (bruises, skin tear, abrasion, rashes). If no signs of complications or worsening in condition of skin alteration and doesn't meet the guideline for IDT Weekly Wound Review the wound management entry can be closed after 72 hours." 4. The clinical record for Resident 45 was reviewed on 2/7/24 at 11:22 a.m. The Resident's diagnosis included, but were not limited to, dermatitis and diabetes. A physician's order, dated 1/6/23, indicated he was to receive Eucerin skin calming cream to his bilateral upper and lower extremities and face daily. A physician's order, dated 8/25/23, indicated he			

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	was to receive Anti-Dandruff shampoo twice weekly on Tuesdays and Fridays with his evening shower. A Quarterly MDS (Minimum Data Set) Assessment, completed 1/16/24, indicated that he was cognitively intact and dependent on staff for bathing. A care plan, last reviewed 1/30/24, indicated Resident 45 was at risk for skin breakdown, skin tears and bruises related to his weakness and decreased mobility secondary to his dx of Diabetes with polyneuropathy (damaged nerves), requires assist with toileting and bed mobility. He occasionally had moist skin and a potential for friction/shearing. The goal was for him to be free from further skin breakdown, skin tears, and bruising. The interventions included, but were not limited to, preventative treatment as ordered, initiated 10/10/2019, assess and document skin condition weekly and as needed. Notify physician of abnormal findings, initiated 10/10/2019, and provide incontinent care as needed using peri wash and moisture barrier, initiated 10/10/2019. On 2/7/24 at 11:22 a.m., Resident 45 was observed laying in bed in his room. He was wearing a hospital gown and had scattered small, scabbed areas on his forehead and around his nose and chin. His hair appeared greasy and unwashed. His skin was flakey and dry. He was scratching his face and arms. Resident 45 indicated his skin was itching and that he needed a shower. On 2/8/24 at 2:47 p.m., Resident 45 was observed laying in his bed with his eyes closed. He was in a hospital gown and his hair appeared unwashed. During an interview on 2/09/24 at 10:40 a.m.,			

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	Resident 45 indicated that the staff did not put lotion on his face or arms. He was observed laying in his bed. His hair looked greasy, and his face had flakey skin. During an interview on 2/09/24 at 10:41 a.m., CNA (Certified Nursing Assistant) 2 indicated Resident 45 received partial baths each morning and he received his showers on the evening shift. He did not normally refuse any care. On 2/9/24 at 11:01 a.m., the treatment cart was observed with RN (Registered Nurse) 3. Resident 45 had an opened 7-ounce bottle of Anti-Dandruff shampoo with a pharmacy fill date of 8/23/23. There was no Eucerin cream labeled with Resident 45's name available in the treatment cart. During an interview on 2/9/24 at 2:09 p.m., Pharmacy Technician 40 indicated that Resident 45's Anti-Dandruff Shampoo had last been filled by the pharmacy on 11/14/23 and that a 7-ounce bottle of shampoo should last approximately 3 to 4 days when administered as ordered twice weekly. The pharmacy had provided a 226-gram bottle of Eucerin on 6/12/23 and a 226-gram supply should have lasted 45 days when applied daily as ordered. During an interview on 2/9/24 at 2:36 p.m., the DNS (Director of Nursing Services) indicated that the Eucerin cream was provided by the pharmacy and that the ordered medications should be available at the facility and applied as ordered. During an interview on 2/09/24 at 2:43 p.m., Resident 45 indicated that his hair had just been washed and he had just had cream put on his face. His itching was a lot better now that the lotion had been applied. 5. The clinical record for			

