STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155443	A. BUILDING 00 B. WING	06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF MUNCIE, THE	2400 CHATEAU DR MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00410808. Complaint IN00410808 - Federal/State deficiencies related to the allegations are cited at F561 and F725. Survey dates: June 26, 27, 28, 29, and 30, 2023. Facility number: 000310 Provider number: 155443 AIM number: 100288970 Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type: Medicare: 5 Medicaid: 40 Other: 7 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 10, 2023.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance **is August 09, 2023.** This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of credible Allegation of Compliance and **requests a desk review in lieu of a revisit.**	
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

Brenda Alfrey | Executive Director | 07/27/2023

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 interview and record review, the facility failed to provide bathing assistance according to residents' preferences for 2 of 3 residents reviewed for choices. (Residents B and C) Findings include: 1. During an interview on 6/26/23 at 4:13 p.m., Resident B indicated he preferred to have showers twice a week. The resident had not received a shower in approximately two months. He had not refused any showers. Staff were only washing his genital areas and his legs due to his incontinence. He required two staff members to provide his care due to his inability to assist himself.	F 0561	F561 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the policy of this facility to provide bathing assistance according to the residents preferences. 1. Resident B received a shower at the time of survey. Resident B's preferences have been updated in the care plan, on the shower sheet, and in the	08/09/2023

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	During an interview on 6/27/23 at 10:45 a.m., CNA 7 indicated Resident B had never refused care from her. The resident got upset when there was a lack of staff due to a decrease in the amount of aides because he required assistance of two staff members for his care. When they only had one aide scheduled on each unit, there were times in which a resident's care was postponed to wait for a nurse or a Qualified Medication Aide (QMA) to get time in their schedule to stop to assist the aide. Resident B's clinical record was reviewed on 6/27/23 at 3:57 p.m. Diagnoses included quadriplegia, stage four pressure ulcer of the right buttock, stage four pressure ulcer of the left buttock, and stage four pressure ulcer of the sacral region. The clinical record lacked care plan interventions for specific preferences. A quarterly Minimum Data Set (MDS), dated 4/12/23, indicated the resident was cognitively intact. He was totally dependent on staff for bed mobility, transfers, eating, toileting, personal hygiene, and bathing. The resident was always incontinent of bladder and bowels. Review of an "Activity Resident Interview", dated 4/7/23, indicated it was very important to the resident to choose between a tub bath, shower, bed bath, or sponge bath. The resident was oriented to person, place, and time. The resident interview for preferences was completed, but the resident's preferences were left blank on the form. Review of the resident's shower sheets from 5/1/23 to 6/28/23 and the shower task in the electronic health record indicated he received one		electronic health record (EHR) to ensure they all coincide. 2. Resident C received a shower at the time of survey. Resident B's preferences have been updated in the care plan, on the shower sheet, and in the EHR to ensure they all coincide. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents currently residing in the facility. Resident preferences for bathing have been updated in the care plans, on the shower sheets and in the EHR to ensure they all coincide. Showers Preferences were completed by the Activity Director on 7.25.23. Coordinator updated the Care Plan and EMR from preferences sheets on 07.26.23. Shower Log to utilize for daily showers was updated on 7.28.23 by DON / Executive Director and designee. 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not	

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	shower, on 5/5/23, during the time period. The facility "400 Hall Shower Days" sheet, provided by the Corporate Nurse Consultant, indicated the resident's shower days were Monday and Thursday on day shift. The shower task in the electronic health record indicated the resident's shower days were Monday and Friday evening shift, which conflicted with the 400 Hall Shower Days sheet. The resident's current care plan indicated he required assistance with activities of daily living. Interventions included the following: bathe the resident two times weekly and as needed per the resident's preferences (10/7/21), follow patient preferences as detailed on the CNA pocket worksheet (10/7/21), and refer to the most current "Choices for Resident Care" document for resident preferences (10/7/21). During an interview on 6/28/23 at 11:27 a.m., Licensed Practical Nurse (LPN) 5 indicated Resident B had not refused care from her when she offered to provide care. During an interview on 6/28/23 at 11:37 a.m., Qualified Medication Aide 9 indicated Resident B had been non-cooperative with care in the past, but he had not refused care from her in a very long time. During an interview on 6/28/23 at 2:23 p.m., CNA 7 indicated Resident B had not refused showers from her. The resident preferred to get showers, and had reported concerns to her because he had not been getting showers according to his preference. Resident B was scheduled to get his showers on Monday and Thursday during day		recur? Nursing staff has been re-educated relative to preferences, including but not limited to, provision of bathing assistance according to residents' preferences. Staff in-service completed on 07/27/23, by the Director of Nursing. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or disciplines as indicated. 1.How will the corrective action(s) will be monitored? DON/Designeewill audit shower sheets at daily 5 times a week for 4 weeks, then daily 3 times a week for 4 weeks, then weekly x 4 months DON/Designee will be responsible to provide audit results in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 6 consecutive months the auditing will be stopped. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Completion date: August 09, 2023,	

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	shift. In the last two weeks, staffing was decreased to one CNA per unit. This was not enough staff to complete all of the showers, according to resident preferences, with the acuity of the residents on the 400 Unit. Resident B had not received his showers on Thursday the last two weeks due to a lack of sufficient staff. During an interview on 6/28/23 at 2:38 p.m., CNA 8 indicated Resident B had not refused showers. She was unable to get all of the resident's showered as scheduled because they only had one aide scheduled for each unit. During an interview on 6/30/23 at 11:17 a.m., the Social Services Director indicated she rounded on the resident, as she was assigned to be his guardian angel. Resident B had spoken to her regarding his lack of showers. He wanted his showers according to his preferences. His shower took two hours and required two staff members for assistance. 2. During an interview on 6/27/23 at 9:57 a.m., Resident C indicated she had not received her showers twice a week since she admitted to the facility in May. She had refused her showers twice since her admission. Even though the resident washed herself up in her bathroom each day, she still wanted to get her showers twice a week as planned. Resident C's clinical record was reviewed on 6/28/23 at 4:37 p.m. Diagnoses included cerebral infarction without residual deficits and unsteadiness on feet. The clinical record lacked a care plan for specific bathing preferences.			

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	An admission MDS, dated 5/8/23, indicated the resident was cognitively intact. Rejection of care behaviors were not exhibited during the assessment period. The resident required extensive staff assistance for transfers, dressing, toileting, personal hygiene, and bathing. She was occasionally incontinent of bladder. Review of the resident's "Activity Resident Interview," dated 5/22/23, indicated it was very important to the resident to choose between a tub bath, shower, bed bath, or sponge bath. The resident was oriented to person, place, and time. The resident interview for preferences was completed, but the preferences regarding bathing was left blank on the form. Review of the resident's shower sheets from 5/1/23 to 6/28/23 and the shower task in the electronic health record, indicated the resident refused a shower on 6/10/23 and 6/14/23. She had received four showers during the time period reviewed. Review of the "400 Hall Shower Days" sheet indicated the resident's shower days were Wednesday and Saturday on the evening shift. The shower task in the electronic health record indicated the resident's shower days were Wednesday and Sunday evenings, which conflicted with the "400 Hall Shower Days" sheet. A current care plan, dated 5/25/23, indicated the resident required assistance with activities of daily living. Interventions included the following: bathe the resident two times weekly and as needed per the resident's preference and follow the resident's preferences as detailed on the CNA pocket worksheet.			

