STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155468	A. BUILDING 00 B. WING	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF SULLIVAN	325 W NORTHWOOD DR SULLIVAN, IN 47882

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00431016 and IN00426555. Complaint IN00431016 - No deficiencies related to the allegations are cited. Complaint IN00426555 - No deficiencies related to the allegations are cited. Survey dates: April 15, 16, 17, 18, and 19, 2024 Facility number: 000525 Provider number: 155468 AIM number: 100267010 Census Bed Type: SNF/NF: 33 Total: 33 Census Payor Type: Medicare: 7 Medicaid: 21 Other: 5 Total: 33 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on April 23, 2024.	F 0000	May 6, 2024 Re: Survey Event ID NVM811 To Whom It May Concern: Please accept this plan of correction for Envive of Sullivan, Survey Event NVM811. I would like to formally request paper compliance in place of a revisit. If you have any questions or concerns, please contact me at 812-268-3351. Sincerely, Jodi Sanders, HFA	
F 0732 SS=B Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jodi Deann Sanders	Executive Director	05/09/2024

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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	must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to ensure accurate staffing sheets were posted daily for 3 of 5 days during the recertification survey.	F 0732	The submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts	05/09/2024

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	Finding includes: During an observation, on 4/15/24 at 12:40 p.m., the staffing sheet posted on the wall across from the nurses' station, was dated correctly, but the posting lacked documentation of the total number and the actual hours worked by licensed and unlicensed nursing staff. During an observation, on 4/16/24 at 11:08 a.m., the staffing sheet posted on the wall across form the nurses' station, was dated correctly, but the posting lacked documentation of the total number and the actual hours worked by licensed and unlicensed nursing staff. During an interview, on 4/17/24 at 8:48 a.m., the Director of Nursing (DON) indicated she was not aware the staffing sheet posted was not completed accurately. She indicated the night shift nurse was responsible for making sure the sheet was posted and was completed accurately. The staffing sheet was to be posted at midnight every night shift. The total number of hours and the actual hours worked by staff should be on the sheet. The DON indicated she would have to address the issue at the next in-service meeting. During an observation, on 4/19/24 at 9:00 a.m., the staffing sheet posted on the wall across from the nurses' station, was dated correctly, but the posting lacked documentation of the total number and the actual hours worked by licensed and unlicensed nursing staff. On 4/17/24 at 10:50 a.m., the DON provided a document, with a revised date of August 2022, titled, "Posting Direct Care Daily Staffing Numbers," and indicated it was the policy		alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted due to requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. **F732** **Nursing Staffing Information** 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? DON/designee in-serviced all-night nurses to ensure the BIPI form is filled out completely and accurately. BIPI is up to date as of 4/19/24 2 How other residents having the potential to be affected by the same deficient practice will be identified? All residents have the potential to be affected by this alleged deficient practice. Please see below for systems and monitoring. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?	

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	currently being used by the facility. The policy indicated, " ...1. At the beginning of each shift, the number of licensed nurses ... and the number of unlicensed nursing personnel ... directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format ...g. The actual time worked during that shift for each category and type of nursing staff; and h. Total number of licensed ang non licensed nursing staff working for the posted shift ...."		All night shift nurses were in-served on completing the BIPI form timely and accurately. 4 How will the corrective action be monitored to ensure the deficient practice will not recur? The DON/Designee will be re will be responsible for completing the monitoring tool. The tool includes monitoring that the BIPI form is accurate and complete. The tool will be reviewed 5 times weekly for 4 weeks, then 1 time weekly for 4 weeks, then 1 time monthly for 3 months. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices based on compliance until 100% compliance is achieved. 5 Completion date: May 9, 2024	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;			

