STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155775	A. BUILDING 00 B. WING	03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CUMBERLAND POINTE HEALTH CAMPUS	1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Complaints IN00402470 and IN00401817. This visit included a State Residential Licensure Survey. Complaint IN00402470 - Federal/State deficiencies related to the allegations are cited at F725. Complaint IN00401817 - Federal/State deficiencies related to the allegations are cited at F677 and F725. Survey dates: February 27, 28 and March 1, 2, 3, 6 and 7, 2023. Facility number: 000547 Provider number: 155775 AIM number: 100267440 Census Bed Type: SNF/NF: 37 SNF: 25 Residential: 47 Total: 109 Census Payor Type: Medicare: 15 Medicaid: 25 Other: 22 Total: 62 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on March 15, 2023.	F 0000	The submission of this plan of correction does not indicate an admission by Cumberland Pointe Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Cumberland Pointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Carol Ward	Executive Director HFA	03/30/2023

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

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F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his			

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	or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview and record review, the facility failed to ensure a cognitively impaired resident had the same bed as other residents to prevent the bed frame from being on the floor for 1 of 1 resident reviewed for dignity. (Resident 59) Finding includes: During an observation, on 2/27/23 at 3:48 p.m., Resident 59 was lying in bed. His bed was in such a low position the bed frame was almost touching the floor and the resident appeared to be lying on a mattress on the floor. The record for Resident 59 was reviewed on 3/1/23 at 5:17 p.m. Diagnoses included, but were not limited to, chronic kidney disease stage 3, Alzheimer's disease, age related physical debility and a history of pulmonary embolism. A care plan, dated 2/8/23 and last revised on 2/21/23, indicated the resident was at a risk for falling related to weakness and confusion. The approaches included, but were not limited to, the bed in the lowest position with a mat on the floor. During an observation, on 3/2/23 at 11:28 a.m., the resident was lying in bed in his room. The bed was almost touching the floor and a mat was next to the bedside. During an interview, on 3/2/23 at 11:33 a.m., RN 4 indicated the resident had rolled out of bed and the bed was in the lowest position so if he rolled out of bed he would not get hurt. The lowest position meant to put the bed as low to the floor	F 0550	1. To ensure resident rights are respected, protected, and provide in an environment in which they can be exercised the identified Carroll bed was immediately removed on 3.3.23 and replaced with a newer model. The Carroll bedframe was immediately taken out of service and removed from the property. 2. The residents plan of care includes a preventative measure to place the bed in the lowest position. When the current bedframe is in the lowest position there is an 8-inch space approximately between the bedframe and floor. 3. 100% of existing campus bedframes were immediately evaluated to confirm no other residents would be impacted in the future.	03/07/2023

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	as it would go. RN 4 did not know if the resident could stand from the lowest position of the bed which was almost to the floor. During an observation, on 3/2/23 at 2:33 p.m., the resident was lying in bed in his room and his eyes were closed. The bed appeared like it was on the floor. During an observation, on 3/3/23 at 2:28 p.m., with the Executive Director (ED) and Clinical Support Nurse, the resident's bed was so low it appeared it was on the floor. The ED indicated the intervention for the bed in the low position was not to put the bed frame directly on the floor. During an interview, on 3/3/23 at 2:32 p.m., LPN 8 indicated the resident's bed was very low to the ground. LPN 8 thought the bed was a facility bed. During an interview, on 3/3/23 at 3:35 p.m., the ED indicated the bed was an old facility bed and the Director of Plant Operations had taken the bed out of storage to use since the facility had a full census. During an interview, on 3/3/23 at 3:40 p.m., the Director of Plant Operations indicated the bed was pulled from storage and they tried not to have residents use the bed although they had to use it due to the facility census. During an interview, on 3/6/23 at 4:32 p.m., the Director of Plant Operations indicated the bed Resident 59 was lying in was a Carroll bed. There were probably only two of those beds left in the facility. The bed would raise all the way up and drop low to the floor. The bed frame would sit on the floor. The other beds in the facility would not go as far down to the floor.			