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	During an interview on 6/28/23 at 2:23 p.m., CNA 7 indicated she had worked over on evening shift at times. Resident C had not refused any showers when they were offered. More than one resident had complained they were not getting their showers according to their preferences on the evening shift. During an interview on 6/28/23 at 2:38 p.m., CNA 8 indicated Residents C had not refused showers from her. During an interview on 6/28/23 at 3:07 p.m., CNA 7 indicated Resident C was scheduled to get her showers on Wednesdays and Saturdays on the evening shift. She required assistance to get her shower set up for her. During an interview on 6/30/23 at 3:00 p.m., CNA 11 indicated she had updated the "Shower Days" preferences with the residents approximately two months ago. She had only asked which days of the week they preferred their showers. She had not asked the residents' preferences on which type of bathing they preferred since they were familiar with their residents. The CNAs did not have a pocket guide in which they referenced. Instead, they referenced the "400 Hall Shower Days" document kept in the shower binder. Review of the "400 Hall Shower Days" document during the interview, lacked the residents' preferred bathing type. CNA 11 indicated it was current. A current facility policy, undated, titled "RESIDENT PREFERENCES," provided by the Administrator on 6/30/23 at 2:34 p.m., indicated the following: "Policy: It is the policy of the facility to ensure that as part of a [person			

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	centered] approach to care, the resident receives care as to their preference and choice. The objective is to deliver care while honoring the resident's [likes] and not subjecting to them to any [dislikes] developed over a lifetime of experiences in living... It is also upholding their Resident Rights. Procedure: 1. Upon admission as part of the admission process, the resident will be interviewed as to their individual preference regarding their personal care... It will be well documented on a specific form dedicated to state and track their choices. 2. The interview will include but will not necessarily be limited to defining the resident's preference for: ...What type of bathing they prefer (bath/shower/other) How many of these baths/showers/other they prefer each week... What time of the day, (before or after breakfast), afternoon or evening would they prefer to receive their bath/shower/other... What days would you prefer to receive your bath/shower/other)... 3. The preferences of the resident will be reviewed with the quarterly care plan meetings as well as with a readmission or a change of condition as appropriate. The preferences will also be amended or changed upon the resident's request to do so. 4. The resident's preferences will be care planned as appropriate. 5. CNA reference/information sheets will reflect resident preferences as appropriate...." Further information regarding resident preferences was not provided prior to survey exit on 6/30/23. This Federal tag relates to complaint IN00410808. 3.1-3(a)			
F 0568 SS=D Bldg. 00	483.10(f)(10)(iii) Accounting and Records of Personal Funds §483.10(f)(10)(iii) Accounting and Records.			

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	(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. Based on interview and record review, the facility failed to provide quarterly statements to resident representatives for 3 of 4 residents reviewed for resident funds (Residents 33, 23, and 32). Findings include: An untitled resident funds balance sheet, provided by the Business Office Manager on 6/27/23 at 4:00 p.m., indicated the following: a. Resident 33 had a 6/27/23 balance of $1,925.68 (one thousand nine hundred twenty five dollars and sixty eight cents). b. Resident 23 had a 6/27/23 balance of $2,733.48 (two thousand seven hundred thirty three dollars and forty eight cents). c. Resident 32 had a 6/27/23 balance of $2,803.65 (two thousand eight hundred and three dollars and sixty five cents). On 6/29/23 at 5:28 p.m., untitled resident funds documents were provided by the Corporate Nurse Consultant. The documents lacked documentation supporting when quarterly	F 0568	F568 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the policy of this facility to provide quarterly statements to resident representatives for resident funds. Quarterly statements were immediately processed and mailed to resident(s) / representatives for Resident #s 33, 23, and 32, including residents who have trust accounts with facility also had statements mailed.7/7/23 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents have the potential to be affected by the cited practice; therefore, this plan of correction applies to all residents who reside in the facility. There was no	08/09/2023

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	statements were mailed and to whom. During an interview on 6/30/23, at 9:55 a.m., the Business Office Manager indicated she had only been serving in her position for approximately three months. She had received training slowly over this period. She did not have record of the quarterly statements she had mailed since beginning her position. 1. Resident 33's clinical record was reviewed on 6/27/23 at 3:40 p.m. Current diagnosis included vascular dementia, and hypertension. A 4/27/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. During an interview on 6/29/23 at 3:55 p.m., Resident 33's family member, who was responsible for money management, indicated she had not received a quarterly statement regarding the resident's personal funds balance and transactions. Until a very recent phone call, she had no idea the resident had excess funds which needed spent before Medicaid began to enforce resource limits once again. The family purchased a TV and refrigerator for the resident at their own cost. They did not know the resident needed to spend some money to maintain his resources within established limits, and these items could have been purchased to reach this goal. They did not want to spend the resident's money for him, however if they had been informed, they would have assisted the facility to make wise choices when purchasing items. 2. Resident 23's clinical record was reviewed on 6/30/23 at 2:39 p.m. Current diagnosis included schizoaffective disorder and anxiety.		negative outcome to any resident. Statements mailed out 07/07/23. Audit for compliance by Executive Director 7/28/23. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? The Business Office Manager was educated relative to Accounting and Records of Personal Funds, including but not limited to, facility policy and expectations of quarterly statements being sent timely. A copy of statements will be obtained prior to mailing, showing addressee name with address. Copies of statements will be secured in a binder in the Business Office, a Quarterly Calendar will be placed in front of the binder, along with facility resident trust policy. Education provided by the Executive Director on 07.25.23 Executive Director along with BOM and or ABOM will conduct an audit on 07.28.23 for compliance. Additionally, if the employee who fails to comply with the points of the in-service may be further educated and/or disciplines as indicated. 4. How the corrective action(s) will be monitored? The ED/Designee will be responsible for auditing the	

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	A 4/4/23, annual MDS assessment indicated the resident was moderately cognitively impaired. During an interview on 6/29/23 at 3:49 p.m., Resident 23's family member, who managed the resident's finances, indicated he had not been issued a quarterly statement of resident funds for a very long time. He had no idea how much money the resident had in his funds account until 6/28/23 when the facility called to inform the family the resident had excess funds that could eventual impact Medicaid eligibility. The family did not know the resident had available funds and had been spending their own money for the resident's needs. If they had been aware the resident had available funds, the family would have made some larger purchases for the resident. The family had spoken of trying to purchase a mobility scooter for the resident, like the one he had previously had, and was discussing how to obtain enough funds for this type of purchase. "Until yesterday," the family was completely unaware the resident had any excess resources and would have looked further into the mobility device if they had been aware of excess funds. 3. Resident 32's clinical record was reviewed in 6/30/23 at 2:45 p.m. Current diagnoses included dementia, anxiety, and depression. A 6/11/23, quarterly MDS assessment indicated the resident was moderately cognitively impaired. During an interview on 6/29/23 at 4:17 p.m., Resident 32's family member, who managed the residents finances, indicated she was just recently notified of the resident's funds balance. The family had not received a quarterly statement regarding the residents funds balance for over a		provision of statements quarterly, ongoing, to ensure compliance x 6 months. Any identified concerns will be addressed immediately. ED/Designee will be responsible for providing audit results in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 6 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Completion date August 09, 2023	

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	year. The family had helped make major purchases out of pocket. The family had no idea the resident had excess funds. The facility had been purchasing the resident's tobacco and snacks from the resident's account. The family believed the resident had very little money in his account. If the family had been aware of the balance, they would have considered purchasing a water resistant recliner. A current, undated facility policy titled "Resident Trust Fund Policy", which was provided by the Administrator on 6/30/23 at 8:32 a.m., indicated the following: "...Resident trust statements will be presented to the resident/responsible party on a quarterly bases...." 3.1-6(g)			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II			

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WATERS OF MUNCIE, THE	2400 CHATEAU DR MUNCIE, IN 47303