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	Based on observation, record review, and interview, the facility failed to ensure proper administration of inhaled medication during the medication administration pass for 1 of 3 residents observed, resulting in a medication error rate of 6.67% (Resident 6). Finding includes: During a medication administration observation, on 4/17/24 at 9:01 a.m., Licensed Practical Nurse (LPN) 7 was administering an Advair (medication used to prevent asthma symptoms) inhaler (small handheld devices that allows you to breath medicine through your mouth, directly to your lungs) to Resident 6. Resident 6 then handed the inhaler back to the nurse and the nurse immediately gave the resident a Spiriva (medication used to prevent bronchospasms) inhaler to use. The resident did not rinse and spit after the use of the first inhaler nor did she wait in between administering the two inhaled medications. Resident 6's record was reviewed on 4/17/24 at 10:00 a.m. The profile indicated the resident's diagnoses included, but were not limited to, emphysema (a condition that causes shortness of breath), unspecified asthma (a chronic disease in which the bronchial airways in the lungs become narrowed and swollen, making it difficult to breathe). A physician order, dated 3/8/24, indicated Advair Diskus inhalation powder breath 100-50mcg (micrograms) one puff inhale orally two times related to emphysema. A physician order, dated 2/28/24, indicated Spiriva Handihaler inhalation capsule 18mcg inhale orally	F 0759	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted due to requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. **F759-Free of Medication Error Rts 5 Prcnt or More** 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #6 care plan was updated to reflect that resident should rinse mouth and spit into a cup after nurse administers the inhaler and wait at least one minute between inhalers. 2 How other residents having the potential to be affected by the same deficient practice will be identified? All residents that are prescribed more than 1 inhaler have the potential to be affected by the alleged deficient practice, however no other residents were.	05/09/2024

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	one time a day for emphysema. A care plan, dated 6/13/23, indicated the resident is at risk for impaired gas exchange related to asthma and emphysema. Interventions included, but were not limited to, administer medication as ordered and monitor for signs and symptoms of respiratory distress and repot to medical doctor. During an interview, on 4/18/24 at 9:04 a.m., LPN 10 indicated the resident should rinse and spit after use of inhaled medications and should wait several minutes in between administrating multiple inhalers to the same resident. During an interview, on 4/18/24 at 9:24 a.m., Registered Nurse (RN) 9 indicated she would wait several minutes in between administering inhaled medications to the same resident. The RN indicated the resident should rinse and spit after use of inhaled medications to prevent thrush (a fungal infection typically on the skin or mucous membranes). During an interview, on 4/18/24 at 11:51 a.m., the Vice President of Clinical Operations, indicated with a steroid inhaler the nurse should have had the resident swish and spit after use per manufacturer guidelines. On 4/18/24 at 11:20 a.m., the Vice President of Clinical Operations provided an undated document, titled, "Oral and Nasal Inhalation Administration," and indicated it was the policy currently being used by the facility. The policy indicated, " ...7. If more than one inhalation is ordered, wait one minute then repeat steps one to six for each inhalation ordered ...." On 4/18/24 at 11:40 a.m., the Vice President of		3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? DNS in-serviced all licensed nursing staff in the proper technique when administering more than one inhaler and following manufacturer's guidelines regarding swish and spit for all corticosteroid inhalers. 4 How will the corrective action be monitored to ensure the deficient practice will not recur? DON/Designee will be responsible for completing the monitoring tool. The tool includes monitoring the nurse during medication passes to ensure that residents that receive more than 1 inhaler are following proper procedure The tool will be reviewed 5 times weekly for 4 weeks, 1 time weekly for 4 weeks, then 1 time monthly for 3 months. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices based on compliance until 100% compliance is achieved.	

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	Clinical Operations provided a document, dated April 2008, titled, "Adviar Diskus" and indicated it was the policy currently being used by the facility. The policy indicated, " ...After each dose, rinse your mouth with water and spit the water out. Do not Swallow ...." 3.1-48(c)(1)		5 Completion date: May 9, 2024	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to ensure expired	F 0761	Submission of this Plan of Correction does not constitute an	05/09/2024