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	A current policy, titled "Resident Rights Guidelines," dated as reviewed on 12/31/22 and received from the Clinical Support Nurse on 3/6/23 at 12:08 p.m., indicated "...To ensure resident rights are respected and protected and provide an environment in which they can be exercised...Residents shall not leave their individual personalities or basic human right behind when they move to a health campus. The following is a list of rights recognized by staff at Trilogy Health Services...Our residents have a right to...Be treated with dignity and respect..." 3.1-3(t)			
F 0552 SS=D Bldg. 00	483.10(c)(1)(4)(5) Right to be Informed/Make Treatment Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or			

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	she prefers. Based on interview and record review, the facility failed to ensure residents who received high risk antipsychotic medication had the risks and benefits reviewed with them and/or their representatives for 2 of 3 residents reviewed for unnecessary medications. (Resident 42 and 51) Findings include: 1. The record for Resident 42 was reviewed on 3/1/23 at 3:12 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbance, psychotic disorder with delusions due to a known physiological condition, depression, and anxiety disorder. A physician's order, dated 6/29/22, indicated to give risperidone (an antipsychotic) 0.25 mg (milligram) twice a day for the psychotic disorder with delusions due to a known physiological condition. During an interview, on 3/2/23 at 4:17 p.m., the Clinical Support Nurse indicated the resident's medications were reviewed during the Resident First Meeting. The Resident First Meeting notes did not include exactly what was reviewed during the meeting or if risks and benefits of the risperidone were reviewed. During an interview, on 3/6/23 at 4:05 p.m., the Social Services Director (SSD) indicated she had not completed teaching or documentation of discussing high risk medication risks versus benefits with any residents/representatives. She was not aware she needed to discuss the risks and benefits and document the information. The Nursing Drug Handbook 2023 indicated	F 0552	1. 1. Residents 42 and 51 were affected. No adverse effects noted. Resident or representative discussed with SSD risks and benefits for high-risk antipsychotic medications. Resident and representative have given consent to administer medications as ordered. 2. All residents who are on high-risk antipsychotic medications have the potential to be affected. Audit completed of all residents that have high-risk antipsychotic medications, ensure that resident and/or representatives are aware of the risk and benefits of high-risk antipsychotic medications. Nurses/SSD to be educated on reviewing risks and benefits of antipsychotic medications with residents or representatives. 3. As a measure of ongoing compliance, the DHS or designee will perform audits on residents with antipsychotic medications and were reviewed with resident or representative 5 residents Weekly x4 weeks, 3 res a week X 4 weeks, 1 resident a week X 4 weeks, one resident a week every other week and then monthly X 3 months. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance	04/28/2023

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	risperidone had a black box alert which included there was an increased risk of mortality in elderly patients with dementia-related psychosis, mainly due to pneumonia and heart failure. The side effects included, but were not limited to, agitation, anxiety, insomnia, headache, aggressive behavior, and orthostatic hypotension. The adverse effects included, but were not limited to, tardive dyskinesia [characterized by tongue protruding, puffing of the cheeks, chewing, or puckering of mouth], muscle rigidity, altered mental status, irregular pulse or blood pressure, cardiac arrhythmias, acute renal failure, hyperglycemia, and death.2. The record for Resident 51 was reviewed on 03/01/23 at 11:50 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, delirium due to known physiological condition, hallucinations, and cerebellar stroke syndrome. A physician's order, dated 12/1/22, indicated lorazepam (an antianxiety) 0.5 milligrams at bedtime. A physician's order, dated 1/23/23, indicated Depakote sprinkles (a mood stabilizer) 250 milligrams three times daily. A physician's order, dated 1/23/23, indicated Seroquel (an antipsychotic) 25 milligrams three times daily. A physician's order, dated 2/27/23, indicated lorazepam 0.5 milligrams every four hours as needed. There was no documentation in the electronic medical record regarding education of the risks of psychoactive medications with the resident or representative.		improvement	