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	resident review upon a significant change in status assessment. Based on record review and interview, the facility failed to complete PASRR (pre-admission screening and resident review) assessments after a new diagnosis for 1 of 3 residents reviewed for PASRR. (Resident 23) Findings include: Resident 23 clinical record was reviewed on 6/27/23 at 11:51 a.m. Diagnoses included major depressive disorder, anxiety, cognitive communication deficit, and schizoaffective disorder. The resident had a current order for Seroquel (antipsychotic) 25 mg daily. The Level 1 clinical assessment, dated 4/26/19, indicated Resident 23 did not have a major mental illness. The record indicated the diagnosis of schizoaffective disorder was added on 7/14/21. A nursing care plan dated 7/14/21, indicated Resident 23 was at risk for behavioral disturbances related to diagnosis of schizoaffective disorder and used an anti-psychotic medication. During an interview on 6/28/23 at 1:54 p.m., the SSD indicated that she was looking for the PASSAR information for Resident 23, and the facility was working a Performance Improvement Project (PIP) for auditing new schizophrenia diagnosis. The PIP had not been updated since April 2023, when the former DON had left employment.	F 0644	F644 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the policy of this facility to complete a PASRR assessment after a new diagnosis. A new Level of Care was completed for Resident #23. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? An audit by Social Services on new level 1 and level 2, 7/11/23 to 7/13/23, was conducted to identify any residents who have received a new psychiatric diagnosis in the past 6 months by Social Services. This plan of correction would apply to identified residents. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? SSD and MDS Coordinator were re-educated on Coordination of PASRR and Assessments, including but not limited to, ensuring residents with new psychiatric diagnoses have a new PASRR/Level of Care completed, and that any recommendations made on Level 2 assessments are followed on 07/25/23completed by	08/09/2023

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	During an interview on 06/30/23 at 11:15 a.m., the SSD indicated when a resident received a new diagnosis of a mental disability, mental health disease, or intellectual disorder the process or policy after this occurs was as follows: The facility psychiatric nurse practitioner would verify the need for the diagnosis and the appropriate medication orders. The social services staff member at the time should have sent the new information into the Division of Aging to ascertain if there was the requirement for a new Level I and/or Level II. She indicated it appeared this was not completed for the resident when he received his diagnosis in 2021. Review of current, 2023 guidance titled "Pre-Admission Screening and Resident Review," retrieved from https://www.in.gov/medicaid/providers/clinical-services/preadmission-screening-and-resident-review-pasrr, indicated the following: "...The Preadmission Screening and Resident Review (PASRR) process is a requirement in all Indiana Health Coverage Programs (IHCP)-certified nursing facilities (NFs). All residents and prospective residents of an IHCP-certified NF are subject to the PASRR process, regardless of known diagnoses or methods of payment (Medicaid or non-Medicaid). Screening occurs prior to admission and when there is a significant change in the physical or mental condition of a resident (resident review or RR)...All applicants to Medicaid-certified NFs in Indiana are entered in the state's web-based PASRR system, and a Level I screen is completed to initiate the PASRR process. When indicated, a Level II evaluation is then performed to identify the specialized needs of individuals with mental illness (MI), intellectual or developmental disability ID/DD, or both		Executive Director. Additionally, if the employees who fails to comply with the points of the in-service may be further educated and/or disciplines as indicated. 4.How the corrective action(s) will be monitored? ED/Designee will audit all residents with new psychiatric diagnoses to ensure a new PASRR is completed. Additionally, ED/Designee will audit all PASRR and Level 2s completed to ensure recommendations are being followed through. These audits will be conducted for 6 months. Daily x 5 times week for 4 weeks, then 3 days a week x 4 weeks, then weekly x 4 months. Any identified concerns will be promptly addressed with the responsible individual(s). ED/ Designee will be responsible for providing audit results in Quality Assurance Meeting monthly x 6 months or until an average of 90% compliance or greater is achieved x 6 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. 5. Completion date August 09, 2023	

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	(MI/ID/DD)...."			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview, and record review, the facility failed to provide sufficient staffing based on resident acuity to meet the needs and preferences for 3 of 3 residents reviewed for sufficient staffing. (Residents B, C, and D) Findings include:	F 0725	F725 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the practice of this facility to provide sufficient staffing in order to attain or maintain our residents	08/02/2023

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	The "Resident Census and Condition of Residents" form (CMS form 672), which was completed by the MDS Coordinator and dated 6/26/23, indicated the facility residents had the following acuity levels and care needs: a. 12 of 52 residents required assistance for bathing. b. 38 of 52 residents were totally dependent on the staff for bathing. c. 48 of 52 residents required assistance for dressing. d. 2 of 52 residents were totally dependent on the staff for dressing. e. 45 of 52 residents required staff assistance for physically transferring. f. 3 of 52 residents were totally dependent on the staff for physically transferring. g. 47 of 52 residents required staff assistance for toileting needs. h. 3 of 52 residents were totally dependent on staff for toileting needs. i. 49 of 52 residents required staff assistance for eating. j. 1 of 52 residents was totally dependent on staff to eat. k. 45 of 52 residents were occasionally incontinent of bladder. l. 21 of 52 residents were occasionally incontinent of bowel. m. 26 of 52 residents had a diagnoses of dementia. n. 24 of 52 residents had behavioral concerns. o. 3 of 52 residents were bedfast. p. 34 of 52 residents were in a chair most of the time. q. 4 of 52 residents had pressure ulcers. r. 50 of 52 residents required preventative skin care.		at their highest practicable physical, mental, and psychosocial well-being as determined by assessments and care planning, including provision of care according to resident preferences and assistance with meals. 1. Resident B received a shower at the time of survey. Resident B's preferences have been updated in the care plan, on the shower sheet, and in the electronic health record (EHR) to ensure they all coincide. 3. Resident D was provided assistance with meal. Although Resident C was listed in the "This REQUIREMENT is not met" statement on page 16 of the 2567, there was not a stated finding for Resident C, facility is unable to identify Resident C. Therefore, no corrective action could be taken for Resident C. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents have the potential to be affected by the cited practice, therefore, this plan of correction applies to all residents of the facility. 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not	

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	s. 51 of 52 residents were on pain management. Review of the worked nursing schedule from 6/18/23 to 6/29/23 indicated the following concerns: a. On 6/20/23, the census was 55. The 200 Unit lacked a CNA from 3:00 a.m. to 7:00 a.m. From 7:00 a.m. to 3:00 p.m., the 300 and 400 units were staffed with one CNA for each unit. b. On 6/21/23, the census was 54. The 300 and 400 Units were staffed with one CNA for each unit from 7:00 a.m. to 3:00 p.m. Three staff were "flexed" off (removed from the schedule based on the resident census) on this day. c. On 6/22/23, the census was 54. The 300 and 400 Units were staffed with one CNA for each unit from 7: 00 a.m. to 3:00 p.m., and 3:00 p.m. to 11:00 p.m. Two day shift CNAs and one evening shift CNA were "flexed" off work. d. On 6/23/23, the census was 54. The 300 and 400 Units were staffed with one CNA for each unit from 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. The 200 unit lacked a CNA from 11:00 p.m. to 7:00 a.m. e. On 6/24/23, the census was 52. The 300 and 400 Units were staffed with one CNA for each unit from 7:00 a.m. to 3:00 p.m. The 300 and 400 Units had one CNA to cover both units on night shift from 11:00 p.m. to 7:00 a.m. f. On 6/25/23, the census was 52. The 300 and 400 Units were staffed with one CNA for each Unit from 7:00 a.m. to 3:00 p.m. and from 3:00 p.m. to 11:00 p.m. The 300 and 400 Units had one CNA to cover both units from 11:00 p.m. to 7:00 a.m.		recur? The ED was re-educated relative to Sufficient Staffing by the RDO, on 07.26.23 including but not limited to provision of sufficient staffing based on resident acuity to meet the needs and preferences of residents. Additionally, if the employee who fails to comply with the points of the in-service may be further educated and/or disciplines as indicated. 1.How the corrective action(s) will be monitored? ED/Designee- audits will be conducted for 6 months. Daily x 5 times week for 4 weeks, then 3 days a week x 4 weeks, then weekly x 4 months. Any identified concerns will be promptly addressed with the responsible individual(s). ED/Designee will be responsible to provide audit results in Quality Assurance Meeting monthly x 6 months, or until an average of 90% compliance or greater is achieved x 6 consecutive months. The QA Committee will identify any trends or patterns and make and make recommendations to revise the plan of correction as indicated . 1.Completion date August 09, 2023	

