STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155653	A. BUILDING 00 B. WING	06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE COUNTY NURSING AND REHABILITATION CENTER	5025 MCCOOK AVE EAST CHICAGO, IN 46312

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: June 7, 8, 9, 10, and 11, 2021 Facility number: 000108 Provider number: 155653 AIM number: 100267410 Census Bed Type: SNF/NF: 60 Total: 60 Census Payor Type: Medicare: 10 Medicaid: 48 Other: 2 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/15/21.	F 0000	1.Please reference the enclosed 2567 as “plan of correction” For the complaint and Annual survey that was conducted at Lake County Nursing and Rehabilitation Center. I will submit signature sheets of the in-servicing, content of in-service and audit tools. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and / or executed solely because it is required by the provision of the Federal State Laws. This facility appreciates the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better our Elders in our community. The Plan of Correction submitted on June 28th, 2021 serves as our allegation of compliance. The provider respectfully request a desk review on or after June 28th, 2021. Should you	

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

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			have any questions or concerns regarding our Plan of Correction , please don't hesitate to Contact me. Sherri Shelby RN, HFA **Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.**	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form			

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	of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to notify the physician of a resident's change in condition related to medication refusal for 1 of 1 residents reviewed for notification of change. (Resident 28)	F 0580	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies.*	06/25/2021

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	Finding includes: The record for Resident 28 was reviewed on 6/10/21 at 10:10 a.m. Diagnoses included, but were not limited to, malignant neoplasm of the esophagus, hypertension, ataxia (loss of control of body movements), depression, anxiety, dementia with behaviors, and psychotic disorder with delusions. The Annual Minimum Data Set (MDS) assessment, dated 5/6/21, indicated the resident was severely cognitively impaired for decision making, required supervision with bed mobility, had no swallowing disorders, no dental concerns, and experienced a weight loss not prescribed by a weight-loss regime. Physician's Orders, dated 5/3/21, indicated the resident was to receive Memantine (a medication used to treat dementia) 10 mg (milligrams) twice daily at 7:00 a.m. and 1:00 p.m. The May 2021 Medication Administration Record (MAR), indicated the resident received his medication on the following days: - 5/7 at 7:00 a.m. - 5/10 at 7:00 a.m. - 5/11 at 7:00 a.m. - 5/12 at 1:00 p.m. - 5/13 at 7:00 a.m. - 5/15 at 7:00 a.m. - 5/17 - 5/20 at 7:00 a.m. and 5/19 at 1:00 p.m. - 5/23 at 1:00 p.m. - 5/27 and 5/28 at 1:00 p.m. and 5/28 - 5/30 at 7:00 a.m. The resident refused his medication on the other days of the month.		*The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 580 Notify of Changes in Condition** It is the facility policy to ensure that each resident's drug regimen is free from unnecessary drugs. **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·R28's attending physician was notified of resident's refusal of memantine medication. No new orders nor changes in dose ordered. ·R28 remained at his baseline of functioning and no adverse side effects noted. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents have the potential to be affected by the same deficient practice. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not	

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	The June 2021 MAR, indicated the resident received his medication on the following days: - 6/1 at 7:00 a.m. - 6/2 at 1:00 p.m. - 6/3 at 7:00 a.m. - 6/5 at 1:00 p.m. - 6/7 at 7:00 a.m. The resident refused his medication on the other days of the month. There was no documentation to indicate the physician was notified of the resident's refusals. Interview with the Director of Nursing on 6/10/21 at 4:05 p.m., indicated the physician should have been notified of the medication refusals. 3.1-5(a)(2)		recur. ·An audit tool will be developed to ensure all medications are administered and signed off in EMAR. At least five random residents will be selected per audit. This will be completed 3 times a week for 4 weeks. Then twice weekly for a total of 6 months. any issues will be addressed immediately. ·Inservice will be provided on the following topic: ·Signing EMAR after administration of all meds. ·Notification of resident's attending physician for refusal of medications. 1.Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for two (2) Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 1.Dates when corrective action will be completed: June 25, 2021	

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F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to a significant weight loss for 1 of 20 MDS assessments reviewed. (Resident 41) Finding includes: The record for Resident 41 was reviewed on 6/9/21 at 10:41 a.m. Diagnoses included, but were not limited to, hypertension, schizophrenia, major depressive disorder, anxiety, and type 2 diabetes. On 11/9/20, the resident weighed 217 pounds. On 5/10/21, the resident weighed 187 pounds, which indicated a 13.8 % weight loss in 6 months. The Quarterly Minimum Data Set (MDS) assessment, dated 5/13/21, indicated the resident was cognitively impaired for daily decision making and needed supervision for eating. Section K Swallowing/Nutritional Status, indicated the resident had a significant weight gain of 5% in the last month or 10% in the last 6 months. Interview with the MDS Coordinator on 6/11/21 at 2:15 p.m., indicated the MDS was coded inaccurately. The MDS should have been coded as having a significant weight loss rather than a gain and a modification would be submitted.	F 0641	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 641 Accuracy of Assessments** **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** R41 MDS assessment 5/10/21 has been modified. Audit was completed of section K for all MDS completed for may & june. 1.How the facility will identify other residents having the	06/25/2021

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	3.1-3(i)		potential to be affected by the same deficient practice. ·All residents have the potential to be affected by the same deficient practice. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·An audit tool will be developed to ensure that Section K is completed accurately At least 3 random residents will be selected per audit. This will be completed weekly for 4 weeks. Then 2 residents weekly for 5 months. Any deficiencies will be corrected immediately. ·The MDS coordinator was in serviced on accuracy of completing section K. 1.Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality	

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			Assurance Committee will add on additional Months until Compliance is sustained. 1.Dates when corrective action will be completed: June 25, 2021	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the	F 0657	*Submission of this plan of*	06/25/2021

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	facility failed to provide documentation of care conferences held with the resident and facility staff for 4 of 4 residents reviewed for care planning decisions. (Residents 12, 47, 45, and 25) Findings include: 1. Interview with Resident 12 on 6/7/21 at 2:17 p.m., indicated she had not been invited to her care conference meetings. The record for Resident 12 was reviewed on 6/9/21 at 3:52 p.m. Diagnoses included, but were not limited to, schizophrenia, dementia with behavioral disturbance, major depressive disorder, hypertension, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 4/21/21, indicated the resident was alert and oriented for daily decision making and she needed supervision with one person physical assistance for dressing, eating, and bathing. There was no documentation within the last 6 months of the resident being invited to her care conference. An interview on 6/9/21 at 1:59 p.m. with the MDS Coordinator and the Social Service Director, indicated there had been no formal care conference with the resident in the last 6 months. They were unsure on who was supposed to send out the letters to inform the family and/or the resident when the care conference was to be scheduled.2. During an interview with Resident 47 on 6/7/21 at 10:20 a.m., she indicated she did not know anything about a care conference meeting.		*correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 657 Care Plan Timing and Revision** **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·R12 has been notified of her care conference schedule and a letter of invitation was sent out to R12's responsible party ·R47 has been notified of her care conference schedule and a letter of invitation was sent out to R47's responsible party ·R45 has been notified of her care conference schedule and a letter of invitation was sent out to R45's responsible party ·R25 has been notified of her care conference schedule and a letter of invitation was sent out to R25's responsible party	

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	The record for Resident 47 was reviewed on 6/9/21 at 3:40 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), chronic kidney disease, atrial fibrillation, rheumatoid arthritis, and history of pneumonia. The Quarterly Minimum Data Set (MDS) assessment, dated 5/18/21, indicated the resident was alert and oriented. She needed limited assistance with 1 person physical assist with bed mobility, transfers, dressing and toilet use. There was no documentation the resident had a care conference in the last 6 months. An interview on 6/9/21 at 1:59 p.m. with the MDS Coordinator and the Social Service Director, indicated there had been no formal care conference with the resident in the last 6 months. They were unsure on who was supposed to send out the letters to inform the family and/or the resident when the care conference was to be scheduled. 3. During an interview with Resident 45 on 6/7/21 at 11:45 a.m., he indicated he did not recall having a care conference meeting with staff. The record for Resident 45 was reviewed on 6/9/21 at 11:45 a.m. Diagnoses included, but were not limited to, left side rib fractures, high blood pressure, type 2 diabetes, COPD (chronic obstructive pulmonary disease), anxiety, tremors, contracture right and left knee, diabetic neuropathy, abnormal gait, and acute respiratory failure.		1. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents have the potential to be affected by the same deficient practice. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·An audit tool will be developed to ensure that care conferences are being scheduled and the resident and a care plan invitation letter is being sent out to the resident's responsible party. At least 3 random residents will be selected per audit. This will be completed weekly for 4 weeks. Then 2 residents weekly for 5 months, Any deficiencies will be corrected immediately. ·The Care plan coordinator and interdisciplinary team were in serviced on the resumption of scheduling resident care conferences and to ensure that the resident is aware of the scheduled conference and a care plan invitation letter is being sent out to their responsible party. 1.Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. All plan of correction audit will be	

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	The Quarterly Minimum Data Set (MDS) assessment, dated 5/17/21, indicated the resident was alert and oriented. The resident needed supervision with set up only for personal hygiene and the activity of bathing did not occur in the assessment reference period. In the last 7 days, the resident received the medication of insulin 6 times and received oxygen while a resident. There was no documentation the resident had a care conference in the last 6 months. An interview on 6/9/21 at 1:59 p.m. with the MDS Coordinator and the Social Service Director, indicated there had been no formal care conference with the resident in the last 6 months. They were unsure on who was supposed to send out the letters to inform the family and/or the resident when the care conference was to be scheduled.4. Interview with Resident 25 on 6/7/21 at 2:44 p.m., indicated she had not had a care plan conference in approximately 2 years. The record for Resident 25 was reviewed on 6/11/21 at 2:31 p.m. Diagnoses included, but were not limited to, heart failure, hemiplegia (muscle weakness), major depression, anxiety, and diabetes. The Annual Minimum Data Set (MDS) assessment, dated 5/5/21, indicated the resident was alert and oriented. There was no documentation to indicate she was invited to, and/or attended, a care conference in 2020 or 2021. Interview with the Social Worker on 6/10/21 at 4:10 p.m., indicated the facility had not yet resumed care conferences since the pandemic in		reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained	

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	March of 2020. 3.1-35(d)(2)(B)			
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,			

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	§483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on observation, record review and interview, the facility failed to ensure residents who needed assistance with ADLs (activities of daily living) were provided assistance related to bathing and nail care for 2 of 11 residents reviewed for ADLs. (Residents 12 and 41) Findings include: 1. Interview with Resident 12 on 6/7/21 at 2:47 p.m., indicated there were times when she only received one shower a week and the rest of the time, she had to wash up on her own. The record for Resident 12 was reviewed on 6/9/21 at 3:52 p.m. Diagnoses included, but were not limited to, schizophrenia, dementia with behavioral disturbance, major depressive disorder, hypertension, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 4/21/21, indicated the resident was alert and oriented for daily decision making and she needed supervision with one person physical assistance for dressing, eating, and bathing. The revised Care Plan, dated 6/2/21, indicated the resident was at risk for a self-care deficit in bathing, dressing, feeding, and transfers related to impaired cognition (dementia), lack of coordination, difficulty walking, and COPD (chronic obstructive pulmonary disease) with shortness of breath. Interventions included, but were not limited to, provide assistance with ADLs as needed.	F 0676	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 676 Activities of Daily Living** It is the facility policy to ensure that each resident's drug regimen is free from unnecessary drugs. **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·R12 is scheduled to receive shower 2x/week with staff assistance. ·R41 is scheduled to receive shower 2x/week with staff assistance. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice.	06/25/2021

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	155653	A. BUILDING 00 B. WING	06/11/2021

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	The resident was scheduled to receive a shower on the day shift on Tuesday and Friday. There was no documentation in the bathing task to determine if the resident received a complete bed bath or a shower for May and June 2021. The documentation in the bathing task, indicated the resident needed supervision/set up help with physical help in the part of bathing on 5/17, 5/18, 5/20, and 6/8/21. There was no documentation indicating the resident received a shower or complete bed bath at least two times a week. Interview with the Director of Nursing on 6/10/21 at 4:05 p.m., indicated there was no documentation if the resident received a shower or a complete bed bath at least 2 times a week for 5/2021 and 6/2021. 2. On 6/7/21 at 12:47 p.m. and 2:40 p.m., Resident 41 was observed in his room lying on top of his bed. His hair was greasy in appearance and his fingernails were long. On 6/8/21 at 10:23 a.m. and 2:00 p.m., the resident was again observed in his room lying on top of his bed. His hair remained greasy in appearance and his fingernails were long. The record for Resident 41 was reviewed on 6/9/21 at 10:41 a.m. Diagnoses included, but were not limited to, hypertension, schizophrenia, major depressive disorder, anxiety, and type 2 diabetes. The Quarterly Minimum Data Set (MDS)		·All residents have the potential to be affected by the same deficient practice. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·An audit tool will be developed to ensure that each resident is being scheduled to receive shower or bed bath (as appropriate) and ensure that such care services are properly documented on the resident's medical records. At least 5 random residents will be selected per audit 2 x weekly. This will be completed for 4 weeks. Then 2 random residents per week for a total of 6 months. social service will do a random interview with 1 resident and 1 responsible party weekly for 4 weeks to ensure that services are being provided. ·The Nursing staff were in serviced on ensuring that resident receives shower or bed bath (as appropriate) as scheduled. 1.Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and	