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	A recent publication of "PDR.net'" indicated "...Seroquel was used in adults for the treatment of schizophrenia, mania associated with bipolar 1 disorder, bipolar depression, maintenance of bipolar one disorder...antipsychotics were not approved for treatment of dementia-related psychosis in geriatric patients and the use of Seroquel in this population should be avoided if possible due to an increase in morbidity and mortality in geriatric patients with dementia receiving atypical antipsychotics...." A recent publication of "PDR.net" indicated "...Depakote was used for seizures, bipolar disorder and migraine prophylaxis...a black box warning...Depakote and its analogs are hepatotoxic (liver toxicity) ...cases of life threatening pancreatitis have been reported in patients...." A recent publication of "PDR.net" indicated "...lorazepam was approved for the diagnosis of anxiety...a black box warning...as with other benzodiazepines, lorazepam causes central nervous system depression that may lead to respiratory (breathing) affects and should be used with extreme caution...." A current policy, titled, "Resident Rights Guidelines," dated 12/31/22 and received from the Clinical Support Nurse on 3/6/23 at 12:08 p.m., indicated "...to ensure resident rights are respected and protected and provide an environment in which they can be exercised...our residents have the right to be given information necessary to participate in decisions which affect them...including all other state specific resident rights according to their public health code...."			

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	3.1-3(n)(2)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview and record review, the facility failed to update the care plan to include the resident's preferred activities for 1 of 4 residents reviewed for activities (Resident 42). Finding includes:	F 0657	1. Resident 42 were affected by this alleged practice and no negative outcomes were observed. Resident care plan updated for preferred activities. 2. All residents have the ability to be affected. All activity care	04/28/2023

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	During an observation, on 2/27/23 at 3:22 p.m., Resident 42 was sitting up on the edge of his bed. Other residents had been in the common area playing bingo. There was no music and no television on in the room and no books. During an observation, on 3/2/23 at 11:27 a.m., the resident was lying in bed, in his room, with his eyes closed. Other residents were in the dining room working on a craft of stringing beads. During an observation, on 3/3/23 at 3:21 p.m., residents were listening to live music outside of the dining area. Resident 42 was not attending the live music event. The record for Resident 42 was reviewed on 3/1/23 at 3:12 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbance, psychotic disorder with delusions due to a known physiological condition, depression, and anxiety disorder. A care plan, dated 6/30/22 and last reviewed/revised on 1/10/23, indicated it was important for the resident to have the opportunity to engage in activities and opportunities meaningful to him. The approaches included, but were not limited to, participate in 1:1 visits two times weekly to increase external stimuli and to enhance the quality of life, it was important for the resident to be able to go outside and get fresh air when the weather was good, it was important for the resident to have the opportunity to listen to music, and it was important to have the opportunity to read. During a review of the point of care activity documentation, from 2/2/23 through 3/1/23, the resident did not participate in any music, reading,		plans audited for accuracy of preferred activities. 3. Activity staff educated on obtaining preferred activity for the resident and updating the care plan. Audits will be completed on 5 residents weekly x4 weeks, 3 res a week X 4 weeks, 1 resident a week X 4 weeks, one resident a week every other week and then monthly X 3 months. 4. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	or outside activities. During an interview, on 3/2/23 at 11:33 a.m., RN 4 indicated the resident did not go to activities and got anxious when he was out of his room. During an interview, on 3/6/23 at 4:05 p.m., the resident's daughter indicated the resident had not been social outside of his family. He had kept the family isolated from others. The resident would be anxious if he was taken to the facility dining area and wanted to eat in his room. The resident kept western books in the tote by his bed. The activity care plan did not include the resident preferred to be alone or the western books were kept in a tote by his bed. A current policy, titled "Comprehensive Care Plan Guideline," reviewed on 12/31/22 and received from the Clinical Support Nurse on 3/7/23 at 3:12 p.m., indicated "To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions, impairment, disability, or disease in accordance with state and federal guidelines...A comprehensive care plan will be developed within 7 days of completion of the admission comprehensive assessment...Interventions should be reflective of the individual's needs and risk influence as well as the resident's strengths...The comprehensive care plan should be reviewed no less than quarterly and revised to reflect changes in the resident's condition as they occur...Comprehensive care plans need to remain accurate and current...." 3.1-35(d)(2)(B)			