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	medications were disposed of properly for 1 of 1 medication storage room reviewed for medication storage. Finding includes: On 4/18/24 at 10:31 a.m., the medication storage room contained an opened multi-use vial of Aplisol (a clear, colorless solution for injection as an aid in the diagnosis of tuberculosis) solution and had an open date of 2/27/24. On 4/18/24 at 10:33 a.m.., the medication storage room contained an opened multi-use vial of flu vaccine solution and had an open date of 11/2/23. During an interview, on 4/18/24 at 10:35 a.m., Registered Nurse (RN) 9 indicated she was not aware of the facility policy for how long the medication was good for once it was opened but did believe they needed to be discarded. During an interview, on 4/18/24 at 10:51 a.m., the Administrator indicated the medication vials were expired. During an interview, on 4/18/24 at 11:20 a.m., Vice President of Clinical Operations indicated both the medications should have been discarded and were expired. On 4/18/24 at 11:20 a.m., the Vice President of Clinical Operations provided as a current facility policy, titled, "Medication with Shortened Expiration Dates," dated 2/11/21. The policy indicated, " ...Aplisol discard vials 30 days after initial use ...Flu Vaccine discard 28 days after initial use ...." 3.1-25(j)		admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted due to requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. **F761 Label/Store Drugs and Biologicals** 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The expired vaccines that were in the med room refrigerator were immediately removed and disposed of. Vaccinations that are past their open date of 28/30 days will be disposed of immediately. 2 How other residents having the potential to be affected by the same deficient practice will be identified? All residents have the potential to be affected by this alleged deficient practice; however, none	

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			were. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? DON in-served all licensed nursing staff to check med room refrigerator and medication carts daily to ensure that there is no expired medication. If there is an expired medication found, the nurse is to dispose of the medication immediately. This includes any vaccinations that are to be disposed of 28/30 past the open date (even if that doesn't exceed the expiration date). 4 How will the corrective action be monitored to ensure the deficient practice will not recur? The DON will be responsible for completing the monitoring tool. The tool includes monitoring that the med room refrigerator and medication carts are free of expired medications. The tool will be reviewed 5 times weekly for 4 weeks, then 1 time weekly for 4 weeks, then 1 time monthly for 3 months. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as	

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			indicated by increasing or decreasing the monitoring practices based on compliance until 100% compliance is achieved. 5 Completion date: May 9, 2024	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to ensure refrigerator temperature logs were maintained for 5 of 15 days in April and freezer temperature logs were	F 0812	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on	05/09/2024

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	maintained for 2 of 15 days in April. Findings include: During the initial kitchen tour, on 4/15/24 at 10:10 a.m., with the housekeeping supervisor, the temperature logs for the walk-in refrigerator and walk-in freezer were observed to have not been completed. At the same time, the housekeeping supervisor indicated she was filling in as the cook for that day. The regular cook, had the day off. The walk-in refrigerator temperature log, was observed sitting on a shelf in the dry storage area. The log lacked documentation of the refrigerator's temperatures for 4/1/24, 4/11/24, 4/12/24, 4/13/24, and 4/14/24. At the same time, the housekeeping supervisor documented the temperature of the walk-in refrigerator for the date of the initial tour, on the log. The walk-in freezer temperature log, was observed posted on the door of the walk-in freezer. The temperature log lacked documentation of the freezer's temperatures for 4/13/24 and 4/14/24. At the same time, the housekeeping supervisor documented the temperature of the walk-in freezer for the date of the initial tour, on the log. During an interview, on 4/15/24 at 10:15 a.m., the housekeeping supervisor indicated she was not sure why the temperature logs had not been completed, or why the refrigerator log was not hanging on the door as it usually was. During an interview, on 4/15/24 at 10:17 a.m., dietary aide 17 indicated he was not aware that the logs had not being completed or why the refrigerator log was not hanging on the door. His understanding was that the temperatures should		the statement of deficiencies. This Plan of Correction is prepared and submitted due to requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. **F812** **Food Procurement, Store/Prepare/Serve-Sanitary** 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Dietary staff received training on monitoring and documenting the temperatures on the refrigerator and freezer. 2 How other residents having the potential to be affected by the same deficient practice will be identified? All residents have the potential to be affected by this alleged deficient practice. Please see below for systems and monitoring. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Dietary staff received training on	