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	assessment, dated 5/13/21, indicated the resident was cognitively impaired for daily decision making and he needed supervision with one person physical assistance for personal hygiene. The resident was independent in bathing with one person physical assistance. The Care Plan, dated 5/17/21, indicated the resident was at risk for an ADL self-care performance deficit related to weakness related to tonsil cancer and breathing difficulty secondary to COPD (chronic obstructive pulmonary disease). Interventions included, but were not limited to, check nail length and trim and clean on bath day and as necessary and the resident required minimum to maximum assistance for bathing/showering. The revised Care Plan, dated 6/8/21, indicated the resident had a preference to shower once a week on Thursday. Interventions included, but were not limited to, resident will be offered a shower on scheduled shower days. If resident refused, staff would assist and supervise washing up. The resident was scheduled to receive a shower on the day shift on Tuesday and Friday. There was no documentation in the bathing task to determine if the resident received a shower for May and June 2021. The documentation in the bathing task, indicated the resident needed supervision/set up help with physical help in the part of bathing on 5/8, 5/20, and 6/8/21. There was no documentation indicating the resident received a shower or complete bed bath		recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. Dates when corrective action will be completed: June 25, 2021	

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	as well as nail care. Interview with the Director of Nursing on 6/10/21 at 4:05 p.m., indicated there was no documentation if the resident received a shower or a complete bed bath at least once or twice a week for 5/2021 and 6/2021. She also indicated the resident's fingernails should have been trimmed as needed. 3.1-38(a)(2)(A)			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to ensure dependent residents received assistance with ADLs (activities of daily living) related to bathing, hair care and nail care for 8 of 11 residents reviewed for ADLs. (Residents 10, 37, 47, 51, 45, 25, 43, and 211) Findings include: 1. Interview with Resident 10 on 6/7/21 at 10:58 a.m., indicated he didn't always get his showers because of issues with the shower room. The record for Resident 10 was reviewed on 6/9/21 at 3:00 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), type 2 diabetes with chronic kidney disease, congestive heart failure, obstructive sleep apnea, and morbid obesity.	F 0677	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 677 ADL for Dependent Residents** **Corrective actions which will be accomplished for those**	06/25/2021

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	The Annual Minimum Data Set (MDS) assessment, dated 3/19/21, indicated the resident was cognitively intact for daily decision making. He required extensive assistance with one person physical assistance for bathing. The revised Care Plan, dated 6/7/21, indicated the resident was at risk for a self-care deficit in bathing, dressing, feeding, and transfers related to pain in his left foot/ankle, difficulty walking, and COPD with shortness of breath. Interventions included, but were not limited to, provide assistance with ADLs as needed. The resident was scheduled for showers on the day shift on Monday and Thursday. There was no documentation in the bathing task to determine if the resident received a complete bed bath or a shower for May and June 2021. The documentation in the bathing task, indicated the resident needed assistance in the part of bathing on 5/17, 5/18, 5/20, and 6/8/21. Interview with the Director of Nursing on 6/10/21 at 4:05 p.m., indicated there was no documentation if the resident received a shower or a complete bed bath at least 2 times a week for 5/2021 and 6/2021. 2. On 6/7/21 at 10:32 a.m., 12:40 p.m., and 2:30 p.m., Resident 37 was observed with a dark substance underneath her fingernails. The record for Resident 37 was reviewed on 6/9/21 at 1:19 p.m. Diagnoses included, but were not limited to, stroke, dementia without behavior disturbance, dysphagia (difficulty swallowing), adult failure to thrive,		**residents found to have been affected by the deficient practice:** ·R10 is scheduled to receive shower 2x/week with staff assistance. ·R37 is scheduled to receive shower 2x/week with staff assistance. ·R47 is scheduled to receive shower 2x/week with staff assistance. ·R51's nails were trimmed, and nail hygiene is maintained. ·R45 is scheduled to receive shower 2x/week with staff assistance. ·R25 is scheduled to receive bed bath 2x/week with staff assistance. ·R43 is scheduled to receive bed bath 2x/week with staff assistance. ·R211 is scheduled to receive bed bath 2x/week with staff assistance. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents have the potential to be affected by the same deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.	

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	schizophrenia, hemiplegia (muscle weakness), and psychotic disorder with hallucinations. The Quarterly Minimum Data Set (MDS) assessment, dated 5/12/21, indicated the resident was cognitively impaired for daily decision making and was totally dependent on staff for personal hygiene and bathing. The Care Plan, dated 5/17/21, indicated the resident had an activities of daily living (ADL) self-care performance deficit related to stroke with hemiplegia, contractures to right hip, wrist, and knee, and lack of coordination. Interventions included, but were not limited to, the resident required extensive assistance with bathing and showering and check nail length and trim and clean on bath day and as necessary. The resident was scheduled to receive a shower on the day shift on Tuesday and Friday. The bathing task sheet indicated the resident was totally dependent on staff for bathing on 5/5, 5/11, 5/17, 5/18, 5/20 and 6/8/21. The documentation did not indicate what type of bathing was performed. Interview with the Director of Nursing on 6/10/21 at 4:05 p.m., indicated there was no documentation if the resident received a shower or a complete bed bath at least 2 times a week for 5/2021 and 6/2021. 3. Interview with Resident 47 on 6/7/21 at 10:22 a.m., indicated "something was wrong with the shower down here and the water was too cold so I have not had a shower in a while." The record for Resident 47 was reviewed on 6/9/21 at 3:40 p.m. Diagnoses included, but		·An audit tool will be developed to ensure that each resident is being scheduled to receive shower or bed bath (as appropriate) 2x/week and such care services are properly documented on the resident's medical records. At least 5 random residents will be selected per audit. This will be completed 2 times a week for four weeks. Then 2 times per week for a total of 6 months. Any deficiencies will be corrected immediately. social services will do a random interview with 1 resident and 1 responsible party weekly for 4 weeks to ensure services are being provided. ·The Nursing staff were in serviced on ensuring that resident receives shower or bed bath (as appropriate) as scheduled. 1.Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained.	

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	were not limited to, COPD (chronic obstructive pulmonary disease), chronic kidney disease, atrial fibrillation, rheumatoid arthritis, and history of pneumonia. The Quarterly Minimum Data Set (MDS) assessment, dated 5/18/21, indicated the resident was alert and oriented. She needed limited assistance with 1 person physical assist with bed mobility, transfers, dressing and toilet use. The activity of bathing did not occur during the assessment reference period. The Care Plan, dated 4/30/21, indicated the resident had an ADL self-care performance deficit related to activity intolerance, fatigue, and impaired balance. The approaches for bathing/showers were to avoid scrubbing and pat dry sensitive skin, and provide a sponge bath when a full bath or shower could not be tolerated. The resident was scheduled for a shower on Tuesday and Friday evenings. There was no documentation in the bathing task to determine if the resident received a complete bed bath or a shower for May and June 2021. The documentation in the bathing task, indicated the resident needed 1 person assist with physical help in the part of bathing on 5/5, 5/24, 5/27, and 6/7/21. There was no documentation indicating the resident received a shower or complete bed bath at least two times a week. Interview with the Director of Nursing on 6/10/21 at 10:00 a.m., indicated there was no documentation if the resident received a shower		1.Dates when corrective action will be completed: June 25, 2021	

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	or a complete bed bath at least 2 times a week for 5/2021 and 6/2021. 4. On 6/7/21 at 9:48 a.m., Resident 51 was observed sitting in a wheelchair. Her fingernails were long and dirty. There was food all over her shirt and pants. On 6/7/21 at 11:30 a.m., and 12:30 p.m., the resident was observed in her wheelchair with long dirty fingernails and still wearing the same stained shirt and pants. On 6/8/21 at 8:20 a.m., and 1:48 p.m., the resident was observed sitting in her wheelchair. Her fingernails were dirty. On 6/9/21 at 9:10 a.m., the resident was observed sitting in her wheelchair. Her fingernails were dirty. The record for Resident 51 was reviewed on 6/9/21 at 10:47 a.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), high blood pressure, muscle weakness, schizoaffective disorder, anxiety, and dementia with behavioral disorder. The Modification of the Significant Change Minimum Data Set (MDS) assessment, dated 5/6/21, indicated the resident was not alert and oriented and needed limited assistance with 1 person physical assist with bed mobility. The resident was totally dependent on staff with 1 person physical assist for dressing, eating, and personal hygiene. The Care Plan, dated 5/4/21, indicated the resident had an ADL self-care performance deficit related to activity intolerance, confusion,			

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	and dementia. The approaches were to check nail length and trim and clean on bath day and as necessary. Provide a sponge bath when a full bath or shower could not be tolerated. The resident was scheduled for a shower on Tuesday and Friday evenings. The documentation in the bathing task indicated the resident needed 1 person assist with physical help in the part of bathing on 5/6, 5/7, 5/8, 5/17, 5/20, 5/27, 6/3, and 6/7/21. There was no indication if the resident received a shower or a bed bath. There was no documentation if nail care had been provided. Interview with the Director of Nursing on 6/10/21 at 10:00 a.m., indicated there was no documentation if the resident had a shower or a complete bed bath in May or June 2021. The resident's nails were to be cleaned during showers or baths and as needed. 5. During an interview with Resident 45 on 6/7/21 at 11:50 a.m., indicated he preferred a bed bath and received it at least 2 times a week, however, his hair had not been washed in very long time and his head itched. The record for Resident 45 was reviewed on 6/9/21 at 11:45 a.m. Diagnoses included, but were not limited to, left side rib fractures, high blood pressure, type 2 diabetes, COPD (chronic obstructive pulmonary disease), anxiety, tremors, contracture right and left knee, diabetic neuropathy, abnormal gait, and acute respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 5/17/21, indicated the resident			

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	was alert and oriented. The resident needed supervision with set up only for personal hygiene and the activity of bathing did not occur in the assessment reference period. The Care Plan, dated 5/17/21, indicated the resident had an ADL self-care performance deficit related to contractures of the left and right knees, tremors, and lack of coordination. The resident was scheduled for a shower on Monday and Thursday evenings. The documentation in the bathing task for the last 30 days indicated there was no documentation if the resident received a complete bed bath or had a shampoo. The resident received physical help with assist with part of the bathing activity on 5/24, 6/3, 6/7, and 6/9/21. There was no documentation indicating the resident received a shower or complete bed bath at least two times a week. Interview with the Director of Nursing on 6/10/21 at 10:00 a.m., indicated there was no documentation if the resident had a shower or complete bed bath in May or June 2021. The resident's hair was to be washed during showers or baths. 6. Interview with Resident 25 on 6/7/21 at 2:44 p.m., indicated she required a 2 personal physical assist with her care. When there was only one CNA scheduled, she did not receive a complete bed bath. The record for the resident was reviewed on 6/11/21 at 2:31 p.m. Diagnoses included, but were not limited to, heart failure, hemiplegia, major depression, anxiety, and diabetes.			

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	The Annual Minimum Data Set (MDS) assessment, dated 5/5/21, indicated the resident was alert and oriented. She required physical help with part of bathing activities and extensive 1 person physical assistance with personal hygiene. A Care Plan, dated 5/3/21, indicated she had an ADL self-care performance deficit. The interventions included, but were not limited to, provide sponge bath when a full bath or shower could not be tolerated. There was no documentation to indicate the resident received a complete bed bath 5/1 - 6/11/21. Interview with the Director of Nursing on 6/10/21 at 4:05 p.m., indicated she was implementing a system to ensure staff properly documented showers and/or complete bed baths. 7. Interview with Resident 43 on 6/7/21 at 11:06 a.m., indicated she was not receiving complete bed baths when the the facility was short staffed. The record for the resident was reviewed on 6/8/21 at 1:53 p.m. Diagnoses included, but were not limited to, injured cervical spine, COPD (chronic obstructive pulmonary disease), hypertension, diabetes, colostomy, anxiety, paraplegia, insomnia, and pressure ulcers. The Quarterly Minimum Data Set (MDS) assessment, dated 5/14/21, indicated she was alert and oriented and required total 1 person physical assistance with bed mobility, transfers, toileting and personal hygiene. Bathing did not occur during the assessment period.			