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	Resident 20 was reviewed on 2/8/24 at 2:28 p.m. Resident 20's diagnoses included, but not limited to, chronic obstructive pulmonary disease (COPD), chronic respiratory failure, congestive heart failure (CHF), chronic kidney disease (CKD), and diabetes type II. A physician's order dated 1/29/24 indicated, Resident 20's diet included a fluid restriction. The total amount of fluid allowed per day was 1000 ml. The total amount of fluids allowed with meals was 500 ml and the total amount allowed between meals was 500 ml. The order included special instructions that read "Special Instructions: Night Shift to calculate the 24 hr total by adding up FLUIDS consumed from the Vitals section plus mL's[sic] given between meals to come up with "24 hour total" 166mL's[sic] allowed for each meal 166mL's[sic] allowed from nursing each shift Every Shift." The resident did not have a care plan in place to address the resident's noncompliance with fluid restriction as ordered. Resident 20's November and December 2023 Medication/Treatment Administration Record (MAR)(TAR) indicated the following total of all 3 shifts of fluid consumption during medication administrations were recorded: 11/2/23 - 240 ml of fluid consumed 11/3/23 - 500 ml of fluid consumed 11/6/23 - 120 ml of fluid consumed 11/8/23 - 500 ml of fluid consumed 11/9/23 - 60 ml of fluid consumed 11/15/23 - 1000 ml of fluid consumed 12/1/23 - 1500 ml of fluid consumed 12/7/23 - 1500 ml of fluid consumed 12/16/23- 1500 ml of fluid consumed			

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	12/21/23 - 166 ml of fluid consumed 12/28/23 - 120 ml of fluid consumed The following were recorded fluid consumption per shift, and the resident's total fluid consumption in the 24 hour day: 11/2/23 - 6:00 a.m. - 2:00 p.m. = 452 ml consumption, 2:00 p.m. - 10:00 p.m. = 286 ml consumption, 10:00 p.m. - 6:00 a.m. = 240 ml consumption, the total amount of fluid consumption that day was documented as 240 ml. 11/3/23 - 6:00 a.m. - 2:00 p.m. = 498 ml consumption, 2:00 p.m. - 10:00 p.m. = 286 ml consumption, 10:00 p.m. - 6:00 a.m. = 166 ml consumption, the total amount of fluid consumption that day was documented as 1000 ml. 11/6/23 - 6:00 a.m. - 2:00 p.m. = 452 ml consumption, 2:00 p.m. - 10:00 p.m. = 286 ml consumption, 10:00 p.m. - 6:00 a.m. = 120 ml consumption, the total amount of fluid consumption that day was documented as 120 ml. 11/8/23 - 6:00 a.m. - 2:00 p.m. = 452 ml consumption, 2:00 p.m. - 10:00 p.m. = 320 ml consumption, 10:00 p.m. - 6:00 a.m. = 166 ml consumption, the total amount of fluid consumption that day was documented as 500 ml. 11/9/23 - 6:00 a.m. - 2:00 p.m. = 452 ml consumption, 2:00 p.m. - 10:00 p.m. = 332 ml consumption, 10:00 p.m. - 6:00 a.m. = 60 ml consumption, the total amount of fluid consumption that day was documented as 60 ml. 11/15/23 - 6:00 a.m. - 2:00 p.m. = 452 ml consumption, 2:00 p.m. - 10:00 p.m. = 332 ml			

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	consumption, 10:00 p.m. - 6:00 a.m. = 166 ml consumption, the total amount of fluid consumption that day was documented as 1500 ml. 12/1/23 - 6:00 a.m. - 2:00 p.m. = 498 ml consumption, 2:00 p.m. - 10:00 p.m. = 332 ml consumption, 10:00 p.m. - 6:00 a.m. = 166 ml consumption, the total amount of fluid consumption that day was documented as 1500 ml. 12/7/23 - 6:00 a.m. - 2:00 p.m. = 452 ml consumption, 2:00 p.m. - 10:00 p.m. = 332 ml consumption, 10:00 p.m. - 6:00 a.m. = 166 ml consumption, the total amount of fluid consumption that day was documented as 1500 ml. 12/16/23 - 6:00 a.m. - 2:00 p.m. = 452 ml consumption, 2:00 p.m. - 10:00 p.m. = 240 ml consumption, 10:00 p.m. - 6:00 a.m. = 166 ml consumption, the total amount of fluid consumption that day was documented as 1500 ml. 12/21/23 - 6:00 a.m. - 2:00 p.m. = 452 ml consumption, 2:00 p.m. - 10:00 p.m. = 286 ml consumption, 10:00 p.m. - 6:00 a.m. = 166 ml consumption, the total amount of fluid consumption that day was documented as 166 ml. 12/28/23 - 6:00 a.m. - 2:00 p.m. = 452 ml consumption, 2:00 p.m. - 10:00 p.m. = 286 ml consumption, 10:00 p.m. - 6:00 a.m. = 120 ml consumption, the total amount of fluid consumption that day was documented as 120 ml. Resident 20's January and February 2024 Medication/Treatment Administration Record			