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review, the facility failed to ensure residents received scheduled showers and had their hair washed for 3 of 5 residents reviewed for activities of daily living (ADL) care. (Resident G, F and J) Findings include: 1. During an observation, on 2/27/23 at 3:03 p.m., the resident's hair was combed, appeared flat and slightly greasy like it had not been washed in a while. During an observation, on 3/1/23 at 12:16 p.m., Resident G was sitting up, in a high back wheelchair, her hair was not combed and appeared dirty. During an observation, on 3/2/23 at 11:23 a.m., the resident was sitting up, in her high back wheelchair in the dining room, her hair was not combed and looked stringy and was separated by two parts in the back of her head. The record for Resident G was reviewed on 3/2/23 at 10:17 a.m. Diagnoses included, but were not limited to, chronic congestive heart failure, chronic kidney disease stage 3, dementia, osteoarthritis, and major depressive disorder. A profile guide, dated 8/24/22 and last updated on 1/23/23, indicated the resident was to receive showers on Tuesdays and Thursdays on the	F 0677	1.Residents G, F, and J were affected, showers were given. 2.All residents have the potential to be affected. Nursing staff educated on shower schedule to be completed and hair washed. All residents were observed in the facility. All residents audited for bathing preference. 3.As a measure of ongoing compliance, DHS or designee will complete audits to ensure showers have been completed and hair is washed to be monitored for 5 residents weekly for 3x weekly x 4 weeks, weekly x 4 weeks, every other week x 4 weeks and monthly x 3 months or until 100% compliance is maintained. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	04/28/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	night shift. A point of care history, for 2/1/23 through 2/28/23, indicated the resident only received one shower. The shower sheets, from 2/1/23 through 2/28/23, indicated the resident received 5 showers. The shower sheet on 2/23/23 indicated the resident's hair was shampooed. There was no documentation of a shower or hair being washed after 2/23/23. The shower sheets and the point of care history did not match for the number of showers received. During an interview, on 3/6/23 at 3:38 p.m., the Clinical Support Nurse indicated the facility had been using a no rinse shampoo and it was not working so they were taking it out of the resident rooms and would not use it any longer. The resident's point of care and shower sheets did not include if no rinse shampoo had been used.2. During an observation, on 2/28/23 at 10:20 a.m., Resident F was sitting in a wheelchair. The resident's hair was not brushed and appeared dirty. During an observation, on 3/2/23 at 10:30 a.m., the resident's hair appeared flat and dirty. The record for Resident F was reviewed on 3/2/23 at 10:32 a.m. Diagnoses included, but were not limited to, anxiety disorder, transient cerebral ischemic attack, and chronic kidney disease. A profile care guide, dated 8/24/22, indicated Resident F's showers were scheduled on Tuesday and Saturday during the evening shift.			

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	The MDS (Minimum Data Set) assessment, dated 1/9/23, indicated the resident needed one-person physical assist with showers and bathing. A point of care history indicated Resident F was missing 8 showers from 12/1/22 through 2/28/23. During an interview, on 3/6/23 at 11:45 a.m., RN 5 indicated Resident F did not refuse care. During an interview, on 3/6/23 at 12:01 p.m., CRCA 7 indicated the resident did not refuse care. During an interview, on 3/7/23 at 2:26 p.m., CRCA 6 indicated the residents were scheduled two showers a week. Resident F's showers were scheduled for Tuesdays and Saturdays on day shift. The resident normally took a shower in the early morning and did not wash her hair. 3. A document indicated Resident J filed a grievance, dated 12/15/22, for not receiving a shower in over one week. The record for Resident J was reviewed on 3/7/23 at 4:32 p.m. Diagnoses included, but were not limited to, anxiety disorder, depression, atrial fibrillation, hypertension, congestive heart failure, anxiety disorder, and depression. The MDS assessment, dated 4/21/22, indicated the resident needed extensive assistance for bathing and personal hygiene. A point of care history indicated Resident J was missing 10 showers or bed baths from 1/1/23 through 2/28/23. During an interview, on 3/7/23 at 2:55 p.m., Resident J indicated she was very upset with the			

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	staff for not getting her showers when they were scheduled. The residents were paying a lot of money to live here, and it was not too much to ask for a shower. The residents could not get showers due to only 1 CRCA working, and they did not have time. The CRCAs tell the residents they were too short staffed. Resident J's showers were scheduled for Thursday and Sunday on day shift. It was very important to the resident a shower was given. A current policy, titled "Guidelines for Bathing Preference," dated as revised 5/11/16 and received from the Executive Director on 3/3/23 at 2:07 p.m., indicated "...The resident will be advised of [name of company] guidelines for residents to self-determine their plan of care and schedule during their stay in the campus...The resident shall determine their preference for bathing upon admission. a. Day of week, b. Time of day - morning or evening. c. Type of bathing - tub bath, bed bath or shower...If the resident is unable to communicate their preference this information shall be obtained from the resident representative based on known history...Bathing shall occur at least twice a week unless resident preference states otherwise...." This Federal tag relates to Complaint IN00401817. 3.1-38(a)(2)(A) 3.1-38(a)(3)(B)			
F 0692 SS=D 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			