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	The May and June 2021 bathing documentation indicated she received a full bed bath on 5/19/21. Interview with the Director of Nursing on 6/10/21 at 4:05 p.m., indicated she was implementing a system to ensure staff properly documented showers and/or complete bed baths. 8. Interview with Resident 211 on 6/8/21 at 9:52 a.m., indicated "I hate it here, I have not had a bed bath since I've been here until today and that is only because you are here." The record for the resident was reviewed on 6/8/21 at 4:11 p.m. She was admitted on 5/28/21. Diagnoses included, but were not limited to, edema, lack of coordination, diabetes, obesity, bacteria pneumonia, and acute respiratory failure. The Admission Evaluation Assessment, dated 6/8/21, indicated the resident was alert and oriented. There was no documentation to indicate the resident received a shower and/or a complete bed bath since her admission. Interview with the Director of Nursing on 6/10/21 at 4:05 p.m., indicated she was implementing a system to ensure staff properly documented showers and/or complete bed baths. 3.1-38(a)(3)(B) 3.1-38(a)(3)(E)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that			

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	applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to ensure areas of bruising were assessed and monitored and treatments were completed as ordered for 3 of 3 residents reviewed for skin conditions (non-pressure related). (Residents 10, 51, and 29) Findings include: 1. On 6/8/21 at 10:55 a.m. and 2:00 p.m., Resident 10 was observed with an area of purple discoloration to his left antecubital area. On 6/9/21 at 9:00 a.m., the discoloration remained to the resident's left antecubital area. The record for Resident 10 was reviewed on 6/9/21 at 3:00 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), type 2 diabetes with chronic kidney disease, congestive heart failure, obstructive sleep apnea, and morbid obesity. The Annual Minimum Data Set (MDS) assessment, dated 3/19/21, indicated the resident was cognitively intact for daily decision making. He required extensive assistance with one person physical assistance for bathing and supervision for bed mobility and transfers. The weekly skin assessment, dated 6/8/21,	F 0684	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 684 Quality of Care** **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·R10's discoloration on the left antecubital area is now resolved. R10 remains within his baseline of functioning. No signs of distress noted. ·R51 is currently not at the facility. ·R29's discoloration on the top of his right and left hands have	06/25/2021

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	155653	A. BUILDING 00 B. WING	06/11/2021

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	indicated the resident had no current skin issues. A Physician's Order, dated 6/3/21, indicated the resident was to receive Aspirin 81 milligrams (mg) daily. Interview with the Director of Nursing (DON) on 6/10/21 at 4:05 p.m., indicated she would review the resident's record. Nurses' Notes, dated 6/11/21 at 2:55 p.m., indicated the resident had a bruise to his left arm. The physician was notified and orders were received to monitor the bruise until it was resolved. Interview with the DON on 6/11/21 at 3:30 p.m., indicated the bruise should have been assessed and monitored until it was healed.2. On 6/7/21 at 9:49 a.m., 11:30 a.m., and 12:30 p.m., Resident 51 was observed sitting in her wheelchair wearing shorts. There was a bandage observed on her lower left leg that was dated 6/5/21. The record for Resident 51 was reviewed on 6/9/21 at 10:47 a.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), high blood pressure, muscle weakness, schizoaffective disorder, anxiety, and dementia with behavioral disorder. The Modification of the Significant Change Minimum Data Set (MDS) assessment, dated 5/6/21, indicated the resident was not alert and oriented and needed limited assistance with 1 person physical assist with bed mobility. The resident was totally dependent on staff with 1 person physical assist for dressing, eating, and personal hygiene. The resident had 1 fall with no injury since the last assessment.		been assessed, monitored and are being documented on the medical records. R29 remains within his baseline of functioning. No signs of distress noted. 1. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents have the potential to be affected by the same deficient practice. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·An audit tool will be developed to ensure that any alteration in skin condition are being assessed, monitored, and properly documented. At least two random residents will be selected per audit. This will be completed 3 times a week for 4 weeks. Then 2 times per week for 5 months. Any deficiencies will be corrected immediately. ·Nurses were in serviced on proper skin assessment, monitoring of alterations in skin, and proper documentation of findings and treatment on the medical records. Quality Assurance Plans to monitor facility performance to make sure that corrections are	

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	The Care Plan, dated 5/25/21, indicated the resident had actual impairment of skin integrity on the left shin related to an evacuated hematoma (a collection of blood outside of the blood vessel). Physician's Orders, dated 5/21/21, indicated "Left shin: Cleanse with normal saline, dry, then pack with wet to moist gauze and cover with dry dressing twice daily." Physician's Orders, dated 5/29/21, indicated "Left shin: Cleanse with normal saline, dry, then apply collagen and foam dressing daily." The Wound Physician note, dated 6/4/21, indicated the left shin measured 0.6 centimeters (cm) by 1 cm, by 0.4 cm. There was 100% granulation tissue noted. The treatment was to apply a foam border three times a week for 23 days. Physician's Orders, dated 6/8/21, indicated "Left shin: Cleanse with normal saline, and apply foam dressing. Every day shift every Monday, Wednesday, and Friday." A skin assessment, dated 6/8/21, indicated the left shin had an open lesion. The Treatment Administration Record (TAR), dated 5/2021, indicated the treatment for the left shin had not been signed out as being completed two times a day on 5/23, 5/24, and 5/27/21 for the day shift. The TAR, dated 6/2021, indicated the left shin treatment of collagen and a foam dressing was signed out as being completed 6/1-6/7/21.		achieved and are permanent. ·All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. Dates when corrective action will be completed: June 25, 2021 1.	

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	Interview with the Assistant Director of Nursing (ADON) on 6/9/21 at 2:00 p.m., indicated the treatment was to be completed as ordered by the Physician. 3. On 6/8/21 at 11:08 a.m., Resident 29 was observed in bed. He had 2 large purple areas of discoloration on the top of his right and left hands. On 6/9/21 at 4:08 p.m., he was observed in bed, the areas of discoloration remained. Interview at the time indicated he had previously pinched his hands in his wheelchair. The record for the resident was reviewed on 6/9/21 at 1:07 p.m. Diagnoses included, but were not limited to, lack of physical exercise, heart failure, hypertension, diabetes, and sepsis. The Admission Minimum Data Set (MDS) assessment, dated 5/7/21, indicated the resident was alert and oriented. He required extensive 1 person physical assistance with bed mobility and transfers. The Weekly Skin Observation assessment, dated 6/9/21, indicated no documentation related to the purple areas of discoloration on both his right and left hands. Interview and observation with the Assistant Director of Nursing on 6/11/21 at 2:20 p.m., indicated the resident had purple discoloration on the top of his hands. She would assess and document the areas. Interview with the Director of Nursing on 6/11/21 at 3:10 p.m., indicated areas of discoloration should have been assessed,			

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	documented, and monitored until healed. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure a resident with a pressure ulcer received the necessary treatment and services to promote healing related to ensuring treatments were completed as recommended by the Wound Physician for 1 of 1 residents reviewed for pressure ulcers. (Resident 15) Finding includes: On 6/7/21 at 10:01 a.m., Resident 15 was observed laying in bed. At that time, both of her feet and heels were directly on the mattress, they were not elevated. The left outer foot bandage was dated 6/4/21. On 6/7/21 at 10:30 a.m., CNA 3 was preparing to	F 0686	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F686 Treatment/Prevent/Heal Pressure Ulcer**	06/25/2021

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	provide morning care for the resident. At that time, she rolled the resident over to her left side. There was a pink bandage noted on the resident's right hip with no date. There were no other bandages noted on the resident's buttocks, coccyx (tail bone), or hip areas. There were no bandages noted on the resident's foot. There was one bandage noted on the resident's left lateral outer foot that was dated 6/4/21. The resident had a pressure sore on her left heel and left outer distal foot. Both areas were open to air and noted with necrotic tissue (dead or devitalized skin tissue). On 6/7/21 at 3:17 p.m., CNA 1 was asked to remove the resident's sock to her left foot. The bandage on the left lateral outer foot was still dated 6/4/21. On 6/8/21 at 2:46 p.m., the Assistant Director of Nursing (ADON) was preparing to change the resident's bandages on her open areas. The resident was observed in bed with both heels lying directly on the mattress without elevation. She applied betadine (a topical antiseptic) to both the right and left heels and left them open to air. The left heel was observed with a large amount of necrotic tissue. The bandage to the left lateral outer foot was still dated 6/4/21. The bandage was removed and there was a moderate amount of dried blood noted on the gauze sponge. The area was open with necrotic tissue and yellow slough (non-viable tissue). The pressure ulcer was cleaned with normal saline and a collagen bandage was placed on the open area followed by a foam dressing. There was no bandage observed on the distal medial left foot near her big toe. The open area had necrotic and pink tissue with no drainage noted. The pressure sore was cleaned with normal saline and a collagen bandage and		**Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·R15 receives wound treatment and wound care daily as ordered. ·R15's wounds are being assessed by the wound care MD weekly. ·R15's wounds remain stable with no signs of infection. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents with pressure ulcers have the potential to be affected by the same deficient practice. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·An audit tool will be developed to ensure that residents with skin alteration receives wound care as ordered. At least 3 random residents will be selected per audit. This will be completed 3 times a week for 4 weeks. Then 2 times weekly for 5 months. Any deficiencies will be corrected immediately. ·Nursing staff has been in-serviced on the wound	

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	foam dressing was placed over it. The bandage on the right hip was removed. The area was pink with slough noted. There was a moderate amount of drainage noted on the old bandage. She cleansed the open area with normal saline and placed a collagen bandage on top of the wound and covered it with a foam dressing. There were no other bandages noted on the resident's body. After a skin assessment there were no other open areas observed on her buttocks. The record for Resident 15 was reviewed on 6/8/21 at 1:53 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, high blood pressure, dementia, muscle weakness, contractures to the right and left knees, convulsions, and a stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 4/28/21, indicated the resident was not alert and oriented. The resident had short and long term memory problems and was severely impaired for decision making. She was totally dependent on staff with 2 person physical assist for bed mobility, transfers, toilet use and bathing. The resident was a limited assist with 1 person physical for eating. The resident had one stage 1 pressure ulcer. The Care Plan, dated 6/2/21, indicated the resident was at risk for further impaired skin integrity related to very limited sensory perception, skin very moist, bedfast, very limited mobility, probably inadequate nutritional intake, and potential problem with friction/shearing. The resident currently presented with impairment to the left heel, left lateral foot, left distal medial foot, right medial first toe, and right distal medial foot pressure sores. The approaches were to administer treatments as ordered and		prevention policy, on skin and wound assessments, timely administration of treatments as ordered, and proper documentation of wound care services provided. 1.Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. Dates when corrective action will be completed: June 25, 2021 1.	

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	monitor for effectiveness. A Braden scale assessment, dated 6/2/21, indicated a score of 11 which indicated the resident was a high risk for pressure sores. Physician's Orders, dated 5/4/21, indicated right and left buttocks cleanse with normal saline and then apply hydrocolloid dressing three times a week. Right and left medial heel apply betadine and leave open to air every night shift. Physician's Orders, dated 5/29/21, were as follows: - cleanse the right hip with normal saline, apply collagen and foam dressing daily until healed. - cleanse the left lateral foot with normal saline apply collagen and foam dressing daily. - cleanse the left distal medial foot with normal saline, dry and then apply collagen and foam dressing daily. The Wound Physician notes, dated 6/4/21, indicated the following: - unstageable pressure ulcer to left heel: measured 4.3 centimeters (cm) by 3.6 cm, 100% thick adherent black necrotic tissue. Apply betadine once daily for 9 days and leave open to air. - Stage 4 pressure ulcer to left lateral foot: measured 2.5 cm by 2.5 cm, 100% of thick adherent devitalized necrotic tissue. Discontinue collagen sheet and apply iodosorb oil emulsion daily and cover with foam dressing. - Unstageable deep tissue injury to left distal medial foot: measured 3.5 cm by 1 cm intact skin. Discontinue collagen sheet and apply skin prep once daily. - Shear wound to right upper buttock: deteriorated, measured 1.7 cm by 2 cm, 50% of			

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	thick adherent devitalized necrotic tissue and 50% of granulation tissue. Discontinue collagen sheet and apply iodosorb oil emulsion daily and cover with foam dressing. There were no new treatment orders put in place for the resident after the above visit and recommendations from the Wound Physician. Physician's Orders, dated 6/9/21, indicated Right upper buttocks: cleanse with normal saline, dry, then apply iodosorb and cover with dry dressing. Left distal medial foot: cleanse with normal saline and apply skin prep and leave open to air. The Treatment Administration Record (TAR) for 6/2021, indicated all of the treatments were signed out as being completed on 6/5, 6/6, and 6/7/21, including the right hip (upper buttocks) observed with an undated dressing and left lateral foot whose dressing had been observed dated 6/4/21 on both 6/7 & 6/8/21. Interview with the ADON on 6/8/21 at 3:20 p.m., indicated the bandages were to be changed as per Physician's Orders and there was no hydrocolloid noted to the left buttock during the wound treatments just completed. Interview with the Director of Nursing on 6/10/21 at 10:00 a.m., indicated the treatments were to be changed as ordered by the Physician. The right hip was the same open area as the right buttock. 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