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	(MAR)(TAR) indicated the following total of all 3 shifts of fluid consumption during medication administrations were recorded: 1/2/24 - 120 ml of fluid consumed 1/12/24 - 166 ml of fluid consumed 1/22/24 - 2834 ml of fluid consumed 2/1/24 - 240 ml of fluid consumed 2/8/24 - 240 ml of fluid consumed The following were recorded fluid consumption per shift, and the resident's total fluid consumption in the 24 hour day: 1/2/24 - 6:00 a.m. - 2:00 p.m. = 498 ml consumption, 2:00 p.m. - 10:00 p.m. = 332 ml consumption, 10:00 p.m. - 6:00 a.m. = 120 ml consumption, the total amount of fluid consumption that day was documented as 120 ml. 1/12/24 - 6:00 a.m. - 2:00 p.m. = 498 ml consumption, 2:00 p.m. - 10:00 p.m. = 332 ml consumption, 10:00 p.m. - 6:00 a.m. = 166 ml consumption, the total amount of fluid consumption that day was documented as 166 ml. 1/22/24 - 6:00 a.m. - 2:00 p.m. = 406 ml consumption, 2:00 p.m. - 10:00 p.m. = 332 ml consumption, 10:00 p.m. - 6:00 a.m. = 166 ml consumption, the total amount of fluid consumption that day was documented as 2834 ml. 2/1/24 - 6:00 a.m. - 2:00 p.m. = 600 ml consumption, 2:00 p.m. - 10:00 p.m. = 360 ml consumption, 10:00 p.m. - 6:00 a.m. = 240 ml consumption, the total amount of fluid consumption that day was documented as 240 ml. 2/8/24 - 6:00 a.m. - 2:00 p.m. = 520 ml consumption,			

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	2:00 p.m. - 10:00 p.m. = 1000 ml consumption, 10:00 p.m. - 6:00 a.m. = 240 ml consumption, the total amount of fluid consumption that day was documented as 240 ml. Resident 20's care plan dated 9/20/19 and last revised/reviewed on 11/16/23 indicated, Resident 20 was at risk for fluid imbalance related to diuretic medication, fluid restriction, and diagnoses of CHF, CKD and diabetes. Interventions included, but not limited to, diet as ordered and to document intake. An interview with Director of Nursing (DON) conducted on 2/9/24 at 3:13 p.m. indicated, tracking the fluid intakes was difficult and the template they use needs to be revamped. 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on observation, interview, and record review, the facility failed to timely follow through with obtaining hearing aides for 1 of 4 residents reviewed for vision or hearing services. (Resident	F 0685	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	03/04/2024