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	be checked and documented every day. On 4/16/24 at 11:00 a.m., the dietary manager provided a document, dated 1/2023, titled, "Kitchen Operations: Food Storage," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...11. Refrigeration: ...b. Thermometers should be checked utilizing an internal thermometer at least two times each day...12. Frozen Foods: a. Temperatures for the freezer should...be checked at least two times daily...." 3.1-21(i)(3)		monitoring and documenting the temperatures on the refrigerator and freezer. 4 How will the corrective action be monitored to ensure the deficient practice will not recur? The Dietary Manager will be responsible for completing the monitoring tool. The tool includes monitoring the temperatures of the refrigerator and freezer. The tool will be reviewed 5 times weekly for 4 weeks, then 1 time weekly for 4 weeks, then 1 time monthly for 3 months. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices based on compliance until 100% compliance is achieved. 5 Completion Date: May 9, 2024	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is			

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	resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss,			

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	destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to ensure the documentation of wound treatments being completed for 1 of 2 residents reviewed for pressure ulcer (damage to an area of the skin caused by constant pressure on the area for a long time) (Resident 25). Findings include: Resident 25's record was reviewed on 4/17/24 at 11:00 a.m. The profile indicated the resident's diagnoses included, but were not limited to, type 2 diabetes mellitus (a disease that occurs when your blood glucose is too high), heart failure (a condition that develops when your heart doesn't	F 0842	Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted due to requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. **F842 Resident Records**	05/09/2024

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	pump enough blood for your body's needs), and end stage renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). An admission Minimum Data Set (MDS) assessment (part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes), dated 3/21/24, indicated the resident had severe cognitive deficit and was at risk for development of pressure ulcers. A care plan, dated 3/30/24, indicated the resident was at risk for impaired skin integrity related to incontinence of bowel and bladder (the inability to control the flow of urine from the bladder or the escape of stool from the rectum), weakness, impaired mobility, and need for assistance with activities of daily living (ADLs-activities related to personal care). A physician's order, dated 3/13/24, indicated weekly skin assessment, every day shift, every Wednesday morning for monitoring. The March 2024 treatment administration record (TAR) lacked documentation of an assessment having been completed on 3/27/24. A physician's order, dated 3/13/24, indicated float heels while in bed. Every shift for monitoring. The March TAR lacked documentation of the order being completed as written on 3/27/24. The April 2024 TAR lacked documentation of the order being completed as written on 4/4/24. A physician's order, dated 3/13/24, indicated offer/assist to turn/reposition resident. Every 2		1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The DON in-serviced all licensed nursing staff on making sure that all medications and treatments were administered as per physician's order and documented accordingly in PCC. The DON in-serviced all licensed nursing staff that when receiving a physician's order it must be documented in PCC immediately. 2 How other residents having the potential to be affected by the same deficient practice will be identified? All residents have the potential to be affected by this alleged deficient practice however, none were. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The DON will monitor all resident's MARs/TARs to ensure that all medications and treatments are administered per physician order. The DON will monitor all residents that require treatment orders to be placed on the TAR immediately upon receiving them.	

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	hours for skin breakdown prevention. The March TAR lacked documentation of the order being completed as written on 3/27/24, at 8:00 a.m., 10:00 a.m., 12:00 p.m., and 4:00 p.m. The April 2024 TAR lacked documentation of the order being completed as written on 4/4/24, at 8:00 a.m., 10:00 a.m., 12:00 p.m., and 4:00 p.m. A wound and skin progress note, dated 3/26/24 at 9:09 a.m., indicated the resident had a deep tissue injury (DTI-purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear) noted to her left buttocks. Treatment orders were provided, at that time. A physician's order, dated 3/26/24, indicated wound assessment to the left buttocks. Every day and night shift for wound care. The March TAR lacked documentation of the order being completed as written on the day shift of 3/27/24. The April 2024 TAR lacked documentation of the order being completed as written on the day shift of 4/4/24. A physician's order, dated 3/26/24, indicated apply triad paste (treatment that allows natural moisture spreads evenly across the wound surface, maximizing contact and creating a moist environment) to bilateral (both sides) buttocks every day and night shift for wound care. The March TAR lacked documentation of the order being completed as written on the day shift of 3/27/24. A physician's order, dated 3/28/24, indicated may use low air loss mattress (designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown). Check functioning every day and night shift. The April		4 How will the corrective action be monitored to ensure the deficient practice will not recur? The DON will be responsible for completing the monitoring tool. The tool includes monitoring of resident's MARs/TARs are completed accurately and all wound orders are documented the day the order is received. During morning meeting 5 random resident ill be reviewed for MAR/TAR completeness 5 times weekly for 4 weeks, then 1 time weekly for 4 weeks, then 1 time monthly for 3 months. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices based on compliance until 100% compliance is achieved. 5 Completion date: May 9, 2024	