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	§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure residents were free from accidents related to ensuring proper footwear was in place for a resident with a history of falls for 1 of 2 residents reviewed for accidents. (Resident 51) Finding includes: On 6/7/21 at 9:48 a.m.,11:30 a.m., and 12:30 p.m., Resident 51 was observed sitting in a wheelchair wearing plain white ankle socks to both feet. There were no non skid soles noted. On 6/8/21 at 8:20 a.m., the resident was observed sitting in her wheelchair wearing plain black socks to both feet. There were no non skid soles noted. At 9:50 a.m., the resident was observed in a low bed with a mattress beside the bed. At that time, she was wearing the same black socks to both feet. On 6/9/21 at 9:10 a.m., the resident was observed sitting in her wheelchair in the hall propelling her wheelchair. She was wearing a pair of knee high socks to both feet. There were no non skid soles noted. On 6/9/21 at 10:45 a.m., the resident was observed on the floor mattress beside the bed. She was crying out loud and holding on to the	F 0689	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F689 Free of accident hazards/supervision** **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·R51 is currently not in the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice.	06/25/2021

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	side of the bed. She was wearing the same knee high socks to both feet. The Assistant Director of Nursing (ADON) was notified immediately the resident had rolled out of her bed. On 6/9/21 at 2:03 p.m., the resident was observed on the floor mattress beside her bed. She was dressed in a hospital gown wearing plain knee high socks. There were no non skids on them. The ADON was right outside the door preparing medication for the resident. The record for Resident 51 was reviewed on 6/9/21 at 10:47 a.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), high blood pressure, muscle weakness, schizoaffective disorder, anxiety, and dementia with behavioral disorder. The Modification of the Significant Change Minimum Data Set (MDS) assessment, dated 5/6/21, indicated the resident was not alert and oriented and needed limited assistance with 1 person physical assist with bed mobility. The resident was totally dependent on staff with 1 person physical assist for dressing, eating, and personal hygiene. The resident had 1 fall with no injury since the last assessment. The Care Plan, revised 5/24/21, indicated the resident was at risk for falls due to incontinence, impaired cognition, and psychotropic medication use. The resident preferred to lay on a mat next to the bed and did move/crawl around on the mat and floor. A fall risk assessment, dated 2/4/21, indicated the resident had a score of 21 indicating a high risk.		·All residents have the potential to be affected by the same deficient practice. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·An audit tool will be developed to ensure that all resident centered fall interventions are in place. At least 2 random residents will be selected per audit. This will be completed for then 3 times for 4 weeks. Then weekly for 3 months. Any deficiencies will be corrected immediately. ·Nursing staff has been in-serviced on fall prevention including but not limited to use of appropriate footwear and nonskid socks. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for 5 Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained.	

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	Nurses' Notes, dated 4/14/21 at 9:30 a.m., indicated the resident was observed sitting on the floor between her bed and the wall. The resident indicated she wanted to get up. Nurses' Notes, dated 6/9/21 at 1:15 p.m., indicated the resident was observed lying on her right side calling out for her mother and wanting to be put back into the bed. Nurses' Notes, dated 6/9/21 at 2:17 p.m., indicated the resident was observed rolling out of bed onto the bedside mat. Interview with the Director of Nursing on 6/10/21 at 10:00 a.m., indicated the resident should have been wearing non skid socks on both feet while in bed and up in the wheelchair. If possible, she should also be wearing shoes. Interview with CNA 2 on 6/10/21 at 3:15 p.m., indicated the resident was dressed every morning by the day shift. She indicated the resident did not have many pairs of non skid socks, she had mostly plain socks with no non skid soles. She was going to get the resident more pairs of non skid socks. 3.1-45(a)(2)		Dates when corrective action will be completed: June 25, 2021 1.	
F 0692 SS=E Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-			

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	155653	A. BUILDING 00 B. WING	06/11/2021

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	§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records not completed, supplements not offered nor documented, and the Registered Dietitian not notified of supplement refusal for residents who were nutritionally at risk for 5 of 5 residents reviewed for nutrition. (Residents 37, 41, 44, 15, and 28) Findings include: 1. On 6/7/21 at 12:34 p.m., Resident 37 was observed in her room in bed eating lunch. The resident was feeding herself. She ate all of her pureed meat and pudding. The resident did not receive ice cream with her meal. On 6/9/21 at 9:05 a.m., the resident was in her room in bed eating. The resident's carton of milk had not been opened for her and super cereal was not observed on her tray.	F 0692	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F692 Nutrition/Hydration Status Maintenance** **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:**	06/25/2021

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	The record for Resident 37 was reviewed on 6/9/21 at 1:19 p.m. Diagnoses included, but were not limited to, stroke, dementia without behavior disturbance, dysphagia (difficulty swallowing), adult failure to thrive, schizophrenia, hemiplegia (muscle weakness), and psychotic disorder with hallucinations. The Quarterly Minimum Data Set (MDS) assessment, dated 5/12/21, indicated the resident was cognitively impaired for daily decision making and needed supervision with eating. She received a mechanically altered, therapeutic diet and had sustained a significant weight loss of 5% in one month or 10% in 6 months. The Care Plan, dated 5/17/21, indicated the resident had a potential nutritional problem. The resident received a mechanically altered diet and had variable intake. She was underweight as evidenced by a body mass index (BMI) below normal range of 18.5-24.9 related to energy intake less than energy expenditure. The resident also had a history weight loss. Interventions included, but were not limited to, provide, serve diet as ordered and monitor intake and record every meal. On 11/9/20, the resident weighed 75 pounds. On 5/13/21, the resident weighed 66 pounds, a 12% weight loss in 6 months. A Physician's Order, dated 4/24/21, indicated the resident was to receive a frozen nutritional treat two times a day and Ensure Plus 237 milliliters (ml) three times a day. A Physician's Order, dated 5/25/21, indicated the resident was to receive a pureed diet with double meat portions, super cereal at breakfast and ice		·R37 was evaluated by the dietitian. Recommendations relayed to MD and carried out. ·R37 remains at his baseline of functioning. No distress noted. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents have the potential to be affected by the same deficient practice. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·An audit tool will be developed to ensure that residents with nutritional risk are properly assessed and nutritional intake including supplement is being monitored and recorded. At least three random residents will be selected per audit. This will be completed 5 times a week for 4 weeks. Then 3 times for 5 months. Any deficiencies will be corrected immediately. ·Nursing staff has been in-serviced on timely MD and dietitian notification of resident's refusal to ordered supplements and proper documentations of meal consumptions. 1.Quality Assurance Plans to monitor facility performance to make sure that corrections are	

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	cream at lunch. The May 2021 Medication Administration Record (MAR), indicated the Ensure was not signed out as being administered midday on 5/7, 5/11, 5/14, 5/19, and 5/23/21. The evening Ensure was not signed out on 5/10 and 5/17/21. The May 2021 Food Consumption log, indicated meals were not documented on the dates as follows: Breakfast: 5/28, 5/29, 5/30, and 5/31/21 Lunch: 5/28, 5/29, 5/30, and 5/31/21 Dinner: 5/12, 5/15, 5/16, 5/17, 5/21, 5/24, 5/25, 5/26, 5/27, and 5/28-5/31/21 The June 2021 Food Consumption log, indicated meals were not documented on the dates as follows: Dinner: 6/1, 6/7, and 6/8/21 Interview with the Director of Nursing on 6/10/21 at 4:05 p.m., indicated the resident should have received her supplements as ordered and her food consumption should have been documented. 2. On 6/7/21 at 12:47 p.m., Resident 41 was observed in his room lying on top of his bed. The resident's lunch tray was placed on his over bed table on the other side of his room. At 2:40 p.m., the lunch tray remained on the over bed table and the resident had not eaten anything. The record for Resident 41 was reviewed on 6/9/21 at 10:41 a.m. Diagnoses included, but were not limited to, hypertension, schizophrenia, major depressive disorder, anxiety, and type 2 diabetes.		achieved and are permanent. ·All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. Dates when corrective action will be completed: June 25, 2021 1.	

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	On 11/9/20, the resident weighed 217 pounds. On 5/10/21, the resident weighed 187 pounds, which indicated a 13.8 % weight loss in 6 months. The Quarterly Minimum Data Set (MDS) assessment, dated 5/13/21, indicated the resident was cognitively impaired for daily decision making and needed supervision for eating. The Care Plan, dated 5/10/21, indicated the resident had a nutritional problem or a potential nutritional problem related to having a therapeutic diet, a diagnosis of tonsil cancer and COPD (chronic obstructive pulmonary disease) as well as a history of weight loss. Interventions included, but were not limited to, provide, serve diet as ordered. Monitor intake and record every meal. The May 2021 Food Consumption log, indicated meals were not documented on the dates as follows: Breakfast: 5/28, 5/29, 5/30, and 5/31/21 Lunch: 5/28, 5/29, 5/30, and 5/31/21 Dinner: 5/12, 5/15, 5/16, 5/17, 5/21, 5/24, 5/25, 5/26, 5/27, and 5/28-5/31/21 The June 2021 Food Consumption log, indicated meals were not documented on the dates as follows: Breakfast: 6/1/21 Lunch: 6/1/21 Dinner: 6/1, 6/4, 6/6, 6/7, and 6/8/21 Interview with the Director of Nursing on 6/10/21 at 4:05 p.m., indicated the resident's food consumption should have been documented for each meal.			

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	3. The record for Resident 44 was reviewed on 6/8/21 at 2:10 p.m. Diagnoses included, but were not limited to, stroke, hemiplegia (muscle weakness), major depressive disorder, dementia with behavior disturbance, anxiety, dysphagia (difficulty swallowing), and type 2 diabetes. The Quarterly Minimum Data Set (MDS) assessment, dated 5/14/21, indicated the resident was cognitively impaired for daily decision making and she needed supervision with eating and received a mechanically altered diet. The Care Plan, dated 5/24/21, indicated the resident had a nutritional problem or potential nutritional problem related to having a mechanically altered diet due to the diagnosis of dysphagia and history of weight loss. Interventions included, but were not limited to, provide, serve diet as ordered. Monitor intake and record every meal. On 11/9/20, the resident weighed 204 pounds. On 5/20/21, the resident weighed 159 pounds, a 22% weight loss in the past 6 months. The May 2021 Food Consumption log, indicated meals were not documented on the dates as follows: Breakfast: 5/28, 5/29, 5/30, and 5/31/21 Lunch: 5/28, 5/29, 5/30, and 5/31/21 Dinner: 5/12, 5/15, 5/16, 5/17, 5/21, 5/24, 5/25, 5/26, and 5/28-5/31/21 The June 2021 Food Consumption log, indicated meals were not documented on the dates as follows: Breakfast: 6/1/21 Lunch: 6/1/21 Dinner: 6/1 and 6/7/21			

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	Interview with the Director of Nursing on 6/10/21 at 4:05 p.m., indicated the resident's food consumption should have been documented for each meal.4. On 6/9/21 at 9:23 a.m., Resident 15 was observed sitting in a wheelchair inside her room. At that time, the Assistant Director of Nursing (ADON) had her breakfast tray and was going to feed her. The resident received a cup of apple juice, a health shake, pureed sausage and pureed cereal. The record for Resident 15 was reviewed on 6/8/21 at 1:53 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, high blood pressure, dementia, muscle weakness, contractures to the right and left knees, convulsions, and a stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 4/28/21, indicated the resident was not alert and oriented. The resident had short and long term memory problems and was severely impaired for decision making. She was totally dependent on staff with 2 person physical assist for bed mobility, transfers, toilet use and bathing. The resident was a limited assist with 1 person physical assist for eating. She weighed 149 pounds with no current weight loss. She received a therapeutic and mechanically altered diet. The resident had 1 stage 1 pressure ulcer. The Care Plan, dated 5/24/21, indicated the resident had nutritional problems due to a mechanically altered diet, increased nutritional needs, and history of weight loss. The approaches were to provide and serve diet as ordered. Monitor intake and record every meal. The resident weighed 197 pounds on 11/9/2020			

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	and 149 pounds on 5/13/21 which was a 23.98% weight loss in 6 months. The weight loss was greater than 10% indicating a significant weight loss. A weight was obtained on 6/8/21 and indicated the resident still weighed 149 pounds. The last documented Registered Dietitian (RD) note, dated 6/7/21, indicated the resident received a pureed diet with house shakes at meals. The current weight on 5/13/21 was 149 pounds with a Body Mass Index of 25.7. The meal consumption logs in the last 30 days indicated breakfast was not documented on 5/8, 5/9, 5/12, 5/21, 5/23, 5/27-5/31, and 6/4/21. Lunch was not documented on 5/7, 5/8, 5/9, 5/12, 5/21, 5/27-5/31, and 6/4/21. Dinner was not documented on 5/6, 5/7, 5/10, 5/11, 5/12, 5/13, 5/15, 5/17, 5/19, 5/24, 5/28-5/31, 6/1, and 6/4-6/7/21. Interview with the Director of Nursing on 6/10/21 at 10:00 a.m., indicated there were many blanks on the food consumption log for all three meals.5. The record for Resident 28 was reviewed on 6/10/21 at 10:10 a.m. Diagnoses included, but were not limited to, malignant neoplasm of the esophagus, hypertension, ataxia (loss of control of body movements), depression, anxiety, dementia with behaviors, and psychotic disorder with delusions. The Annual Minimum Data Set (MDS) assessment, dated 5/6/21, indicated the resident was severely cognitively impaired for decision making, required supervision with bed mobility, had no swallowing disorders, no dental concerns, and experienced a weight loss not prescribed by a weight-loss regime.			