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	g. On 6/26/23, the census was 52. The 300 and 400 Units were staffed with one CNA for each Unit from 7:00 a.m. to 3:00 p.m. and from 3:00 p.m. to 11:00 p.m. The 200 unit lacked a CNA from 11:00 p.m. to 7:00 a.m. h. On 6/27/23, the census was 52. The 300 and 400 Units were staffed with one CNA for each Unit from 7:00 a.m. to 3:00 p.m. and from 3:00 p.m. to 11:00 p.m. i. On 6/28/23, the census was 51. The 300 and 400 Units were staffed with one CNA for each Unit from 7:00 a.m. to 3:00 p.m. and from 3:00 p.m. to 11:00 p.m. j. On 6/29/23, the census was 52. The 300 and 400 Units were staffed with one CNA for each Unit from 7:00 a.m. to 3:00 p.m. and from 3:00 p.m. to 11:00 p.m. The 200 Unit lacked a CNA from 11:00 p.m. to 7:00 a.m. 1. During an interview on 6/26/23 at 4:13 p.m., Resident B indicated he preferred to have showers twice a week. The resident had not received a shower in approximately two months. He had not been offered showers and refused. Staff were only washing his genital areas and his legs due to his incontinence. He had not been getting bathed according to his preferences. He indicated he required assistance of two staff members to provide his care due to his lack of mobility. The resident had concerns regarding a decrease in the scheduled amount of CNAs who provided the activities of daily living. There had been an increase in the amount of shifts when only one CNA was scheduled on each Unit. On night shift, there were times the facility did not have two staff members available to change him when he had			

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	been incontinent due to low staffing. He waited for what he felt was an excessive amount of time when this occurred. During an interview on 6/27/23 at 10:45 a.m., CNA 7 indicated Resident B had never refused care from her. The resident got upset when there was a lack of staff due to a decrease in the amount of Aides because he required assistance of two staff members for his care. When they only had one Aide scheduled on each unit, there were times in which a resident's care was postponed approximately 15 minutes because they had nine residents between the 300 unit and 400 unit who required assistance of two staff members. It was necessary to wait for a nurse or a Qualified Medication Aide (QMA) to provide safe assistance based on the resident's needs. This took time for them to stop their duties of medication administration, IV management, gastrostomy tube care, and wound dressing changes to assist the aides. This had been a problem since they began removing CNAs from the schedule due to the census. During an interview on 6/28/23 at 2:23 p.m., CNA 7 indicated Resident B had not refused showers from her. The resident preferred to get his showers and had reported concerns to her because he had not been getting his showers according to his preference. Resident B was scheduled to get his showers on Monday and Thursday during day shift. In the last two weeks they decreased Aide staffing to one CNA per Unit. This was not enough staff to complete all of the showers, according to resident preferences, with the acuity of the residents on the 400 Unit. When this was brought to the attention of the DON, she felt like the subject was changed and her staffing concerns were dismissed. Resident B			

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	had not received his showers on Thursday the last two weeks due to a lack of sufficient staff. Staff had not been made aware of any changes made to correct the problem. The schedule continued to reflect one Aide on each unit. During an interview on 6/28/23 at 2:38 p.m., CNA 8 indicated Resident B had not refused showers from her. She was unable to get all of the resident's showered as scheduled because they only had one aide scheduled for each unit. This became a problem since staff were removed from the schedule due to a decrease in census in the last two weeks. Due to the acuity of the residents on the 300 and 400 unit, two CNAs (one on each unit) were unable to provide proper safe assistance to meet the resident's needs and preferences in regard to showers. CNA 8 indicated 9 out of 31 residents who resided on the 300 and 400 Units required two person assistance to total dependence for their activities of daily living. During an interview on 6/30/23 at 11:17 a.m., the Social Services Director indicated she rounded on the resident as she was assigned to be his guardian angel. Resident B had spoken to her regarding his lack of showers. The resident wanted his showers according to his preferences. His shower took two hours and required two staff members for assistance. 3. During a dining observation on 6/29/23 at 12:15 p.m., Resident D was seated in the common area across from the 400 Unit Nurse's Station. CNA 8 delivered a meal tray to the resident in the common area and immediately exited the area. No staff were in the common or any areas in which they could see the resident for safe monitoring during dining. The resident had a divided plate and pureed food. She did not have a clothing			

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	protector over her clothing. Staff were not present as she fed herself. Confidential interviews were conducted during the course of the survey. The confidential interview indicated Resident D should not have been left eating in the common area with out staff monitoring for safety. It was not uncommon for the resident to sit and eat by herself in the common area across from the nurse's station with the overbed table in front of her. The resident ate a pureed diet and may be at risk for choking. Since they only had two CNAs for the 300 and 400 Unit, the two CNAs were unable to be in all of the different locations during meal time for monitoring. Staffing had been this way for the last couple of weeks. Two CNAs could not get everything completed. Resident D's clinical record was reviewed on 6/29/23 at 1:00 p.m. Diagnoses included unspecified dementia with other behavioral disturbance, pharyngeal phase dysphagia, and anorexia nervosa. A quarterly Minimum Data Set, dated 4/22/23, indicated the resident had severe cognitive impairment. Resident D required extensive staff assistance with transfers, toileting, eating, and personal hygiene. A modified diet was required. During an interview on 6/30/23 at 10:13 a.m., the DON indicated Resident D should not have been left to eat in the common area across from the Nurse's station without staff supervision on 6/29/23. During an interview on 6/29/23 at 12:01 p.m., the DON and ADON indicated staff who were			

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	"flexed" off on the schedule had been removed for their entire shift based on the census. During an interview on 6/29/23 at 2:52 p.m., the Administrator indicated the facility determined when to "flex" staff members based on the census and hours allotted per day per resident (PPD) 3.09. Corporate had recently corrected her for using too many staff based on the census. Typical staffing for the 300 and 400 unit, with a census of 60, was two licensed staff and three CNAs for days and evenings and one licensed staff and two CNAs for nights. As census decreased, the census calculation was used to determine staffing as follows: Multiply 3.09 x census, divided by 8 = Number of staff for 24 hours. During an interview on 6/29/23 at 3:48 p.m., the Administrator indicated the facility lacked a policy for sufficient staffing. A current facility policy, undated, titled "Policy and Procedure Meal Service," provided by the Administrator on 6/30/23 at 2:34 p.m., indicated the following: "...Policy Statement: It is the policy of this facility that all residents are provided adequate supervision to meet each resident's nursing and personal care needs including meal service and assistance with eating...." A current facility policy, undated, titled "RESIDENT PREFERENCES," provided by the Administrator on 6/30/23 at 2:34 p.m., indicated the following: "...Policy: It is the policy of the facility to ensure that as part of a [person centered] approach to care, the resident receives care as to their preference and choice. The objective is to deliver care while honoring the resident's [likes] and not subjecting to them to any [dislikes] developed over a lifetime of			