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	resident's comprehensive assessment, the facility must ensure that a resident- §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 interview and record review, the facility failed to obtain a weight on a resident who was identified as a risk for malnutrition for 1 of 3 residents reviewed for nutrition. (Resident 59) Finding includes: The record for Resident 59 was reviewed on 3/1//23 at 5:17 p.m. Diagnoses included, but were not limited to, chronic kidney disease stage 3, Alzheimer's disease, anxiety disorder, age related physical debility, hypocalcemia, and hypokalemia. A physician's order, dated 1/25/23, indicated to provide a regular diet with thin liquids. A care plan, dated 1/26/23, indicated the resident was malnourished/at a risk for malnutrition related to his diagnoses, inadequate nutrient and energy intakes and metabolic demands. The goal was for the resident to consume adequate intakes to improve nutritional status, achieve and/or maintain an optimal weight range for the resident	F 0692	1. Resident 59 was affected, and weight was obtained, no negative outcomes. 2. All residents have the ability to be affected. Nursing staff educated on obtaining admission, weekly, daily, and monthly weights. All residents with orders for weights have been obtained. 3. As a measure of ongoing compliance, DHS or designee will complete audits to ensure residents with orders for weights are obtained for 5 residents weekly x 4 weeks, 3 residents weekly x4 weeks, weekly x4 weeks, every other week x4 weeks, and monthly x3 or until 100% compliance is maintained. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until	04/28/2023

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	and prevent any significant weight changes. The approaches included, but were not limited to, dietitian to re-evaluate as indicated and to obtain a weight as ordered/needed. A care plan, dated 2/20/23, indicated the resident was on hospice with a potential for unavoidable weight loss and nutritional decline. The approaches included, but were not limited to, weight monthly or as ordered by the physician. A physician's order, dated 3/4/23, indicated to weigh once a month on the 5th day of the month. During an observation, on 3/1/23 at 11:43 a.m., the resident was sitting up in a high back wheelchair in the dining area. During an interview, on 3/6/23 at 10:54 a.m., the Clinical Support Nurse indicated the resident had been combative and had not had a weight taken since admission. During an interview, on 3/6/23 at 12:46 p.m., the Clinical Support Nurse indicated the facility did have a scale to weigh residents while in their wheelchair. During an interview, on 3/7/23 at 4:15 p.m., the Clinical Support Nurse indicated the facility still had not obtained a weight for the resident. A current policy, titled "Guidelines for Weight Tracking," dated as last reviewed on 12/31/22 and received from the Clinical Support Nurse on 3/6/23 at 12:08 p.m., indicated "...To ensure resident weight is monitored for weight gain and/or loss to prevent complications arising from compromised nutrition/hydration...Residents will have their weight taken and recorded upon admission to		campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	establish a baseline...Unless otherwise indicated or ordered by the physician the resident will have their weight taken and recorded monthly...The facility dietitian or representative will review the resident's nutritional status, usual body weight and current weight to implement a nutritional program when warranted...The weight should be recorded in the individual resident medical record...." 3.1-46(a)(1)			
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. Based on observation, interview and record review, the facility failed to ensure the resident or representative had been instructed on the specific	F 0700	1. Resident 12 was affected, no negative outcomes, resident representative was educated on	04/28/2023