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	Physician's Orders, dated 5/12/21, indicated Protein liquid supplement (Ensure) twice a day at 7:00 a.m. and 1:00 p.m., to promote weight. A Care Plan, dated 5/10/21, indicated he had a potential for nutritional problems. The interventions included, but were not limited to, Registered Dietitian (RD) to evaluate and make diet changes as needed. The May 2021 Medication Administration Record (MAR), indicated the resident refused the Ensure on the following dates: 7:00 a.m. - 5/14, 5/21-5/24, 5/27, and 5/30/21 1:00 p.m. - 5/14-5/18, 5/20, 5/22, and 5/28-5/31/21 The June 2021 MAR, indicated the resident refused the Ensure on the following dates: 7:00 a.m. - 6/4-6/6, and 6/9/21 1:00 p.m. - 6/1, 6/3-6/4, 6/6, and 6/8/21 There was no documentation to indicate the RD was notified of the refusals. Interview with the Director of Nursing on 6/10/21 at 4:05 p.m., indicated the RD should have been notified of the resident's refusals. 3.1-46(a)(1)			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.			

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	The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to provide proper respiratory care and services related to oxygen at the correct flow rate and connected to the concentrator, having orders for oxygen, monitoring of humidification bottles, and changing and dating the oxygen tubing for 4 of 4 residents reviewed for oxygen. (Residents 10, 47, 45, and 211) Findings include: 1. On 6/7/21 at 11:03 a.m. and 12:37 p.m., the oxygen tubing for Resident 10 was dated 5/17/21. The humidification bottle, dated 4/26/21, was not connected to the oxygen concentrator and was on the floor. The resident was wearing oxygen by the way of a nasal cannula and his oxygen concentrator was set at 4 liters per minute. On 6/8/21 at 10:37 a.m., 2:00 p.m., and 2:58 p.m., the resident's oxygen tubing was dated 5/17/21 and the oxygen concentrator was set at 4 liters. On 6/9/21 at 9:00 a.m., 11:55 a.m., and 1:05 p.m., the resident's oxygen tubing was dated 5/17/21 and the oxygen concentrator was set at 4 liters. On 6/10/21 at 9:00 a.m., the resident's oxygen	F 0695	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F695** **Respiratory/Tracheostomy Care and Suctioning** **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·R10's oxygen set-up and settings are corrected and is now set per md order, O2 tubing is dated per policy, R10's O2 saturation remains within baseline. No signs of distress noted. ·R47's oxygen set-up and	06/25/2021

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	tubing was dated 5/17/21 and the oxygen concentrator was set at 4 liters. The record for Resident 10 was reviewed on 6/9/21 at 3:00 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), type 2 diabetes with chronic kidney disease, congestive heart failure, obstructive sleep apnea, and morbid obesity. The Annual Minimum Data Set (MDS) assessment, dated 3/19/21, indicated the resident was cognitively intact for daily decision making and he required the use of oxygen during the assessment reference period. The Care Plan, dated 5/26/21, indicated the resident was at risk for impaired gas exchange secondary to chronic respiratory failure, obstructive sleep apnea requiring bipap use, and COPD. The resident experienced positional shortness of breath as well as shortness of breath while lying flat and with activity secondary to COPD. Interventions included, but were not limited to, oxygen as ordered. A Physician's Order, dated 4/29/21, indicated may apply nasal cannula oxygen at 3 liters per minute as needed (prn) for shortness of breath or oxygen saturation less than 92%. The resident's oxygen saturation was to be checked every shift. The oxygen tubing and mask or cannula were to be changed as needed. When changed, the tubing and/or mask were to be dated. The May and June 2021 Medication Administration Records (MAR's), indicated the resident's oxygen tubing had not been signed out as changed and the prn oxygen had not been signed out as being applied.		settings are corrected and is now set per md order, O2 tubing is dated per policy, R47's O2 saturation remains within baseline. No signs of distress noted. ·R45's oxygen set-up and settings are corrected and is now set per md order, O2 tubing is dated per policy, R45's O2 saturation remains within baseline. No signs of distress noted. ·R211's oxygen set-up and settings are corrected and is now set per md order, O2 tubing is dated per policy, R211's O2 saturation remains within baseline. No signs of distress noted. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents who are receiving Oxygen therapy have the potential to be affected by the same deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·An audit tool will be developed to ensure that resident's oxygen therapy is administered correctly per doctor's order and ensure that the O2 tubing's and humidifiers are checked and dated appropriately per policy. At least five random residents will be selected per audit. This will be	

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	Interview with the Director of Nursing (DON) on 6/10/21 at 4:05 p.m., indicated the resident had been hospitalized twice in May and his tubing should have been changed each time he returned. The DON also indicated a clarification order needed to be obtained related to the correct flow rate and if the oxygen should be used continuously. 2. On 6/7/21 at 10:12 a.m., Resident 47 was observed laying in bed. She was wearing oxygen per nasal cannula and it was connected to the portable tank which was set at 2 liters per minute. The humidification bottle on the concentrator was empty. There were 2 bottles on top of the concentrator one dated 5/17 and the other dated 5/23/21. The resident indicated she had not been on the concentrator in the room due to the facility was running out of the humidification bottles. There was no date on her oxygen tubing. On 6/8/21 at 1:51 p.m. and 6/9/21 at 9:00 a.m., the resident was observed wearing oxygen at 2 liters per minute per nasal cannula. The record for Resident 47 was reviewed on 6/9/21 at 3:40 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), chronic kidney disease, atrial fibrillation, rheumatoid arthritis, and history of pneumonia. The Quarterly Minimum Data Set (MDS) assessment, dated 5/18/21, indicated the resident was alert and oriented. She needed limited assistance with 1 person physical assist with bed mobility, transfers, dressing and toilet use. A Care Plan, dated 4/30/21, indicated the		completed 3 times a week for 4 weeks. Then 2 times weekly for 3 months. Any deficiencies will be corrected immediately. ·Nursing staff has been in-serviced on proper oxygen set-up: O2 rate, correct concentrator set-up, checking the functionality of humidification bottles, proper dating of oxygen tubing and proper documentation of respiratory services provided on the resident's medical record. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for 5 Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. Dates when corrective action will be completed: June 25, 2021 1.	

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	155653	A. BUILDING 00 B. WING	06/11/2021

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	resident was at risk for a complication of COPD. The approach was to wear oxygen as ordered. Physician's Orders, dated 5/3/21, indicated may apply oxygen per nasal cannula 2 liters per minute as needed for shortness of breath or if oxygen saturation less than 90%. The Medication Administration Record (MAR) for 5/2021, indicated the resident's oxygen saturations were checked every shift and there were none below 90%. The 6/2021 MAR, indicated all of the oxygen saturation levels checked were greater than 90%. Interview with the Director of Nursing on 6/10/21 at 10:00 a.m., indicated the humidification bottle was empty on 6/7/21 and not dated, nor was the oxygen tubing. She indicated the resident will dip below 90% with her oxygen saturation if she did not have any on, so she would get the order changed for continuous oxygen. 3. On 6/7/21 at 11:50 a.m. and 2:30 p.m., Resident 45 was observed sitting on the side of his bed. At that time, he was wearing oxygen per nasal cannula at 4 liters per minute. The humidification bottle on the concentrator was empty. The oxygen tubing was not dated. The record for Resident 45 was reviewed on 6/9/21 at 11:45 a.m. Diagnoses included, but were not limited to, left side rib fractures, COPD (chronic obstructive pulmonary disease), anxiety, and acute respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 5/17/21, indicated the resident			

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	was alert and oriented. The resident needed supervision with set up only for personal hygiene and received oxygen while a resident. The Care Plan, dated 5/17/21, indicated the resident was at risk for impaired gas exchange related to respiratory failure and COPD. The approach was to provide oxygen as ordered. Physician's Orders, dated 5/3/21, indicated oxygen per nasal cannula at 4 liters continuously. Physician's Orders, dated 4/29/21, indicated to change oxygen tubing and mask or cannula weekly and date tubing and mask. Interview with the Director of Nursing on 6/10/21 at 10:00 a.m., indicated the humidification bottles and oxygen tubing were to be changed weekly and dated when changed. 4. On 6/8/21 at 9:52 a.m., Resident 211 was observed in bed. Her oxygen concentrator was set at 3.5 liters per minute and her oxygen tubing was not dated. On 6/9/21 at 10:26 a.m., the resident was observed in bed. Her oxygen concentrator remained at 3.5 liters per minute and her tubing remained undated. The record for the resident was reviewed on 6/8/21 at 4:11 p.m. She was admitted on 5/28/21. Diagnoses included, but were not limited to, edema, lack of coordination, diabetes, obesity, bacteria pneumonia, and acute respiratory failure. A Care Plan, dated 6/1/21, indicated she was at risk for impaired gas exchange. The interventions included, but were not limited to,			

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	administer oxygen as prescribed or per standing order. The June 2021 Physician's Order Summary (POS) indicated the resident was to receive oxygen at 4 liters. Interview with the Director of Nursing on 6/10/21 at 4:05 p.m., indicated the resident's oxygen rate should have been set as ordered and her oxygen tubing should have been dated. 3.1-47(a)(6)			
F 0730 SS=D Bldg. 00	483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). Based on record review and interview, the facility failed to ensure performance reviews for every nurse aide were completed at least once every 12 months for 3 of 3 records reviewed for annual performance reviews. Finding includes: The Employee Files were reviewed on 6/11/21 at 9:10 a.m., the following was not completed: 1. CNA 4, hired on 12/26/13, no annual performance review. 2. CNA 5, hired on 8/3/17, no annual performance review. 3. CNA 6, hired on 10/12/12, no annual	F 0730	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.*	06/25/2021

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	performance review. Interview with the Healthcare Manager on 6/11/21 at 1:32 p.m., indicated the above CNAs did not have annual performance reviews. 3.1-14(h)		**F 730 Nurse Aide Perform Review-12 hr/yr In-service** It is the policy of the facility to complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·No resident was affected by this deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·No residents have the potential to be affected as no resident was affected by this deficient practice. However, facility recognizes that annual performance evaluation contribute to increase job satisfaction and high customer service satisfaction. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. 1. ·A tool will be developed to audit Certified Nursing Aides with no annual performance review. This will be completed by Human	

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			Resource Department and discuss schedule of reviews with Director of Nursing. ·Nursing aides: C.N.A 4, C.N.A 5, and C.N.A 6 will be evaluated by completion date of June 25, 2021. ·A 1:1 in-service will be provided to Human Resource Director and Director of Nursing by the Facility Administrator to ensure that annual performance reviews are scheduled and conducted annually. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction audit will be reported by the Administrator to the Quality Assurance Committee and reviewed by the Committee per Month for 5 Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. Dates when corrective action will be completed: June 25, 2021	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General.			