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	experiences in living... It is also upholding their Resident Rights. Procedure: 1. Upon admission as part of the admission process, the resident will be interviewed as to their individual preference regarding their personal care... It will be well documented on a specific form dedicated to state and track their choices. 2. The interview will include but will not necessarily be limited to defining the resident's preference for: ...What type of bathing they prefer (bath/shower/other) How many of these baths/showers/other they prefer each week... What time of the day, (before or after breakfast), afternoon or evening would they prefer to receive their bath/shower/other... What days would you prefer to receive your bath/shower/other)... 3. The preferences of the resident will be reviewed with the quarterly care plan meetings as well as with a readmission or a change of condition as appropriate. The preferences will also be amended or changed upon the resident's request to do so. 4. The resident's preferences will be care planned as appropriate. 5. CNA reference/information sheets will reflect resident preferences as appropriate...." This Federal tag relates to complaint IN00410808. 3.1-17(a) 3.1-3(a)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.			
	Based on observation, interview, and record review, the qualified medication assistant (QMA) failed to obtain authorization from a licensed nurse or physician prior to administering an as needed (PRN) medication for 1 of 4 residents observed during medication administration observation. (Resident 30) Findings include: During medication administration observation on 6/28/23 at 8:45 a.m., QMA 9 was observed administering Resident 30's medication. The resident requested a Tessalon Perl (benzonatate) (to treat a cough) from QMA 9 after taking her	F 0726	F726 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the policy of this facility to have the Qualified Medication Assistant (QMA) to obtain authorization from the licensed nurse or physician prior to administering as needed medication. QMA #9 was re-educated at the time of survey relative to the QMA	08/09/2023

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	155443	A. BUILDING 00 B. WING	06/30/2023

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	regular medication. She indicated she had a cough. QMA 9 indicated she would return with the medication. QMA 9 obtained the resident's requested medication from the cart, returned to the resident's room, and administered the medication. The clinical record for Resident 30 was reviewed on 6/28/23 at 10:40 a.m. Diagnoses included atrial fibrillation, history of pulmonary embolism, and diastolic heart failure. A current physician's order, dated 5/2/23, indicated resident could have benzonatate 100 mg (milligram), one capsule every eight hours as needed for cough. During an interview, on 6/28/23 at 9:04 a.m., QMA 9 indicated she would request a licensed nurse's permission prior to administering a narcotic medication for pain, but did not need to for a resident complaining of a cough. She would inform the licensed nurse regarding the cough after she finished her medication pass. During an interview, on 6/28/23 at 11:04 a.m., the Administrator indicated QMA 9 should have obtained authorization from a licensed nurse prior to administering any PRN medication. A current, undated facility document titled "Qualified Medication Aide Job Description," provided by the Administrator on 6/28/23 at 11:05 a.m., indicated the following: "...Position Summary: The Qualified Medication Aide (QMA) will administer medications with safety techniques and sound judgment under the supervision of a licensed nurse.....Essential Job Functions:....8. Reports to the nurse on duty for instructions before administering any PRN medication...."		Scope of Practice, the need to report to the licensed nurse on duty, and to obtain authorization to administer any PRN medications, prior to administering them to residents. Resident 30 was assessed and not negative outcome. 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All residents receiving PRN medications have the potential to be affected by the cited practice, therefore, this plan of correction applies to all those residents. 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses and QMAs have been re-educated relative to Competent Nursing Staff, including but not limited to the Scope of Practice for QMAs, including the need for QMAs to obtain authorization from a licensed nurse prior to administering any PRN medication to a resident. Reeducation completed by the Director of Nursing on 07.27.23. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or disciplines as	

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	3.1-14(i)		indicated. 1.How will the corrective action(s) be monitored? DON/Designee will randomly audit the EHRs of at least 5 residents who have had PRN medications administered weekly times 4 weeks to ensure continued compliance with receiving authorization from the licensed nurse, and documentation of the same. Any identified concerns will be promptly addressed with the responsible individual(s). Thereafter, DON/Designee will randomly audit the EHRs of at least 3 residents who have had PRN medications administered-these audits will be conducted for 6 months. Daily x 5 times week for 4 weeks, then 3 days a week x 4 weeks, then weekly x 4 months. Any identified concerns will be promptly addressed with the responsible individual(s). . Any identified concerns will be promptly addressed with the responsible individual(s). ED/ DON/Designee will be responsible to provide audit results in Quality Assurance Meeting monthly x 6 months, and make recommendations to revise the plan of correction as indicated 5. Completion date August 09, 2023	

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F 0744 SS=E Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, interview, and record review, the facility failed to ensure residents who resided on the secured dementia unit had physician orders to reside on a secured unit, had assessments to reside on a secured dementia unit, and had care plans regarding the need to reside on a dementia unit for 4 of 4 residents reviewed for dementia services (Residents 24, 25, 33 and 39). Findings include: 1. During an observation on 6/26/23 at 10:23 a.m., Resident 24 was in his room on the secured dementia unit. He was in bed watching TV. He was calm. During an observation on 6/26/23 at 1:50 p.m., the resident was napping in his bed. During an observation on 6/29/23 at 9:44 a.m., the resident was napping in bed with his TV playing. Resident 24's clinical record was reviewed on 6/27/23 at 3:46 a.m. Current diagnoses included dementia with behavioral disturbances and bradycaria. The resident was moved to reside on the secured dementia unit on 11/3/21. A 4/2/23, quarterly Minimum Data Set (MDS)	F 0744	F744 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the policy of this company to ensure residents that reside on the dementia unit have a physician order and complete an assessment and care plan to reside on the secured unit. Orders were received for Resident #s 24, 25, 33, and 39 to reside on the secured unit. b. Assessments for the need for a secured unit have been completed for Resident #s 24, 25, 33, and 39. c. The care plans of Resident #s 24, 25, 33, and 39 have been reviewed and updated to reflect the need for a secured unit. Audit for the above residents were completed by DON / Designee 1.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? All other residents currently residing in the secured dementia unit have the potential to be affected by the cited practice,	08/09/2023

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	assessment indicated he was severely cognitively impaired and displayed zero maladaptive behaviors during the assessment period. The clinical record lacked the following: a. An order to reside on a secured dementia unit, b. An assessment for the need for a secured dementia unit upon admission or at any time thereafter, c. A care plan regarding the resident's need for a secured dementia unit. 2. On 6/26/23 at 1:51 p.m., Resident 25 was in bed in his darkened room resting. His room was located on the secured dementia unit. He was calm. On 6/27/23 at 9:58 a.m., the resident was calmly participating in an activity on the secured dementia unit. Resident 25's clinical record was reviewed on 6/27/23 at 3:44 p.m. Current diagnoses included dementia with behavioral disturbances, schizoaffective disorder, and anxiety. The resident was admitted to the secured dementia unit on 10/29/18. A quarterly, 4/7/23, MDS, assessment indicated the resident was rarely or never understood, had long and short term memory loss, had displayed zero maladaptive behaviors during the assessment period, and received an antianxiety medication 7 of 7 days of the assessment period. The clinical record lacked the following: a. An order to reside on a secured dementia unit, b. An assessment for the need for a secured		therefore, this plan of correction applies to those residents. Orders have been obtained for residents to reside on the secured unit, assessments for the need for a secured unit have been completed, and care plans have been reviewed and updated, as necessary. Audit to be completed by DON and Designee by 8/4/23 in entirety. 1.What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Nursing staff and Social Service staff have been re-educated relative to Treatment/Service for Dementia, including but not limited to ensuring physician orders are obtained to reside on a secured unit, assessments are completed, and care plans are updated to reflect the need for a secured dementia unit. Education was provided by the Director of Nursing / Executive Director. 07/25/23 & 07/27/23. Additionally, any employee who fails to comply with the points of the in-service may be further educated and /or disciplines as indicated. 1.How the corrective action(s) will be monitored? DON/Designee will be responsible for providing audit results in Quality Assurance Meeting	