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	66) Findings include: The clinical record for Resident 66 was reviewed on 2/8/24 at 10:30 a.m. His diagnoses included, but were not limited to, dementia. The 10/7/21 communication care plan indicated he had some bilateral hearing loss and wore hearing aids. He received new hearing aids on 3/8/22. The goal was for him to hear and understand communication. An approach was to refer him to the audiologist/speech-language pathologist/speech therapist and follow recommendations, starting 10/7/21. The physician's orders indicated to place his hearing aids in his ears at the beginning of the day and on the charging dock at bedtime, starting 6/27/22. An observation of Resident 66 was made in the dining room on 2/8/24 at 10:43 a.m. He had a hearing aid in his left ear, but not in his right ear. An observation of Resident 66 was made on 2/9/24 at 3:18 p.m. He was sitting at a table in the dining room during an activity. He had a hearing aid in his left ear, but not in his right ear. The 12/7/23 progress note, written by the MCF (Memory Care Facilitator,) read, "Residents hearing aid misplaced and unable to locate. This writer placed call to [name of provider] to order replacement. Resident will also receive a new set of hearing aids in January of 2024. Daughter aware. Will continue to monitor and follow up as needed."		**practice?** Audiology appointment was made, and Hearing Aids have been received for resident 66 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All residents with hearing impairment have been reviewed by DNS/Designee to ensure residents have hearing aids as prescribed. CEN/Designee will Inservice all Nurses on Appointments including the need for follow through with follow up appointments. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** Residents with identified hearing impairments will be monitored to ensure orders for hearing aids are initiated as ordered. This will be reviewed during IDT meetings.	

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	The 12/12/23, 4:05 p.m. progress note, recorded as a late entry on 12/18/23 at 4:05 p.m. by the MCF, read, "Resident received hearing aid replacement on 12/12/23 by [name of hearing aid provider] mobile hearing." An interview was conducted with the MCF on 2/9/24 at 3:19 p.m. She indicated she remembered Resident 66 having a hearing aid for his right ear. She thought it was replaced once, but was now missing again. The left hearing aid was just replaced. A hearing aid provider who came to the facility informed her he would be eligible for a new set of hearing aids at a later date., but at the time, only the left hearing aid could be replaced, for which the facility paid. To her knowledge, the new set was supposed to be brought to the facility for Resident 66, so they'd just been using the left hearing aid until it arrived. On 2/9/24 at 3:33 p.m., a telephone interview was conducted with the Hearing Aid Dealer from the hearing aid provider referenced in the 12/7/23 and 12/12/23 progress notes. She indicated for Resident 66 to receive a new set of hearing aids, she first needed to come to the facility and conduct a hearing test on him. She could come as early as next week. Normally, she spoke with the MCF to set up a time to come to the facility. Currently, there was no appointment scheduled for Resident 66. The Vision and Hearing Services policy was provided by the DNS (Director of Nursing Services) on 2/12/24 at 2:20 p.m. It read, "It is the policy of this facility to ensure that residents are provided with vision and hearing services as needed." 3.1-39(a)(1)		**How will the corrective action (s) 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 DNS/Designee will complete POC CQI audit tool weekly for 4 weeks and monthly for six months. The audit tool will be reviewed monthly by the IDT for six months after which the IDT will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. **By What date will the systematic changes be completed** Compliance date 3/4/2024	

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure fall interventions were appropriately implemented for a resident that has a history of falling for 1 of 1 residents reviewed for accidents. (Resident 58) Findings include: The clinical record for Resident 58 was reviewed on 2/7/24 at 2:27 p.m. The diagnosis for Resident 58 included, but was not limited to, moderate dementia. The Quarterly 1/24/23 Minimum Data Set (MDS) assessment indicated Resident 58 was moderately impaired. A care plan date 7/24/19 indicated "...Resident is at risk for falls related to weakness, decreased mobility and cognitive impairments...She requires assist with transfers, walking/locomotion, toileting and bed mobility. Resident has impaired balance/gait and hx [history] frequent falls, uses w/c [wheelchair] & walker..." The approaches included but was not limited to, "...assist x 1 (staff person) with transfers...assist x 1 with bathing/grooming..."	F 0689	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Foam Cushion in Wheelchair for resident 58 was initiated Staff are using a gait belt when transferring resident 58. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. DNS/Designee will complete a facility-wide audit to ensure all fall interventions are in place per order and resident profile. Corrective Action will be taken as needed. All nursing staff will be in-service by CEN/Designee on Fall Management Policy including	03/04/2024