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	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure insulin was given as ordered and blood sugars were monitored, as well as medications not being held per blood pressure parameters for 2 of 5 residents reviewed for unnecessary medications. (Residents 4 and 45) Findings include: 1. Interview with Resident 4 on 6/8/21 at 9:41 a.m., indicated he did not receive his insulin on a consistent basis. The record for Resident 4 was reviewed on 6/8/21 at 2:46 p.m. Diagnoses included, but were not limited to, type 2 diabetes with hyperglycemia (high blood sugar), peripheral	F 0757	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 757 Drug Regimen is Free from Unnecessary Drugs**	06/25/2021

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	vascular disease and cellulite of the left lower limb. The Quarterly Minimum Data Set (MDS) assessment, dated 4/8/21, indicated the resident had received insulin injections 7 times within the assessment reference period. The Care Plan, dated 5/25/21, indicated the resident was at risk for complications related to diabetes. Interventions included, but were not limited to, administer medications as prescribed and evaluate blood glucose level per ordered frequency. A Physician's Order, dated 4/26/21, indicated the resident was to receive Flatus insulin 33 units at bedtime and Homology insulin 24 units with meals. A Physician's Order, dated 5/1/21, indicated the resident's blood sugar was to be monitored before meals and the physician was to be notified if the blood sugar was below 60 or above 400. The Medication Administration Record (MAR), dated 5/2021, indicated there was no documentation of the resident's Homology insulin administration on 5/8 at 8:00 a.m. and 12:00 p.m., 5/10 at 6:00 p.m., 5/14 at 12:00 p.m., 5/17 at 6:00 p.m., 5/19 at 12:00 p.m., and 5/23/21 at 12:00 p.m. The resident's Flatus insulin was not signed out as being given on 5/10 and 5/17/21 at 8:00 p.m. The 5/2021 MAR also indicated the resident's blood sugar was not checked on 5/5 at 7:30 a.m. and 11:30 a.m., 5/10 at 5:30 p.m., 5/14 at 11:30 a.m., 5/17 at 5:30 p.m., and 5/19/21 at 11:30 a.m.		It is the facility policy to ensure that each resident's drug regimen is free from unnecessary drugs. **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·R4's Insulin order was reviewed and verified with MD. R4 received scheduled Insulin and was monitored for any hypo/hyperglycemia. ·R4's Midodrine order was reviewed. Blood pressure obtained prior to administration of Midodrine. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents receiving meds may have the potential to be affected by the same deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·An audit tool will be developed to ensure that Insulin are administered and signed off in EMAR. At least five random residents will be selected per audit. This will be completed 3 times a week for 4 weeks. Then 2 times a week for 5 months. ·An audit tool will be developed	

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	The 6/2021 MAR, indicated the resident's Homology was not signed out as being given on 6/4/21 at 12:00 p.m. Interview with the Director of Nursing on 6/10/21 at 4:05 p.m., indicated the resident's insulin should have been signed out as ordered as well as the blood glucose monitoring completed and documented. 2. The record for Resident 45 was reviewed on 6/9/21 at 11:45 a.m. Diagnoses included, but were not limited to, high blood pressure, type 2 diabetes, COPD (chronic obstructive pulmonary disease), anxiety, diabetic neuropathy, and acute respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 5/17/21, indicated the resident was alert and oriented. The resident needed supervision with set up only for personal hygiene and the activity of bathing did not occur in the assessment reference period. In the last 7 days the resident received the medication of insulin 6 times and received oxygen while a resident. The Care Plan, dated 5/17/21, indicated the resident had Diabetes Mellitus and was at risk for adverse effects of hypo/hyperglycemia (low and high blood sugar). The approaches were to provide diabetes medication as ordered by doctor and monitor/document for side effects and effectiveness. A Care Plan, dated 5/17/21, indicated the resident had hypertension and was at risk for complications. The approaches were to give antihypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension (low blood pressure) and increased heart rate.		to ensure that all medications are administered and signed off in the EMAR. At least 5 random residents will be selected per audit. this will be completed 3 a week for 2 weeks then 2x a week for 6 months. ·Inservice will be provided on the following topic: ·Signing EMAR after administration of Insulin and blood sugar monitoring ·Obtaining blood pressure reading prior to administration of Midodrine. ·all medications with Parameters are monitored and documented. notification of attending physician if results are outside the parapmeters. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained.	

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	Physician's Orders, dated 5/3/21, indicated blood glucose monitoring two times a day. Novolog Insulin Solution 100 units/ml, inject 8 units subcutaneous two times a day for diabetes. Midodrine (a medication to treat low blood pressure) HCl Tablet 2.5 milligrams (mg) 1 tablet by mouth two times a day for hypotension. Hold for blood pressure greater than 120/80. The Medication Administration Record (MAR), dated 5/2021 indicated the Novolog Insulin was not signed out as being administered for the a.m. dose on 5/5, 5/6, 5/11, 5/14, 5/16, 5/23, and 5/28/21 and for the p.m. dose on 5/17 and 5/31/21. There was no documentation on the 5/2021 and 6/2021 MAR or in the vital sign section of the resident's blood pressure being monitored two times a day at 9:00 a.m. and 4:00 p.m. before the medication Midodrine was administered. Interview with the Director of Nursing on 6/10/21 at 10:00 a.m., indicated the resident's blood pressure was to be taken before the administration of the Midodrine. The Novolog Insulin was to be signed out as being administered as ordered by the physician. 3.1-48(a)(3)		Dates when corrective action will be completed: June 25, 2021 1.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in			

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	the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or			

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	prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on record review and interview, the facility failed to discontinue and/or provide a rationale for continued use of an as needed (prn) psychotropic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 43) Finding includes: The record for Resident 43 was reviewed on 6/8/21 at 1:53 p.m. Diagnoses included, but were not limited to, injured cervical spine, COPD (chronic obstructive pulmonary disease), hypertension, diabetes, colostomy, anxiety, paraplegia, insomnia, and pressure ulcers. The Quarterly Minimum Data Set (MDS) assessment, dated 5/14/21, indicated the resident was alert and oriented and required total 1 person physical assistance with bed mobility, transfers, toileting and personal hygiene. She received insulin, anti-anxiety medications, antidepressant medications, antibiotics, and opioids during the past 7 day look back period. A Physician's Order, dated 2/5/21, indicated Xanax (an anti-anxiety medication) 0.5 mg (milligrams) as needed for sleep. The Pharmacy Recommendation, dated 5/1-5/25/21, indicated "please consider Xanax 0.5 mg as needed psychotropic medication in use past 14 days." The choices were to discontinue, add a stop date, or no change (with indication for use and duration). There was no documentation to indicate the	F 0758	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 758 Free from Unnecessary Use of Psychotropic Meds/PRN Use** It is the facility policy to ensure that residents are not gives psychotropic drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·R 43's Xanax 0.5 mg order was reviewed. Pharmacy recommendation to either discontinue or add a stop date or no change was relayed to MD. MD order was obtained.	06/25/2021

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	physician was notified of the recommendation to consider the as needed medication in use for the past 14 days. Interview with the Director of Nursing on 6/10/21 a 4:05 p.m., indicated the physician should have been notified and the medication should not have been in use past 14 days without proper documentation for its use. 3.1-48(a)(2) 3.1-48(a)(4)		1.How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents with order for PRN psychotropic drugs with no stop date past 14 days will have the potential to be affected by this deficient practice. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·An audit tool will be developed to ensure that all PRN psychotropic drugs past 14 days with pharmacy recommendation to discontinue, put a stop date or change order will be relayed to MD for order. After the audit, facility will review new PRN psychotropic drug orders This will be completed 3 times a week for 4 weeks. Then 2 times a week for 5 months. ·Inservice will be provided on the following topic: ·PRN Psychotropic Drug orders should have stop date of 14 days from start date. ·Pharmacy recommendations should be relayed to MD. 1.Quality Assurance Plans to monitor facility performance to	

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	155653	A. BUILDING 00 B. WING	06/11/2021

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			make sure that corrections are achieved and are permanent. ·All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained.	
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; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 1 of 6 residents observed during medication pass. Three errors were observed during 25 opportunities for error during medication administration. This resulted in a medication error rate of 12%. (Resident 45) Finding includes: During medication pass on 6/8/21 at 3:57 p.m., QMA 1 was observed preparing and pouring medication for Resident 45. She removed a hand held inhaler of Proventil HFA Aerosol Solution 108 (90 Base) micrograms (mcg), administer 2 puffs every 6 hours prn (as needed) for wheezing.	F 0759	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 759 Free of Medication Errors**	06/25/2021

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	She also removed another hand held inhaler of Arnuity 100 mcg inhale 1 puff daily. After gathering all of her supplies she entered the resident's room. She handed the Proventil inhaler to the resident and instructed him to take 2 puffs. The resident placed the inhaler in his mouth and pushed down on the dispenser and inhaled 1 puff and he immediately pushed down again and inhaled the second puff. He did not wait in between puffs nor was he instructed by the QMA to wait 1 to 2 minutes in between puffs. The QMA immediately handed him the inhaler of Arnuity. The resident placed it in his mouth and pressed down and inhaled 1 puff. He did not wait any time in between the 2 different inhalers nor was he instructed to wait in between the inhalers. Interview with the QMA at that time, indicated she was unsure about the wait time in between puffs of the same inhaler or between 2 different inhalers. The record for Resident 45 was reviewed on 6/10/21 at 9:15 a.m. Physician's Orders, dated 5/3/21, indicated Arnuity Ellipta Aerosol Powder Breath Activated 100 mcg (Fluticasone Furoate), 1 inhalation orally one time a day. Symbicort Aerosol 160-4.5 mcg 2 inhalations orally two times a day. Proventil HFA Aerosol Solution 108 (90 Base) mcg, 2 puffs inhale orally every 6 hours as needed (prn) for wheezing The Medication Administration Record (MAR), dated 6/2021, indicated the Arnuity was scheduled daily for morning pass, the Symbicort was scheduled for morning and evening pass, and Proventil was only prn.		It is the facility policy to ensure that medication error rates are not 5 percent or greater. **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·R 45 was assessed for any possible side effects of the medication error committed by QMA1. R46 is in stable condition with no signs and symptoms of possible ill effects from medication error. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents who receives oral inhalers have the potential to be affected by the same deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·QMA 1 was provided with 1:1 education and competency on proper administration of oral inhalation drugs. ·Inservice will be provided on the following topic: ·Proper Administration of Oral Inhalers to include wait time in between puffs and another oral inhaler. ·DON and or nurse	

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	155653	A. BUILDING 00 B. WING	06/11/2021

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	The current 10/25/14 "Oral Inhalation Administration" policy, provided by the Director of Nursing (DON) on 6/10/21 at 12:29 p.m., indicated if another puff of the same or different medication was required, wait at least 1 to 2 minutes between. Interview with the DON at that time, indicated the QMA should have waited in between puffs and she was aware she had administered the wrong inhaler. 3.1-48(c)(1)		manager/pharmacy nurse consultant will observe two random nurses or more twice a week for four weeks on how to properly administer oral inhalers. Then 1 nurse ongoing weekly for a total of 6 months. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction observation audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. Dates when corrective action will be completed: June 25, 2021 1.	
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.			

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	§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, record review and interview, the facility failed to properly store topical medications for 1 of 1 random observations. (Resident 29) Finding includes: On 6/9/21 at 4:08 p.m., during a random observation and interview with Resident 29, three topical medications were observed on his night stand. Moisture barrier, Diphenhydramine/Zinc (an antihistamine topical cream used to treat pain and itching), and Diclofenac (a nonsteroidal anti-inflammatory topical cream used to treat actinic keratoses). Interview at the time with the resident, indicated he used the creams to treat itching and shoulder pain. The record for the resident was reviewed on 6/9/21 at 1:07 p.m. Diagnoses included, but were not limited to, lack of physical exercise,	F 0761	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 761 Label/Store Drugs and Biologicals** It is the facility policy to ensure that drugs and biologicals used must be labeled in accordance	06/25/2021

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	heart failure, hypertension, diabetes, and sepsis. The Admission Minimum Data Set (MDS) assessment, dated 5/7/21, indicated the resident was alert and oriented. He required extensive 1 person physical assistance with bed mobility and transfers. There were no Physician's Orders to indicate the use of the above medications. Interview with the Director of Nursing on 6/10/21 at 4:10 p.m., indicated she was unaware the resident had the topical medications at his bedside. She would look into the concern. 3.1-25(m)		with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·R 29's three topical medications (moisture barrier, Dipenhydramine/Zinc topical cream, and Diclofenac) observed on his nightstand were removed and stored properly with his permission. R29 was in good spirit and not in any form of distress. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents who receives medications in the facility may have the potential to be affected by the same deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·Facility will inspect all resident rooms for medications left at bedside/nightstand, remove, and store properly in medication rooms/carts as appropriate. ·Inservice will be provided on the following topic:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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			·Proper Medication Storage-no medications will be left at bedside/nightstand/resident rooms ·DON or nurse manager will conduct random observation of 2 random rooms for any medications left at resident room/bedside/nightstand. This will be completed 3 times a week for 4 weeks then weekly for 5 months. 1.Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. All plan of correction observation audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns	
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental			

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	services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.			
	Based on record review and interview, the facility failed to provide routine dental services for a resident with complaints related to his teeth for 1 of 1 residents reviewed for dental services. (Resident 28)	F 0791	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies.*	06/25/2021

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	Finding includes: The record for Resident 28 was reviewed on 6/10/21 at 10:10 a.m. Diagnoses included, but were not limited to, malignant neoplasm of the esophagus, hypertension, ataxia (loss of control of body movements), depression, anxiety, dementia with behaviors, and psychotic disorder with delusions. The Annual Minimum Data Set (MDS) assessment, dated 5/6/21, indicated the resident was severely cognitively impaired for decision making, required supervision with bed mobility, had no swallowing disorders, no dental concerns, and experienced a weight loss not prescribed by a weight-loss regime. A Nutrition/Dietary Note, dated 5/12/21 at 3:08 p.m., indicated the resident's family member was questioning if he could be seen by a dentist, he had complaints related to his teeth causing him not to eat. The writer indicated she would notify Social Services to schedule a dental evaluation. Interview with the Social Worker and the Designee on 6/10/21 at 3:50 p.m., indicated they were not notified of the concern from the resident's family member related to scheduling a dental evaluation. 3.1-24(a)(1)		*The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 791 Routine Emergency Dental Services** It is the facility policy to assist residents in obtaining routine and 24-hour emergency dental care. **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·R 28 was assessed for oral care and pain. Pain was managed. Dental appointment was scheduled by the facility for 6/29/21. 1.How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents with teeth have the potential to be affected by the same deficient practice. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·Facility monitoring will include completion of routine requested	

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	155653	A. BUILDING 00 B. WING	06/11/2021

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			dental care and will identify residents who have dental care needs. Appropriate nursing assessments and pain management will be performed. MD and Family/POA will be notified, Dental services/appointment will be scheduled. DOB or designee will do at least 5 random residents per audit 2X weekly. this will be completed for 4 weeks then 2 random residents per week for 6 months. ·Inservice will be provided on the following topic: ·Proper notification to social worker/nurse for any dental consult needed due to teeth pain. Scheduling of dental appointment timely to address resident's teeth discomfort. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction observation audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for 5 Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained.	