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	dementia unit upon admission or at any time thereafter. 3. During an observation on 6/26/23 at 10:26 a.m., Resident 33 was ambulating in his room. His room was located on the secured dementia unit. He was calm. During an observation on 6/29/23 at 9:43 a.m., the resident was seated in the dining/activity room located on the secured dementia unit. Resident 33's clinical record was reviewed on 6/27/23 at 3:40 p.m. Current diagnosis included vascular dementia, and hypertension. The resident was moved to reside on the secured dementia unit on 11/4/20. A 4/27/23, Quarterly Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired and displayed zero maladaptive behaviors during the assessment period. The clinical record lacked the following: a. An order to reside on a secured dementia unit, b. An assessment for the need for a secured dementia unit upon admission or at any time thereafter. 4. During an observation on 6/26/23 at 2:21 p.m., Resident 39 was in her room on the secured dementia unit. She was calm and conversational. During an observation on 6/29/23 at 9:49 a.m., the resident was ambulating calmly in the secured dementia unit dining and activity area. Resident 39's clinical record was reviewed on		monthly x 6 months. These audits will be conducted for 6 months. Daily x 5 times a week for 4 weeks, then 3 days a week x 4 weeks, then weekly x 4 months. Any identified concerns will be promptly addressed with the responsible individual(s). The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. ED/ Designee will be responsible for providing audit results in Quality Assurance Meeting monthly x 6 and make recommendations to revise the plan of correction as indicated, 5. Completion date August 09, 2023	

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	6/27/23 at 3:36 p.m. Current diagnoses included dementia with behavioral disturbances, depression, and schizoaffective disorder. The resident was admitted to the secured dementia unit on 9/25/21. A 6/5/23, quarterly, MDS, indicated the resident was moderately cognitively impaired was verbal aggressive 1 to 3 days of the assessment period and rejected care 1 to 3 days of the assessment period. The clinical record lacked the following: a. An order to reside on a secured dementia unit, b. An assessment for the need for a secured dementia unit upon admission or at any time thereafter, c. A care plan regarding the resident's need for a secured dementia unit. During an interview on 6/29/23 at 11:01 a.m., both the Administrator and Social Services Director indicated they had worked in the facility for approximately one year. Neither one had been aware of preadmission and continued placement assessment for the Hope Springs Unit prior to 6/28/23. Formal documented assessments for admission and continuing stay had not been completed for residents who resided on the secured dementia unit. In addition, Residents 24, 25, 33 and 39 did not have orders to reside on the secured dementia unit until 6/28/23. Residents 24 and 39 did not have care plans to reside on the secured unit prior to 6/28/23. A current, undated, facility policy titled "Admission/Discharge Criteria for Hope Springs (secured dementia care unit), provided by the Administrator on 6/28/23 at 12:10 p.m., indicated			

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	the following: "...A pre-admission assessment, which addresses medical; status, stage of illness, psychosocial circumstance and family understanding of the disease, is completed before admission. The decision to admit to the Hope Springs Unit is made jointly between the physician, Social Services Department, Admission Coordinator, Nurse Administration, family/legal representative, and Administration...Social Services and the nursing staff will continue to observe all residents for appropriate placement on the Hope Springs Unit. This will foster further assessment opportunity to ensure placement is appropriate and continue to protect the controlled environment of the unit..." 3.1-37(a)			
F 0755 SS=F Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-			

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	§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to ensure narcotics were reconciled per facility policy for 2 of 3 nursing unit's medication carts reviewed for medication storage. (300 Hall cart and 400 Hall cart) Findings include: 1. During a medication storage observation on 6/28/23 at 11:57 a.m. with LPN 5, the narcotic book on the 300 Hall medication cart lacked any shift-to-shift sign-in/out sheets or narcotic count reconciliation documentation. LPN 5 indicated there were no sheets to document the narcotic counts that she was aware of, and the nurses counted the narcotics in the drawer during shift change, but did not document this anywhere. 2. During an observation of the narcotic book on the 400 Hall medication cart with the ADON on 6/28/23 at 12:07 p.m., the book lacked any shift-to-shift sign-in/out sheets or narcotic count reconciliation documentation. The ADON indicated each nurse was to report off to the on-coming nurse. The narcotic medication in the drawers were counted. There was no sign-in/out	F 0755	F755 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the policy of this facility to ensure narcotics are reconciled each shift daily. Narcotic reconciliation count was completed at the time of survey for all medication carts in the facility. Immediate education was conducted with licensed nurses and QMAs on duty at the time of survey relative to completion of narcotic count and documentation of the same on the Narcotic Shift Count form. Education was provided by the Director of Nursing on 7/25/23 & 07/27/23 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken?	08/09/2023

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	sheets or documentation of narcotic counts or indication of who had the medication cart keys. During an interview, on 6/28/23 at 2:04 p.m., the Administrator indicated the 300 and 400 Hall medication carts had no sheets documenting on-coming and off-going staff or documentation of narcotic count reconciliation for June 2023. This should be completed any time the medication cart keys were transferred to another staff member. A current facility policy, dated 5/2019 and titled "Controlled Substances," was provided by the Regional Nurse Consultant on 6/28/23 at 1:51 p.m., and indicated the following: "...Procedure:...4. While a controlled substance is in use the nursing staff will maintain the following medication records:...b. All schedule II controlled substances (and other schedules if facility policy so dictates) will be counted each shift or whenever there is an exchange of keys between off-going and on-going licensed nurses...2. Both nurses will count the number of packages of controlled substances that are being reconciled during the shift/shift count and document on the Shift Controlled Substance Count Sheet....4. Both nurses will sign the Shift/Shift Controlled Substance Count Sheet acknowledging that the actual count of controlled substances and count sheet matches the quantity documented...." 3.1-25(n)		All residents who have orders for narcotics have the potential to be affected; therefore, this plan of correction applies to those residents. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? Licensed nurses and QMAs were re-educated relative to pharmacy services, procedures, pharmacist, and records, including but not limited to, shift-to-shift narcotic count and narcotic count reconciliation documentation by the Director of Nursing 7/27/23. . Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or disciplines as indicated. 4. How the corrective action(s) will be monitored? DON/Designee will review narcotic count sheets to ensure completion These audits will be conducted for 6 months. Daily x 5 times week for 4 weeks, then 3 days a week x 4 weeks, then weekly x 4 months. Any identified concerns will be promptly addressed with the responsible individual(s). Any identified concerns will promptly be addressed with the responsible individual(s).	