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	risks versus benefits of bed rails and to have a signed consent for 1 of 2 residents reviewed for accident hazards. (Resident 12) Finding includes: During an observation, on 2/27/23 at 2:43 p.m., the resident had two upper quarter side rails on the bed. The record for Resident 12 was reviewed on 3/1/23 at 4:27 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, dementia, anxiety disorder, age related macular degeneration, and difficulty in walking. A care plan, dated 7/6/2020, indicated the resident had an impairment in functional status related to transfers, bed mobility, toileting, and eating. The approaches included, but were not limited to, bed rail assessed as an enabler for safe transfers or increased mobility. A physician's order, dated 2/20/23, indicated the side rails had been assessed as an enabler for safe transfers or increased mobility. During an interview, on 3/3/23 at 3:33 p.m., the Clinical Support Nurse indicated the facility had a consent form for side rails and this resident did not have a signed consent. The resident first meeting did show the family was aware of the resident's plan of care although it did not include the risks versus benefits of the side rails. A current policy, titled "Guidelines for the Use of Bed Rails," dated as last reviewed on 12/31/22 and received from the Clinical Support Nurse on 3/3/23 at 4:55 p.m., indicated "...The facility must attempt to use appropriate alternatives prior to installing a		the risks and benefits of bed rails and consent was obtained. 2. All residents that have bed rails have the ability to be affected. Nursing staff educated on the need to perform an evaluation and obtain consent from resident or resident representative. All residents with bed rails have been audited for evaluation and consent. 3. As a measure of ongoing compliance, the DHS or designee will complete audits to ensure residents with bed rails in place have an evaluation and consent completed 5 residents weekly x 4 weeks, 3 residents weekly x4 weeks, weekly x4 weeks, every other week x4 weeks, and monthly x3 or until 100% compliance is maintained. 4. As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	bed rail. If a bed rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements...The campus must also assess the resident's risk from using bed rails. The following includes potential risks regarding the use of bed rails...Accident hazards...Barrier to residents from safely getting out of bed...Physical restraint...Skin integrity issues...Other potential negative psychosocial outcomes...After alternatives have been attempted and prior to installation, the facility must obtain informed consent form the resident or if applicable, the resident representative for the use of bed rails. The facility should maintain evidence that is has provided sufficient information so that the resident or resident representative could make an informed decision. Information that the facility must provide to the resident, or resident representative include, but are not limited to...The resident's benefits from the use of bed rails...The resident's risk from the use of bed rails and how these risks will be mitigated...." 3.1-45(a)(1)			
F 0725 SS=E Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment			

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	required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, interview and record review, the facility failed to ensure there were enough staff to complete showers, to complete hair care, to administer medications on time and to obtain physician ordered medications for 3 of 5 residents reviewed for activities of daily living (ADL) care, 5 of 5 residents reviewed for timely medication administration, and 4 of 5 residents reviewed for missing medications. (Resident G, C, D, E, F, H, J, K, L, M and B). Findings include: 1. During an observation, on 2/27/23 at 3:03 p.m., Resident G's hair was combed, appeared flat and slightly greasy like it had not been washed in a while. The record for Resident G was reviewed on 3/2/23 at 10:17 a.m. Diagnoses included, but were not limited to, chronic congestive heart failure, chronic kidney disease stage 3, dementia, osteoarthritis, and major depressive disorder.	F 0725	1. No resident were affected by the alleged deficient practice. 2. All residents have the ability to be affected. Nursing staff educated on showers, hair care, medication administration times and on medications that are unavailable. All residents have been audited for showers and hair care preference. Medication carts have been audited to ensure medications ordered are available. Medication orders have been audited for timeliness. 3.As a measure of ongoing compliance, the DHS or designee will complete audits to ensure residents received showers and hair care; medication administration for 5 residents weekly x 4 weeks, 3 residents weekly x4 weeks, weekly x4 weeks, every other week x4 weeks, and monthly x3 or until	04/28/2023