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	155653	A. BUILDING 00 B. WING	06/11/2021

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			Dates when corrective action will be completed: June 25, 2021 1.	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure food was palatable and served at an appetizing temperature for 5 of 8 residents reviewed for food. (Residents 4, 10, 12, 45, and 47) Finding includes: On 6/8/21 at 9:36 a.m., Resident 4 indicated the food did not taste good and it was served cold. On 6/7/21 at 10:53 a.m., Resident 10 indicated the food was bland and it was served cold. Interview with Resident 12 on 6/7/21 at 2:20 p.m., indicated the eggs were cold in the morning. Interview with Resident 45 on 6/7/21 at 11:47	F 0804	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 804 Nutritive Value/Appear, Palatable/Prefer Temp** It is the policy of the facility to	06/25/2021

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	a.m., indicated the food was horrible and cold. On 6/7/21 at 10:21 a.m., Resident 45 indicated the food was always cold. On 6/10/21 at 9:04 a.m., a test tray was obtained. The scrambled eggs were 101.4 degrees Fahrenheit and the cinnamon raisin toast was soggy in appearance. Interview with Resident 4 on 6/10/21 at 9:06 a.m., indicated the cinnamon toast was just warm bread, not toasted, and the eggs were luke warm. He indicated breakfast wasn't very good. Interview with Resident 10 on 6/10/21 at 9:10 a.m., indicated the eggs weren't that warm but he ate them anyway and the bread was barely warm. When informed about the eggs being cold on 6/10/21, the Dietary Cook had no comment. Interview with the Director of Nursing on 6/11/21 at 3:30 p.m., indicated the eggs should have been warmer. 3.1-21(a)(2)		ensure that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor and appearance. Food and drink are palatable, attractive, and at a safe and appetizing temperature, **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·R4 was satisfied with taste and temperature of food served during next meal and at breakfast. ·R 10 was satisfied with taste and temperature of food served during next meal. ·R12 was satisfied with temperature of eggs served during breakfast. ·R45 was satisfied with taste and temperature of food served during next meal. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents who receive food and nutrition in the facility will have the potential to be affected of the same deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. 1. ·An observation tool will be	

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	155653	A. BUILDING 00 B. WING	06/11/2021

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			developed to test appearance, food temperature and palatability during mealtimes. This observation will be conducted by the Administrator on five different meals weekly for two weeks. . ·A 1:1 in-service will be provided to Dietary Manager on nutritive value/appearance, palatability and preferred temperature of food ·In-service will be provided to all dietary and nursing staff who prepares and serve meal trays to ensure that food temperature is maintained when it is served and food is presentable and palatable when served. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. Administrator will conduct observation on five different meals to check on food temperature, palatability, and appearance. This observation will be conducted by the Administrator on five different meals weekly for 4 weeks. Then 2 meals weekly for 3 months. ·All plan of correction observation tool will be reported	

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	155653	A. BUILDING 00 B. WING	06/11/2021

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			by the Administrator to the Quality Assurance Committee and reviewed by the Committee per Month for 5 Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. Dates when corrective action will be completed: June 25, 2021 1.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (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.			

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	155653	A. BUILDING 00 B. WING	06/11/2021

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure food was stored, prepared, and served under sanitary conditions related to an accumulation of ice build-up in the reach in cooler, an accumulation of calcium build-up in the ice machine, debris in the utensil holder, crumbs and dried substances in the hot plate holder, debris on the floors of the walk-in refrigerator and freezer, and prepoured cereal bowls with no date, and two 2 tier carts with rusted wheels and dried food substances. This had the potential to affect all 60 residents who received food from the kitchen. (The Main Kitchen) Finding includes: During the Initial Tour of the kitchen with the Dietary Food Manager (DFM) on 6/7/21 at 9:09 a.m., the following was observed: a. The reach in cooler had an accumulation of ice build-up. b. There was an accumulation of calcium build-up in the ice machine. c. The was debris in the utensil holder. d. There were crumbs and dried substances in the hot plate holder. e. There was debris on the floors of the walk-in refrigerator and freezer. d. There were 6 bowls of prepoured cereal stored in the dry food storage area with no date.	F 0812	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 812 Food procurement Store/prepare/Serve-Sanitary** It is the policy of the facility to procure food from sources approved or considered satisfactory by federal, state or local authorities. **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·No resident was affected by this deficient practice. 1.How the facility will identify other residents having the potential to be affected by the same deficient practice. ·This had the potential to affect all 60 residents who receive food	06/25/2021

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	e. There were two, 2 tier carts with rusted wheels and dried food substances. Interview at the time with the DFM, indicated the above was in need of cleaning. 3.1-21(i)(3)		from the kitchen. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·The reach in cooler was defrosted and cleaned. ·The calcium build-up in the ice machine was removed and ice machine cleaned. ·The debris from the utensil holder was removed and utensil holder cleaned. ·The crumbs and dried substances in the hot plate holder were removed and hot plate holder cleaned. ·Debris on the floors of the walk-in refrigerator and freezer were removed and floors cleaned. ·The cereal content in a bowl identified was discarded and replaced with one that was dated. ·The two-tier carts with rusted wheels and dried food substances were cleaned. ·In-services were provided to dietary staff, including dietary manager on food safety requirements that include procurement of food from approved sources, proper storage, preparation, distribution, and sanitation of kitchen. ·Dietary consultant and or Administrator will conduct observation of the kitchen to cover	

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			sanitation and proper storage of food at least three times weekly for 4 weeks. Then 2 times weekly for 5 months. 1.Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction observation tool will be reported by the Administrator and or Dietary Consultant to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. 1.Dates when corrective action will be completed: June 25, 2021	
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, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to hand hygiene not completed after direct resident contact and glove removal, not wearing the appropriate personal protective equipment (PPE) while doing COVID-19 testing and for completing an aerosol breathing treatment, and not monitoring for COVID-19 signs and symptoms while in transmission based precautions for 1 of 2 COVID-19 testing observations, 3 of 6 medication pass observations, and 1 of 2 residents in transmission based precautions. (LPN 1, Residents 45, 4, and 211) Findings include: 1. On 6/7/21 at 11:23 a.m., LPN 1 was asked by Dietary Cook 1 to perform a rapid COVID-19	F 0880	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F880 Infection Control** **Corrective actions which will be accomplished for those residents found to have been**	06/25/2021

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	test on him. The LPN donned a pair of clean gloves without performing hand hygiene. She opened the swab and placed it in the employee's nose and then placed it in a Binax Now rapid test card and laid it on the nurses' station counter. The LPN was not wearing a N95 face mask or face shield when she obtained the specimen. She did not clean the counter top of the nurses' station before placing the specimen on the counter. After she had obtained the sample, with her gloved hands she picked up her pen and wrote on the Binax card and then placed the box of test kits back under the shelf with the same gloved hands she had used to test with. She removed the gloves and left the station. She returned minutes later and with her ungloved hands she picked up the Binax card with the swab and specimen in place and walked down the hallway. Interview with the Director of Nursing on 6/10/21 at 2:00 p.m., indicated the nurse should have worn the correct PPE while doing COVID-19 testing. She should not have placed the Binax card on top of the nurses' station or carried it out of the station without gloves on. 2. During medication pass on 6/8/21 at 3:57 p.m., QMA 1 was observed preparing medication for Resident 45. At that time, she indicated she needed to check the resident's blood sugar with the glucometer. She removed the glucometer from the medication cart, a lancet, and the bottle of strips and entered the resident's room. She administered his oral medications first and then, without performing hand hygiene, she wiped the resident's finger with an alcohol wipe. She did not donn a pair of clean gloves to either hand. She pricked his finger and obtained the blood on the strip that was already inserted in the glucometer machine. After the reading was		**affected by the deficient practice:** ·There was no noted spread infection and communicable diseases. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents have the potential to be affected by the same deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·An audit tool will be developed to ensure that proper infection control observation is in place to control and prevent spread of infection. At least 2 staff members will be selected per audit. This will be completed 3 times a week for 4 weeks. Then 2 times for 5 months. Any deficiencies will be corrected immediately. ·Nursing staff has been in-serviced on the infection control policy including but not limited to: 1.Hand hygiene before and after donning and doffing of gloves. 2.Wearing of appropriate personal protective equipment (PPE) when administering aerosol generating procedures, when rendering care of residents that	

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	obtained, she picked up her supplies and walked out of the room. She threw the used lancet into the garbage can and placed the machine on top of the medication cart. She started to open the medication cart and was immediately stopped and asked to perform hand hygiene before she proceeded. Interview with QMA 1 at that time, indicated she was aware she was to wear gloves when performing a glucometer. She was also aware the lancet was to be placed in the sharps container. On 6/9/21 at 1:15 p.m., the resident was seated in his wheelchair in his room. At that time, he was observed holding a hand held nebulizer and facing towards the wall next to his bed. The room door was open and there was no staff observed in his room. Interview with the Assistant Director of Nursing on 6/9/21 at 1:42 p.m., indicated she did not wear full PPE (N95 face mask, an isolation gown or a face shield) to set the resident up for the nebulizer treatment and when she disconnected the nebulizer treatment. She wore a surgical face mask in his room. The record for the Resident 45 was reviewed on 6/9/21 at 11:45 a.m. The resident was fully vaccinated with the first COVID-19 dose on 1/6/21 and the second on 2/3/21. An Indiana Department of Health (IDOH) document, dated 6/1/21 and titled, "Long-term Care Facilities Guidelines in Response to COVID-19 Vaccination," indicated, " .... Staff providing direct care within six feet of the resident while AGP [Aerosol Generating		are on TBP (transmission based precautions) and when performing covid testing. 3.Observance of proper infection control while performing blood glucose check Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction audit will be reported by the Director of Nursing and or ADON to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. Dates when corrective action will be completed: June 25, 2021 **Directed Plan of Correction** F880 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute any admission of guilt or liability by the facility and is submitted only on	

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	Procedure] is in progress should wear full PPE including N-95 mask and eye protection for all types of scenarios ...." 3. On 6/8/21 at 4:13 p.m., LPN 2 was observed checking Resident 4's blood sugar by the way of a glucometer. He donned a pair of clean gloves to both hands, wiped the resident's finger with an alcohol wipe and pricked the finger with the lancet and obtained his blood. He discarded the gloves in the trash can and did not perform hand hygiene. LPN 2 prepared an insulin injection for the resident. He donned a pair of clean gloves to both hands and removed the vial from the medication cart. He drew up 24 units of insulin and administered it to the resident. Interview with LPN 2 at that time, indicated he was aware hand hygiene was to be performed after glove removal. 4. During medication pass on 6/10/21 at 8:38 a.m., RN 1 was observed preparing medication for Resident 211. After pouring all of her medications she entered the resident's room with her pills, the glucometer, and the blood pressure machine. The RN donned a pair of clean gloves to both hands without performing hand hygiene. She checked the resident's blood sugar and then with the same gloved hands, she placed the blood pressure cuff on the resident's arm. She then administered the medications to the resident. The RN left the room to get a pair of scissors to cut off an arm bracelet from the hospital on the resident's arm. She removed her gloves and did not perform hand hygiene. She came back into the room and donned another pair of clean gloves, again without performing hand hygiene, and took the arm band off and checked the resident's blood pressure and pulse.		response to the regulatory requirements. 1.Staff received education from Assurance with links to pertinent CDC guidance on Covid 19. The following links included: Clean Hands - https://youtu.be/xmYMUly7qiE Lessons - https://youtu.be/YYTATw9yav4 2.The Infection Preventionist, Director of Nursing in conjunction with the Medical Director and senior leadership completed policies related to the development and implementation of the following: ·Develop and implement procedures to allow visitors into the facility as per CDC & ISDH guidelines. ·At the door symptom check, symptom check for all essential employees, vendors and others before entering the facility ·Develop and implemented procedures for screening of all staff at the beginning of their shift, mid shift and end of their shift for fever, respiratory symptoms. This includes actively measuring and recording staff temperatures and assessment of shortness of breath, new or changed cough, and sore throat.	