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			The results of these audits will be reviewed in Quality Assurance Meeting monthly x6 months, and make recommendations to revise the plan of correction as indicated 5. Completion date: August 09, 2023	
F 0806 SS=E Bldg. 00	483.60(d)(4)(5) Resident Allergies, Preferences, Substitutes §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; Based on observation and interview, the facility failed to honor dietary preferences for 4 of 4 residents reviewed for food preferences. Finding includes: During an interview on 6/26/23 at 12:13 p.m., Resident 20 indicated he disliked chicken salad. He had spoken to the Dietary Manager regarding his dislikes and discussed dislikes in resident council. Regardless of the list of dislikes, the items continued to be sent on his meal tray on a regular basis. During the interview, the resident's meal tray was delivered to his room. His lunch was a chicken salad sandwich, a cup of peas, cookie, and lemonade. The meal ticket on his tray listed peas and chicken as dislikes. The resident	F 0806	F806 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the policy of the facility to honor dietary preferences. Resident #20's dietary preferences were updated at the time of survey by the Dietary Manager. . Resident #10 no longer resides in the facility; therefore, no further corrective action could be taken for this resident. 2. How other residents having the potential to be affected	08/09/2023

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	indicated the cookie and the lemonade were the only items on his tray that he would consume. During a meeting with the Resident Council group, on 6/29/23 at 11:00 a.m., the following concerns were indicated during confidential interviews: A resident indicated pears were listed on the meal ticket dislikes and the resident continued to receive them on the meal trays. A resident indicated green beans were listed on the resident's meal ticket dislikes and the resident continued to receive them on the meal trays. During a random interview on 6/29/23 at 12:28 p.m., Resident 10 indicated the residents did not have the opportunity to select their meal. Instead, staff delivered meals prepared without regard to preferences. During an interview on 6/30/23 at 10:36 a.m., the Dietary Manager indicated he spoke with the residents regarding their dietary dislikes and food allergies. These items were entered into the system so they printed on the dietary tickets for the cook to reference. The cook was required to ensure a substitute of equal nutritive value was provided to the residents in place of their dislikes. Each day, dietary substitutes were prepared and readily available to replace. He was aware a resident reported they had received turkey on their tray when it was on their dislike list. He did not know why Resident 20 received two dietary dislikes on his lunch tray on 6/26/23. During an interview on 6/30/23 at 10:53 a.m., Resident 20 indicated he had reported concerns about receiving his list of dietary dislikes on his		by the same deficient practice will be identified and what corrective action(s) be taken? All residents who have diets have the potential to be affected; therefore, this plan of correction applies to all those residents. The Dietary Manager has interviewed all identified residents to update their food preferences and corrected preferences on tray cards 07.28.23 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All staff have been re-educated relative to Resident Allergies, Preferences, Substitutes, including but not limited to ensuring that resident's tray cards are reviewed prior to serving trays to ensure they are not served anything listed on their dislikes list. Education provided by the Director of Nursing 7.27.23. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or disciplines as indicated. . 4. How the corrective action(s) will be monitored? Dietary Manager/Designee will be responsible to audit tray cards- these audits will be conducted for	

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	meal tray to many of the staff members who delivered and picked up the meal trays. His efforts to bring this to the attention of staff seemed futile, as he continued to receive those items. During an interview on 6/30/23 at 10:59 a.m., LPN 6 indicated she had been made aware the dietary department was sending dietary dislikes out to the residents on their meal trays. She removed the tickets from the lunch trays and gave them to any dietary staff member in the kitchen to let them know who received the dislikes. There were no specific roles that LPN 6 reported these concerns to for correction and follow through. A current, undated, facility policy, titled "Offering Choices," provided by the Administrator on 6/30/23 at 11:19 a.m., indicated the following: "...In keeping with the new Dining Practice Standards and embracing the rights of residents including self-determination, it is suggested that planned meals be offered versus served... The practice of offering versus automatically serving also prevents unplanned and undesired food waste...." 3.1-21(a)(4)		6 months, and make recommendations to revise the plan of correction as indicated Daily x 5 times a week for 4 weeks, then 3 days a week x 4 weeks, then weekly x 4 months. Any identified concerns will be promptly addressed with the responsible individual(s) thereafter. 5.. Completion date: August 09, 2023	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection			

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	prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the			

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	disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to promptly implement enhanced barrier precautions (EBP) for residents at high risk for acquiring or spreading multi-drug resistant organisms (MDRO's) for 5 of 5 residents reviewed for infection control. (Residents B, 46, 20, 4, and 16) This deficient practice had the potential to effect 52 of 52 residents who resided in the facility. Findings include: During a facility tour observation on 6/26/23 at 11:47 a.m., the resident rooms on the 300 and 400 units lacked isolation signs in place or personal protective equipment (PPE) canisters. 1. During an observation on 6/26/23 at 10:23 a.m., Resident B's room lacked a sign for transmission based precautions. A PPE canister was not readily available with PPE. Two staff members answered	F 0880	F880 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? It is the policy of this facility to promptly implement enhanced barrier precautions for residents at high risk of acquiring or spreading mulit-drug resistant organisms (MDRO's) Residents B, #46, 20, 4 & 16 were placed in Enhanced Barrier Precautions (EBP) at the time of survey with stocked PPE canisters placed and signage posted. Additionally, physician orders were obtained for EBP and care plans were updated to reflect the need for EBP.	08/09/2023

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	the resident's call light. No personal protective equipment was donned prior to entering the resident's room for care. During an interview on 6/26/23 at 4:13 p.m., Resident B indicated he was receiving intravenous antibiotics for a wound infection on his buttocks. The antibiotic infused during the observation. During an interview on 6/27/23 at 10:10 a.m., with the Corporate Nurse Consultant, the resident's room contained an enhanced barrier precautions sign and a PPE canister to left of the resident's door. The Corporate Nurse Consultant indicated the resident was in enhanced barrier precautions due to wounds. She was unaware why the enhanced barrier precaution sign and PPE canister were not in place on 6/26/23. Resident B's clinical record was reviewed on 6/27/23 at 3:57 p.m. Diagnoses included quadriplegia, stage four pressure ulcer of the right buttock, stage four pressure ulcer of the left buttock, and stage four pressure ulcer of the sacral region. The clinical record lacked an order or care plan for transmission based precautions prior to 6/27/23. A quarterly Minimum Data Set (MDS), dated 4/12/23, indicated the resident was cognitively intact. He was totally dependent on staff for bed mobility, transfers, eating, toileting, personal hygiene, and bathing. Three stage four pressure ulcers were present on admission. A current care plan, dated 5/15/23, indicated the resident was receiving antibiotic and at risk for adverse reactions related to a wound infection. Interventions included, follow universal/standard		2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) be taken? Residents who meet the criteria for placement in EBP have the potential to be affected by the cited practice. These residents have been identified with stocked PPE canisters placed and signage posted. Physician orders were obtained for EBP, and care plans were updated to reflect the need for EBP. An audit was completed by the DON / Designee on 07/28/23 for other residents that may be risk for MDRO's. Residents found to be at risk were placed in EBP. 3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur? All staff have been re-educated relative to Infection Prevention & Control, including but not limited to, criteria for placing a resident in EBP, and ensuring all necessary components are in place (e.g., stocked PPE canisters, physician orders, and care plans). Education provided by Director of Nursing 07.27.23. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or disciplines as indicated.	

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	precautions to prevent cross contamination and spread of infection. A current care plan, initiated on 6/27/23, indicated the resident was in enhanced barrier precaution isolation for high contact resident care. A gown and gloves were required for the following activity each shift: bathing/showering, changing linens, providing hygiene, toileting/changing briefs, device care or use (central line), or wound care. 2. During an observation on 6/26/23 at 4:39 p.m., Resident 46 mumbled incomprehensible words, uncovered his gastrostomy tube, and pointed to his feeding tube. His door lacked any isolation sign. PPE was not readily available outside or inside the resident's room. During an observation on 6/27/23 at 10:10 a.m., Resident 46's room had an enhanced barrier precaution sign on the door and PPE readily available (which were not present during the prior observation). During an interview on 6/27/23 at 10:10 a.m., the Corporate Nurse Consultant indicated Resident 46 was in enhanced barrier precautions due to his gastrostomy tube. She was unaware why the enhanced barrier precaution sign and PPE canister were not in place on 6/26/23. Resident 46's clinical record was reviewed on 6/29/23 at 5:47 p.m. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side and oropharyngeal phase dysphagia. The clinical record lacked a transmission based precaution order or care plan for transmission based precautions prior to 6/26/23.		. 4. How the corrective action(s) will be monitored? The IP nurse/DON/designee will complete random visual rounds daily, on scheduled days of work, for 6 weeks, and until continued compliance is maintained, to ensure staff are practicing appropriate Infection Control Practices, including but not limited to, identified residents are placed in EBP with all of the necessary components in place. Any identified concerns will be promptly addressed with the responsible individual(s). The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months, and make recommendations to revise the plan of correction as indicate. Daily x 5 times week for 4 weeks, then 3 days a week x 4 weeks, then weekly x 4 months. Any identified concerns will be promptly addressed with the responsible individual(s). 5. Completion date: August 09, 2023	