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	A therapy referral dated 10/13/23 indicated the resident needed services for safe transfers due to falling. An Occupational Therapy discharge summary provided by Therapy Director on 2/13/24 at 9:35 a.m., indicated Resident 58 was provided therapy services starting on 10/16/23 and ending on 11/14/23. The recommendation by therapy at that time of discharge was "continue with current level of activity with supervision recommended for functional transfers due to assistance required with any loss of balance." An event report 11/13/23 indicated Resident 58 had a witnessed fall. "...Res [resident] was transferring to w/c [wheelchair] after taking shower. Sat on edge of w/c lost balance and was assisted to the floor. No injuries...Interventions was put into place to prevent another fall...Encourage resident to make sure back of both legs are in contact with w/c before sitting and continue to use brakes to avoid any chair movement..." A nursing progress note dated 11/13/23 indicated "Resident was finished with shower when she fell while sitting on wc [wheelchair], witnessed fall, no injury; res was not properly seated and was on the edge of the wc when she lowered to the ground by CNA [Certified Nurse Aide] as fall could not be prevented; res asst [assisted] from floor to wc after nurse assessment..." An Interdisciplinary team note dated 11/14/23 indicated the root cause of the fall "res was not properly positioned when attempting to sit down in wc...Intervention put in place to address root cause of fall: change roho cushion to foam		ensuring fall interventions are in place, and gait belts are used with transfers by 3/4/2024. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·All Nursing staff will be in-serviced by CEN/Designee on fall management policy including ensuring all interventions are in place by 3/4/2023 ·Care companions/Designee will round to ensure fall interventions are in place. ·DNS/Designee will complete transfer audits weekly. ·DNS/Designee will round each shift to ensure gait belts are being used for transfers. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** POC/QAPI Tool will be utilized weekly x 4 weeks, then monthly x 6 months, and quarterly thereafter for one year with results reported to the Quality Assurance and Performance Improvement committee overseen by the Executive Director. If a threshold of 95% is not	

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	cushion..." An event dated 1/20/24 indicated the resident had a witnessed fall. "...Res had just went to restroom and I was helping her put on her pull up pants when she lost balance and I tried to guide her into the w/c but she fell on buttocks on floor..." An IDT note dated 1/22/24 indicated "...Res [resident] had a witnessed fall this shift. She had just came from the restroom and i was helping her put her pull up et [and] pants on when she lost her balance. I tried to guide her back into w/c but she fell to the floor...Immediate/short term interventions put in place at time of the fall: request wc drop [tilt wheelchair seat so seat is lower than back] (not warranted at this time)...Determine root cause of fall: res lost balance while nurse assist w [with] toileting; this is res 2nd fall while in bathroom...Intervention put in place to address root cause of fall: labs obtained following r [right] hip x-ray - results negative..." An interview was conducted with Resident 58 on 2/8/24 at 2:27 p.m. She indicated she has had falls. The staff have "dropped me" during a transfer after voicing to the staff person she was going to fall. The staff do not use gait belts to transfer her. About 5 months ago, she had also had a fall in the shower room with a staff person present. An observation was made of Resident 58 with the Regional Infection Preventionist (RIP) on 2/9/24 at 3:32 p.m. The resident's wheelchair was observed. The RIP indicated the resident did not have a foam cushion in her wheelchair as indicated as a fall intervention, but he would get her one. An interview was conducted with License		achieved, an action plan will be developed to ensure compliance. **By What date the systematic changes be completed** Compliance date 3/4/2024	

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	Practical Nurse (LPN) 8 on 2/12/24 at 3:57 p.m. She indicated she was the staff person that was transferring Resident 58 from the toilet to the wheelchair on 1/20/24 when she fell. The resident was in the bathroom sitting on the toilet with her call light on. She assisted the resident to a stand position. LPN 8 was unable to put a new brief on the resident due to the positioning of the wheelchair, so she requested the resident to walk toward the door to get away from the wheelchair. The resident was still in the bathroom, but had walked with non-slid socks on toward the doorway of the bathroom as LPN 8 had requested. During that time, the resident lost her balance and started sliding. LPN 8 then assisted the resident to the floor. She did not use a gait belt prior to asking resident to walk toward the doorway of the bathroom. An interview was conducted with the Physical Therapist Director on 2/13/24 at 9:26 a.m. The resident was picked up on caseload from 10/16/23 through 11/14/23. Resident 58 was not always complaint with asking for assistance by staff to transfer. At times, the resident believes she was able to transfer herself resulting in falling. She can successfully transfer without difficulty at times, but other times she loses her balance. The resident was unable to correct herself when she does lose her balance causing her to fall. She was discharged by therapy with supervision needed by a staff person with sit to stand and transfers and was currently still supervision by 1 staff person. Due to the resident being supervision with transfers; the staff need to utilize a gait belt during transfers with the resident. The fall the resident had in the shower room with a staff person on 11/13/23; the CNA should have positioned the resident further back in the chair and ensured the wheelchair brakes were locked. It			