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	Interview with RN 1 on 6/10/21 at 2:10 p.m., indicated she was aware she was supposed to perform hand hygiene after glove removal. The current 12/31/20 "Hand Hygiene" policy, provided by the Director of Nursing on 6/10/21 at 12:30 p.m., indicated use alcohol based hand sanitizer or wash hands with soap and water after touching a patient and immediately after glove removal. 5. The record for Resident 211 was reviewed on 6/8/21 at 4:11 p.m. She was admitted on 5/28/21. Diagnoses included, but were not limited to, edema, lack of coordination, diabetes, obesity, bacteria pneumonia, and acute respiratory failure. The Admission Evaluation Assessment, dated 6/8/21, indicated the resident was alert and oriented. Physician's Orders, dated 5/28/21, indicated contact and droplet isolation related to new admission/re-admission, end date 6/8/21, and "COVID-19 monitoring (+/-) Loss of smell, fatigue, GI upset, SOB, Cough, Decreased appetite. Document: + = Symptoms present (add note) - = Symptoms absent, every shift." The June 2021 Treatment Administration Record (TAR), indicated no COVID-19 monitoring on the following dates: Days: 6/1 and 6/5/21 Evenings: 6/7/21 Nights: 6/1, 6/3-6/6/21 Interview with the Director of Nursing on 6/10/21 at 4:05 p.m., indicated the resident should have been assessed and monitored for		·Remind residents to practice social distancing and perform frequent hand hygiene. ·Educate and assist the resident to utilize an appropriate mask to reduce droplet spread. ·Coordinate with medical provider to obtain necessary testing to identify cause of symptoms. **1.Root Cause Analysis:** ***Problem statement*** Staff failed to perform hand hygiene before entering and after exiting rooms and proper donning and doffing of PPE ***Why?*** Lack of staff training. ***Why?*** Lack of supervised return observations ***Why?*** Staff trying to rush through assignments ***Why?*** Accessibility of hand sanitizer dispensers ***Root Cause(s)*** 1. Staff education on proper hand hygiene 2. Making hand sanitizer more accessible 3. Staff education of proper	

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	COVID-19 symptoms every shift as ordered. 3.1-18(b)		donning and doffing of PPE To validate root causes, ask the following: If you removed this root cause, would this event or problem have been prevented? **1.Implemented system changes:** ·Increase routine in-servicing of staff on Infection control prevention basics including but not limited to hand hygiene, mask, gloves, gown, utilizing proper PPE for transmission based precautions. ·Increase routine return demonstration for hand hygiene and proper PPE use ·Develop and implement infection signs and symptom tracking tool to monitor all residents and staff for communicable, respiratory infections. All nursing leaders will be educated on how to use the tool. ·Staff involved were educated (with return demonstration) for hand washing and ABHS and have an understanding on when to perform HH, that handwashing with soap and water will be performed when	

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			hands are visibly soiled or the use of ABHS as appropriate. ·All staff will receive education on using PPE related to droplet precautions. Education will include demonstration and knowledge check testing. 1.Monitoring: Monitoring of approaches to ensure infections are controlled will include: ·The Facility will ensure adequate supplies of PPE are readily available to all staff ·The Infection Preventionist and/or the Director of Nursing, each day and more often as necessary, will review infection prevention tracking and trending. Any unexpected increases in infection will result in communication with the Medical Director, Public Health Department and the state survey agency in order to obtain further assistance to control infection. Such monitoring will continue until the facility has been infection free for at least four weeks. ·The Infection Preventionist, Director of Nursing and other nursing leadership will conduct Daily rounds throughout the facility to ensure staff are exercising appropriate use of PPE and to ensure infection control procedures are followed for 6 weeks.	

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			·The facility conducted RCA with the help of the Infection Preventionist. 1.The facility through QAPI program will review, update, and make changes to the DPOC as needed for substantial compliance for no less than 6 months. Completion date: **6/25/21** 1.	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to rust, missing base boards, chipped paint, marred walls and doors, dried food spillage on walls, holes in walls, and loose heat registers for 2 of 2 units. (The First and Second floors) Findings include: During the Environmental Tour with the Housekeeping and Maintenance Supervisors on	F 0921	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please*	06/25/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	6/11/21 at 11:29 a.m., the following was observed: 1. The First floor: a. The wall next to bed 1 in Room 103 was marred and had an accumulation of dried food spillage. The wall behind the head of the bed for bed 1 also had dried food spillage. The bathroom walls and doors were also marred. Two residents resided in the room and 3 residents shared the bathroom. b. The base of the closet doors in Room 104 had areas of chipped paint. The bathroom walls and doors were also marred. One person resided in the room and 3 residents shared the bathroom. c. The cover for the heat register in Room 107 was loose and pulled away from the wall. One resident resided in the room. d. The base board in the bathroom of Room 108 was peeling away from the wall near the toilet. Two residents shared the bathroom. e. The bathroom sink in Room 109 was pulling away from the wall. The sink was being propped up with two pieces of wood There were rust stains on the wall underneath the bathroom sink. One resident used the bathroom. f. The door frame in Room 116 was marred along with the walls. One resident resided in the room. g. The walls in Room 119 were scratched and marred. The bathroom door was also hard to open. One resident resided in this room and used the bathroom.		*find enclosed this plan of correction for this survey.* **F 921** **Safe/Functional/sanitary/Comfo rtable Environment** It is the policy of the facility to provide a safe, functional, sanitary, and comfortable environment for resident's, staff and the public. **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·No resident was affected by this deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents residing in the facility have the potential to be affected by the deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. 1. ·The wall next to bed 1 in Room 103 that was marred and had an accumulation of dried food spillage was cleaned. ·The base of the closet doors in Room 104 had areas of chipped paint. Area was fixed and	

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	155653	A. BUILDING 00 B. WING	06/11/2021

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	h. The walls in Room 121 were marred as well as the bathroom door and door frames. Two residents resided in the room and 2 residents used the bathroom. i. There was a large hole behind the door in Room 123. Two residents lived in this room. j. The walls in Room 125 were marred as well as the closet door and door frame. One resident resided in this room. 2. The Second floor: a. There were sections of missing base board in the bathroom of Room 204. Three residents shared the bathroom. b. The base board heat register cover was hanging off in Room 209. Two residents resided in this room. c. There were areas of peeling paint and missing base boards in Room 226. One resident resided in the room. Interview with the Housekeeping Supervisor at the time, indicated all of the above areas were in need of cleaning and/or repair. 3.1-19(f)		repainted. ·The bathroom walls and doors in Room 104 was marred. The walls and doors were repaired. ·The cover for the heat register in Room 107 was loose and pulled away from the wall. Cover was tightened and appropriate repair was done. ·The base board in the bathroom of Room 108 was peeling away from the wall near the toilet. This has been inspected and repaired. ·The door frame in Room 116 was marred along with malls. This has been repaired. ·Two walls in Room 119 were scratched and marred. This was repaired. ·The bathroom door that was hard to open in Rm 119 was repaired. ·The walls in Room 121 were marred as well as the bathroom door and door frames. This was repaired. ·There was a large hole behind the door in Room 123. This was inspected and repaired. ·The walls in Room 125 were marred as well as the closet door or door frame. This was inspected and repaired. ·The base board heat register cover was hanging off in Room 208. This was inspected and fixed. ·The areas of peeling paint and missing base boards in Room 224	

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			was fixed and base boards replaced. ·1:1 Inservice was provided to Housekeeping/Maintenance Director on addressing and managing environmental conditions that should be safe, functional, sanitary, and comfortable for residents, staff, and public. Inservice will include system for staff to report timely any environmental/maintenance issues that need repair. ·Inservice will be provided to all staff to ensure timely reporting of any repair/maintenance/environmental issues to housekeeping director and or Administrator. ·Administrator will facilitate system to report areas in the facility that need repair and will in-service staff on how and when to report maintenance and environmental issues. ·Administrator will ensure all areas identified during survey were fixed and repaired and will conduct environmental rounds twice weekly for four weeks with Housekeeping/Maintenance Director. Then weekly for 5 months. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction environmental rounds tool will be reported by the Administrator and	

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			Housekeeping/Maintenance Director to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. Dates when corrective action will be completed: June 25, 2021 1.	
F 0925 SS=F Bldg. 00	483.90(i)(4) Maintains Effective Pest Control Program §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. Based on observation and interview, the facility failed to maintain an effective pest control program to ensure the facility was free from pests and rodents related to live ants and roaches in the kitchen. This had the potential to affect 60 of the 60 residents who resided in the facility and received food from the kitchen. (The Main Kitchen) Finding includes: During the Initial Tour of the Kitchen on 6/7/21 at 9:09 a.m., with the Dietary Food Manager (DFM), the following was observed: There were 2 live roaches crawling on the floor of the kitchen. There were also small ants crawling on the floor. They were not near any	F 0925	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 925 Maintains Effective Pest Control Program**	06/25/2021

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	food, clean dishes, or food prep equipment. Interview at the time with the DFM, indicated the kitchen had recently been sprayed for pests last week. Interview with the Administrator on 6/9/21 at 3:00 p.m., indicated when the roaches and ants were first noted on June 1st, the pest control company was called out to spray. This was the first time any bug activity had been observed. Pest control was out previously in December 2020 for preventative maintenance with no bugs noted. The pest control company came back out on either June 7 or June 8th and sprayed again. The kitchen was also being deep cleaned on the night shift and the base boards were being removed due to that helping in the past. Interview with the Dietary Cook on 6/11/21 at 11:30 a.m., indicated when pest control sprays, the pests come out into an open area to die. 3.1-19(f)(4)		It is the policy of the facility to maintain an effective pest control program so that the facility is free of pests and rodents. **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·No resident was affected by this deficient practice. 1.How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents residing in the facility have the potential to be affected by the deficient practice. 1.The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·Kitchen was cleaned. Pest Control was called for inspection and elimination of the infestation. ·1:1 Inservice will be provided to Dietary Manager and Housekeeping/Maintenance Director on managing kitchen sanitation. ·Inservice will be provided to all staff to maintain cleanliness of the environment and reporting immediately any observation of pest infestation.	

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			·An observation tool will be developed to check the kitchen for any pests. This observation will be conducted twice weekly for four weeks and issues identified will be addressed immediately. Then weekly for 5 months. Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction observation tool will be reported by the Administrator , Dietary Manager and Housekeeping/Maintenance Director to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. Dates when corrective action will be completed: June 25, 2021	
F 9999 Bldg. 00	3.1-14 PERSONNEL (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall include, but not be limited to, the following: (1) Residents' rights.	F 9999	*Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is*	06/25/2021

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	(5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure annual resident rights, abuse training, and dementia training was completed for 5 of 5 employee records reviewed. (LPN 1, Dietary Cook 2, CNA 7, Housekeeper 1, and the Social Service Designee) Finding includes: The employee records were reviewed on 6/11/21 at 3:45 p.m., and indicated the following: - LPN 1, who was hired on 8/11/16, had no documentation indicating she had received her annual resident rights and abuse inservices. The LPN had also not received 3 hours of annual dementia training. - Dietary Cook 2, who was hired on 1/22/19, had no documentation indicating she had received her annual resident rights inservice. - CNA 7, who was hired on 4/28/17, had no		*prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey.* **F 9999 1.1-14 PERSONNEL** It is the facility policy to conduct an organized ongoing in-service education and training program planned in advance for all personnel. This training shall include nut not limited to, the following: 1.Resident's Rights 1.Needs of specialized populations served 2.Care of cognitively impaired residents **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** ·No resident was affected by this deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice. ·All residents who receives care and services from staff required to complete training in the facility may have the potential to be affected by the deficient practice. The measures the facility will take	

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	documentation indicating she had received her annual resident rights and abuse inservices. - Housekeeper 1, who was hired on 12/31/19, had no documentation indicating he had received his annual resident rights and abuse inservices. The Housekeeper had also not received 3 hours of annual dementia training. - The Social Service Designee, who was hired on 2/28/17, had no documentation indicating he had received his annual resident rights inservice. Interview with the Administrator on 6/11/21 at 4:00 p.m., indicated she thought the above training had been completed on "Relias" but they couldn't access the system since they changed corporations.		or systems the facility will alter to ensure that the problem will be corrected and will not recur. ·1:1 in-service was provided to HR and Administrator of the training required annually. ·Facility Administrator will work with Human Resource Director and Director of Nursing to implement a training program to cover required training and in-services for staff. This will include a training process for new hire and other staff annually. The new hire training will be incorporated on the onboarding and new hire orientation schedule and annual training will be part of the Facility's Annual Skills Fair for Staff. Dementia Management Training will be offered at least twice a year in the facility and the operator will review available online learning programs that may be utilized by staff for online learning and education. ·Facility provided the required training for the sampled staff during the health inspection survey: ·LPN1-Completed Residents rights and abuse in-services. Dementia training has been scheduled. ·Dietary Cook 2-completed annual residents rights in-service ·C.N.A 7 completed annual resident rights and abuse in-services ·Housekeeper 1 completed	

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			annual resident rights and abuse in-services. Annual Dementia training has been scheduled. ·Social Service Designee completed his annual resident rights in-service Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent. ·All plan of correction will be reported by the Administrator and HR to the Quality Assurance Committee and reviewed by the Committee per Month for four Months and recommendations given in order to assist in ensuring that the facility stay in compliance and if concerns are identified the Quality Assurance Committee will add on additional Months until Compliance is sustained. Dates when corrective action will be completed: June 25, 2021 1.	