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	2024 TAR lacked documentation of the order being completed as written on the day shift of 4/4/24. A wound and skin progress note, dated 4/2/24 at 8:29 a.m., indicated the area to the resident's left buttocks had been restaged to a stage 3 pressure ulcer (full thickness tissue loss where subcutaneous [beneath, or under, all the layers of the skin] fat may be visible). New treatment order to cleanse with wound cleanser, apply hydrogen (dressings that provide a mechanical barrier and moist wound environment), and cover with border foam. During an interview, on 4/17/24 at 3:15 p.m., the Director of Nursing (DON) indicated the TAR should always be signed off when the treatment was completed. Without a signature, there was no way to ensure the treatment was completed as ordered. On 4/17/24 at 3:07 p.m., the DON provided a document, dated 2020, titled, "Medication Administration and General Guidelines," and indicated it was the policy currently being used by the facility. The policy indicated, "...Procedure: ...11. The resident's...administration record is initialed by the person administering the medication...Or if utilizing and Electronic Medical Record, the initials of the nurse are electronically stamped into the record...." 3.1-50(a)(1)			
F 9999 Bldg. 00	3.1-14 PERSONNEL	F 9999	The submission of this Plan of Correction does not constitute an	05/09/2024

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	(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 record review and interview, the facility failed to ensure annual dementia training had been completed for 3 of 10 employees records reviewed. Findings include: The review of the facility employee records (State Form 5440), on 4/19/24 at 1:05 p.m., indicated the following: a. Certified Nursing Aide (CNA) 13's record indicated the CNA had a hire date of 2/22/22. The record lacked documentation of annual dementia training having been completed within the required timeframe. b. Licensed Practical Nurse (LPN) 14's record indicated the LPN has a hire date of 2/3/15. The record lacked documentation of annual dementia training having been completed within the required timeframe. c. Qualified Medication Aide (QMA) 15's record indicated the QMA had a hire date of 12/20/19. The record lacked documentation of annual		admission or agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted due to requirements under State and Federal law. Please accept this plan of correction as our credible allegation of compliance. **F9999 Personnel Dementia Training** 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? CNA #13, LPN #14, and QMA #15 completed the required 6 hours of Dementia training. 2 How other residents having the potential to be affected by the same deficient practice will be identified? All residents have the potential to be affected by this alleged deficient practice. Please see below for systems and monitoring. 3 What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?	

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	dementia training having been completed within the required timeframe. During an interview, on 4/19/24 at 1:17 p.m., the Business Office Manager (BOM) indicated she had recently audited the employee records and found that the dementia training was lacking. The facility did not have a specific policy on their dementia training, but would follow the state regulation.		All existing staff are up to date with the training. BOM/designee will monitor all new employees to ensure that they have completed the required 6 hours of Dementia training within the first 6 months of employment. 4 How will the corrective action be monitored to ensure the deficient practice will not recur? The BOM/Designee will be responsible for completing the monitoring tool. The tool includes monitoring of new employee files to ensure that the required Dementia training is completed as required. The tool will be reviewed 1 time weekly for 4 weeks, then 1 time monthly for 4 months. Should a concern be found, immediate corrective action will occur. Results of these reviews and any corrective actions will be discussed during the facility's quarterly QA meetings. The plan will be adjusted as indicated by increasing or decreasing the monitoring practices based on compliance until 100% compliance is achieved. 5 Completion date: May 9, 2024	