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	A current order for a gastrostomy tube (G- tube) was dated 5/24/23. All medications were given via G-tube each shift. An admission Minimum Data Set (MDS), dated 5/13/23 , indicated the resident was rarely or never understood. The resident required limited assistance of 2 staff for bed mobility, transfers, and dressing. He required extensive assistance to total dependence on staff for eating, dressing, toileting, and bathing. A feeding tube was required for nutrition. A current care plan, initiated on 6/27/23, indicated the resident was in enhanced barrier precaution isolation for high contact resident care related to a feeding tube. A gown and gloves were required for the following activity each shift: bathing/showering, changing linens, providing hygiene, toileting/changing briefs, device care or use (feeding tube), or wound care. 3. During an observation on 6/26/23 at 11:00 a.m., Resident 20 exited his room with a dressing on his right lower extremity. His door lacked any transmission based precaution signs and a PPE canister for readily available PPE. During an interview on 6/26/23 at 11:50 a.m., the resident indicated he had been treated for cellulitis and his right lower extremity (leg) weeped. The staff changed the dressing to his right lower extremity each day. Resident 20's clinical record was reviewed on 6/29/23 at 5:52 p.m. Diagnoses included acute on chronic diastolic congestive heart failure and non-pressure chronic ulcer of the right lower leg. The clinical record lacked a transmission based precaution order or care plan for transmission			

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	based precautions prior to 6/27/23. An admission Minimum Data Set (MDS), dated 5/8/23 , indicated the resident was cognitively intact. The resident required extensive assistance for bed mobility, transfers, dressing, toileting, and personal hygiene. A current care plan, initiated on 6/27/23, indicated the resident was in enhanced barrier precaution isolation for high contact resident care. A gown and gloves were required for the following activity each shift: bathing/showering, changing linens, providing hygiene, toileting/changing briefs, device care, or wound care. 4. During an observation on 6/26/23 at 11:13 a.m., Resident 4's room lacked transmission based precaution signs and a PPE canister with readily available PPE. During an interview on 6/26/23 at 2:48 p.m., the resident indicated staff administered all of his medications through his feeding tube each day. This was not a new process. Resident 4's clinical record was reviewed on 6/29/23 at 10:36 a.m. Diagnoses included alcohol dependence with alcohol- induced persisting dementia and pharyngoesphageal phase dysphagia. The clinical record lacked a transmission based precautions order and a care plan for transmission based precautions prior to 6/27/23. A current order for enhanced barrier precautions, initiated 6/27/23, indicated a gown and gloves were required every shift for the following high contact care: bathing/showering and device care related to the feeding tube.			

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A quarterly Minimum Data Set, dated 4/8/23, indicated the resident had moderate cognitive impairment. Swallowing difficulties included complaints of difficulty or pain with swallowing. He required physical assistance of 1 staff member for dressing, personal hygiene, and bathing.

During an interview on 6/29/23 at 3:36 p.m., CNA 7 indicated the following residents were not in transmission based precautions until 6/27/23: Residents B, 46, 20, and 4. She was familiar with the 400 Unit and she had not worn a gown and gloves for high contact activities when she provided care to the above mentioned residents through 6/26/23. CNA 7 was unaware the enhanced barrier precautions also included residents with feeding tubes. Showers had been provided without wearing gowns.

During an interview on 6/29/23 at 3:47 p.m., Qualified Medication Aide (QMA) 9 indicated enhanced barrier precautions had not been implemented for any residents on the 400 unit until 6/27/23. She had provided high contact care for the following resident without using a gown and gloves prior to 6/27/23: Residents B, 46, 20, and 4. QMA 9 indicated she had not received enhanced barrier precaution education until 6/27/23.

During an interview on 6/29/23 at 4:06 p.m., the DON indicated she had received the enhanced barrier precaution information from the Corporate Nurse Consultant on an unknown date. She failed to implement the enhanced barrier precautions prior to 6/27/23. The lack of implementation was a risk for potential infection for residents who resided in the facility.

5. On 6/26/23 at 10:24 a.m., Resident 16 was

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	observed lying in bed. There were no signs on the door. During an observation on 6/27/23 at 10:15 a.m., Driver 12 placed Enhanced Barrier precaution signage and storage containers with personal protection equipment (PPE) to multiple rooms on the 300 and 400 halls. The clinical record for Resident 16 was reviewed on 6/28/23 at 2:26 p.m. The resident's diagnosis included a stage 4 pressure wound (wound penetrates all three layers of skin, exposing muscles, tendons and bones in your musculoskeletal system) to her right thigh, present on admission. The clinical record lacked an order or care plan for transmission based precautions prior to 6/27/23. The resident had a quarterly Minimum Data Set (MDS) dated 3/27/23, which indicated a pressure wound on admission. A nursing care plan initiated 3/20/23, and updated 5/2/23, indicated a pressure ulcer to right thigh, now classified as stage 4. During an interview on 6/27/23 at 10:06 a.m., Resident 16 indicated she did not know why there was a new sign for precautions on her door. During an interview on 6/28/23 at 9:32 a.m., Resident 16 indicated that she spoke with staff about the new precaution sign and was informed it was for when staff worked with her wound dressing changes. She had this wound to her thigh for some time now. During a follow-up interview on 6/29/23 at 3:15			

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	p.m., Resident 16 indicated that her wound dressing was changed but the floor nurse did not wear the gown as described on the sign. She remembered having precautions the first few weeks she was in the facility, and then they stopped. A current, 12/19/22, facility policy titled "Landmark/The Waters- Clinical Standard and Guidelines, Enhanced Barrier Precautions" provided by the Corporate Nurse Consultant on 6/29/23 at 4:45 p.m. indicated the following: "...Policy: It is the policy of the facility to ensure that additional and appropriate PPE (Personal Protective Equipment) is utilized, when indicated to prevent the spread of Multidrug-resistant Organisms also known as MDRO's. ...Enhanced Barrier Precautions: Enhanced Barrier Precautions are defined as the use of PPE (gowns and gloves) during high-contact resident care activities that generate opportunities for transfer of MDRO's in the form of blood or bodily fluids, onto the hands and/or clothing of the rendering caregiver ...These precautions are generally in place for the duration of the residents stay, or until there is a resolution of the wound or discontinuation of the device that placed the resident at "higher risk". ...Who is at "High Risk" for acquiring or spreading an MDRO? Resident known to be infected or colonized with an MDRO. Residents with an indwelling medical device including but not limited to: a) Central Venous Catheters...c) Feeding tubes (any type)...Residents with wounds regardless of MDRO status.			

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	...Examples of "High Contact" Resident Care Activities at which time EBP is to be practiced are: a) Dressing care/changes management of dressing, b) bathing/showering, c) transferring, d) providing hygiene-ADL's, e) changing linen, f) changing briefs/assisting with toileting, g) Device care or use of to include: central lines... feeding tubes (any type)... wound care ...Procedure: 1). When engaging in any of the afore mentioned "High Risk" resident care activities with a resident who has a known MDRO, or a colonized MDRO, or who would be at high risk to contract a MDRO- use gown and gloves (EBP), with the same technique/practice as in contact precautions use. This includes all required hand hygiene before and after donning/doffing gloves and gowns...." 3.1-18(a)(2)			