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	had been decided even though she had the fall on 11/13/23, therapy would not be extended. She would be discharged as planned on 11/14/23; due to the error of the staff person during the transfer. A transfer to wheelchair procedure form was provided by the RIP on 2/13/24 at 10:44 a.m. It indicated "...6. lock wheelchair wheels...11. Place gait belt around resident's waist. 12. Grasp belt securely on both sides...15. Help resident to pivot to front of wheelchair with back of resident's legs against wheelchair. 16. Ask resident to place hands on wheelchair arm rest, if able. 17. Gently lower resident into wheelchair. 18. Reposition resident with hips touching back of wheelchair. Make sure resident is comfortable..." 3.1-45(a)(2)			
F 0776 SS=D Bldg. 00	483.50(b)(1)(i)(ii) Radiology/Other Diagnostic Services §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. Based on interview and record review, the facility	F 0776	**What corrective action(s) will be accomplished for those**	03/04/2024

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	failed to timely schedule a mammogram, as ordered by the physician, for 1 of 4 residents reviewed for skin conditions (Resident 43) Findings include: The clinical record for Resident 43 was reviewed on 2/7/24 at 12:15 p.m. The Resident's diagnosis included, but were not limited to, anxiety and hypertension. An Admission MDS (Minimum Data Set) Assessment, completed 11/29/23, indicated that she was cognitively intact. A progress note, dated 1/3/24 at 12:16 p.m., indicated that the nurse practitioner had given an order for a diagnostic mammogram. The order had been faxed to an outside provider so that an appointment could be scheduled. During an interview on 2/7/24 at 12:15 p.m., Resident 43 indicated that she had felt a lump in her left breast and had been asking to have a mammogram done for about 4 months. She had not had a mammogram yet and the lump was worrying her. During an interview on 2/8/24 at 3:45 p.m., the Regional Infection Preventionist indicated that the mammogram had not been completed as yet, it had just been scheduled for 4/4/24. During an interview on 2/9/24 at 11:00 a.m., Unit Manager 4 indicated that the original order had been for a diagnostic mammogram, however there was not enough information available to schedule a diagnostic mammogram, so a regular mammogram had to be scheduled instead. She did not remember the specific date when she had been		**residents found to have been affected by the deficient practice?** Resident 43 has a scheduled Mammogram per MD order. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. All residents with orders for Mammograms were reviewed by DNS/Designee to ensure appointments were made per MD order. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·An in-service will be completed by DNS/Designee for nurse managers regarding appointments. ·UM/Designee to audit all appointments for the next day. ·Nurse Managers/Designee to audit appointments during clinical meetings to ensure accuracy of	

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	informed of the need to change the type of mammogram. On 2/9/24 at 3:00 p.m., The Regional Infection Preventionist provided the Scheduled Appointment Policy, last reviewed April 2023, which read "...It is the policy of this facility that continuity of care and safety during resident's scheduled appointments outside of the facility will be maintained..." 3.1-49(g)		date and time of appointment. **How will the corrective action (s) 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 DNS/Designee will complete POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 6 months by a nurse manager or designee. The POC CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. **By What date the systematic changes be completed** Compliance date 3/4/2024	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure residents' rooms were in good repair and a call light was functioning as	F 0921	**What corrective action(s) will be accomplished for those residents found to have been**	03/04/2024

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	appropriate for 3 of 4 resident rooms were observed during a environmental tour. (Residents' 45, 57 and 71) Findings include: An observation was made of Resident 45's room on 2/7/24 at 11:22 a.m. The wall behind the bed was observed to be marred and scratched. An observation was made of Resident 71's room on 2/7/24 at 2:11 p.m. The resident's wall behind the bed was marred. An observation was made of Resident 57's room on 2/7/24 at 2:48 p.m. The resident's wall by the bed was marred. The resident indicated the wall had been marred and scratched for a few months. He reported the call light has to be pushed multiple times before it will turn on. He has to watch the light on the call light wall mount turn green indicating the call light was on. It does not turn on with one push. At that time, he pushed the call light button three times before the green light turned on. During an environmental tour with the Maintenance Director (MD) and the Housekeeping Supervisor (HS) on 2/13/24 at 10:28 a.m., Resident 57's room was observed. The wall behind the bed was marred. The MD indicated the resident's bed was hitting the walls. A brown foam piece was observed hanging on the back side of the resident's bed. The MD indicated he was currently placing the foam pieces behind the residents' beds to prevent the beds from hitting the walls. The MD pushed the resident's call light button twice before the green light would like up on the call light wall mount. He indicated he would replace the call light. He was unaware of Resident		**affected by the deficient practice?** Resident 45 room wall was repaired Resident 71 room wall was repaired Resident 57 room wall was repaired, and call light was repaired **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. —— All walls in rooms were observed by maintenance for scratches by maintenance, all identified areas were repaired. —— All call lights were inspected/checked by care companions to ensure they are operating appropriately, and any concerns were repaired. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·An in-service will be completed by Maintenance/Designee to all assigned room care companions regarding policy for work request.	

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	57's wall damage and call light not working appropriately. Then, Resident 71's room was observed. The resident's wall behind the bed was observed to be marred and scratched. After, Resident 45's room was observed. The resident's wall behind the bed was observed to be marred. The MD was unaware of Resident 71 and 45's walls were marred and needed repair. 3.1-19(f)(5)		·Care companions/designee will conduct room inspections daily to ensure call lights are working properly and walls in rooms are in good repair. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** To ensure compliance Maintenance/Care Companions will complete POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The POC CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. **By What date the systematic changes be completed** Compliance by 3/4/2024	
F 9999 Bldg. 00	"3.1-14 Personnel... (k) There shall be an organized ongoing inservice education and training program planned in	F 9999	**What corrective action(s) will be accomplished for those residents found to have been**	03/04/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 00 B. WING	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROSEWALK VILLAGE	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

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	advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents... (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia..." This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure staff members who have regular contact with residents had a minimum of 3 hours annually of dementia-specific training for 2 of 10 employee personal files reviewed. (Certified Nursing Assistant (CNA)55 and CNA 56) Findings include: The staff personal files were provided by the Business Office Manager (BOM) on 2/13/24 at 9:40 a.m. The following Personnel files were reviewed on 2/13/24 and the following was found to be missing and their date of hire: 1. CNA 55's file contained only 1 hour of		**affected by the deficient practice?** C.N.A 55 to complete the 3-hour dementia training. C.N.A 56 to complete the 3-hour dementia training **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. — BOM/designee to conduct an audit on all employee files to ensure compliance with dementia training. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?** ·HR/business office will review all employee records to ensure each employee has 3 hours of dementia care training each year. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	dementia-specific training within the last year. Date of hire: 10/13/18 2. CNA 56's file contained only 2.5 hours of dementia-specific training within the last year. Date of hire: 3/21/19 An interview with Executive Director (ED) conducted on 2/13/24 during the exit conference indicated, the facility was unable to provide evidence for the additional dementia-specific training missing from each of the listed employee files. 3.1-14(k) 3.1-14(u)		**into place?** To ensure compliance the DNS/designee will complete a POC CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 6 months by a nurse manager or designee. The Resident POC CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. **By What date the systematic changes be completed** Compliance by 3/4/2024	