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	The shower sheets, from 2/1/23 through 2/28/23, indicated the resident's hair was shampooed on 2/23/23. There was no documentation of a shower or the resident's hair being washed after 2/23/23. There was no documentation to show the resident's hair had been shampooed prior to 2/23/23 for the month. During an interview, on 3/6/23 at 3:38 p.m., the Clinical Support Nurse indicated the facility had been using a no rinse shampoo and it was not working so they were taking it out of the resident rooms and would not use it any longer. The resident's point of care and shower sheets did not include if no rinse shampoo had been used. During an interview, on 3/3/23 at 2:32 p.m., LPN 8 indicated staffing had been an issue since Covid started. The facility was short of CNAs (Certified Nursing Assistants). During an interview, on 3/7/2023 at 11:20 a.m., the Executive Director (ED) indicated the facility had staff in environmental services, the kitchen, and life enrichment who were also cross trained as CNAs. The cross trained staff might be used to assist with showers.2. The record for Resident C was reviewed on 3/1/23 at 12:30 p.m. Diagnoses included, but were not limited to, history of thrombosis and embolism (blood clot), asthma, hypertension, heart failure, depression, and long-term use of anticoagulants (for blood clots). During a record review, on 3/1/23 at 12:30 p.m., the resident received the following medications late: a. Artificial Tears eye drops on 3/6/23. b. Florastor (a probiotic) 250 mg on 3/5 and 3/6/23.		100% compliance is maintained. 4.As a quality measure, the DHS or designee will review any findings and corrective action at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	c. fluoxetine (an antidepressant) 20 mg tablets give 3 tablets on 3/5 and 3/6/23. d. magnesium oxide (a supplement) 400 mg capsule give 1 capsule on 3/5 and 3/6/23. e. pantoprazole (acid reflux medication) 20 mg on 3/5 and 3/6/23. f. potassium chloride (a supplement) on 3/5 and 3/6/23. g. enoxaparin (a blood thinning medication) 0.9 milliliter (ml) on 2/14/23. h. levothyroxine (a hormone replacement)100 mcg(micrograms) on 2/14/23. 3. The record for Resident D was reviewed on 3/2/23 at 2:27 p.m. Diagnoses included, but were not limited to, pressure ulcer of left buttocks, pancytopenia (lower than normal number of red and white blood cells and platelets in the blood), chronic kidney disease, atrial fibrillation, and cardiomegaly (enlarged heart). During a record review, on 3/2/23 at 2:27 p.m., the resident received the following medications late: a. Sevelamer carbonate (used to lower high blood phosphorus levels) on 1/12/23 and 2/11/23. b. sennoside-docusate sodium (a stool softener) 8.6-50 mg on 1/17, 1/18, 1/19, 1/27 and 1/31/23. c. torsemide (a diuretic medication) 10 mg tablet on 1/31/23. d. aspirin 81 mg tablet on 2/19/23. e. calcium carbonate (a supplement) 500 mg on 2/11/23. During a record review, on 3/2/23 at 2:27 p.m., the resident did not receive the following medication due to the medication was unavailable. a. Eliquis (a blood thinning medication) 5 mg tablet on 1/9/23. 4. The record for Resident E was reviewed on			

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	3/2/23 at 1:24 p.m. Diagnoses included, but were not limited to, fracture of the right lower leg, anxiety disorder, and depression. During a record review, on 3/2/23 at 1:24 p.m., the resident received the following medication late: a. Acetaminophen (a pain/fever reducer) 500 mg on 2/23/23. During a record review, on 3/2/23 at 2:27 p.m., the resident did not receive the following medication due to the medication was unavailable. a. Vitamin C (a supplement) on 2/25/23. 5. During an observation, on 2/28/23 at 10:20 a.m., Resident F was sitting in a wheelchair. The resident's hair was not brushed and appeared dirty. During an observation, on 3/2/23 at 10:30 a.m., the resident was dressed, and her hair appeared flat and dirty. The record for Resident F was reviewed on 3/2/23 at 10:32 a.m. Diagnoses included, but were not limited to, anxiety disorder, transient cerebral ischemic attack, and chronic kidney disease. The resident's profile care guide indicated the resident had showers Tuesday and Saturday on the evening shift. Resident F was missing 8 showers from 12/1/22 through 2/28/23. During an interview, on 9/20/22 at 10:59 a.m., the resident's family member indicated the staff was shorthanded and took a long time to respond. The resident was supposed to get a shower two times a week and was not sure when he had one.			

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6. The record for Resident H was reviewed on 3/1/23 at 11:00 a.m. Diagnoses included, but were not limited to, congestive heart failure, hypertension, atrial fibrillation, and history of repeated falls.

During a record review, on 3/1/23 at 11:00 a.m., the resident received the following medications late:
a. Lantus (insulin) 16 units on 12/6/22.
b. Lantus 16 units on 12/12/22.
c. metoprolol tartrate (a blood pressure medication) 100 mg on 12/12/22.
d. aspirin 81 mg on 2/13/23 and 2/17/23.
e. gabapentin (a medication used to treat nerve pain) 400 mg on 2/13/23 and 2/17/23.
f. Zetia (a cholesterol medication) 10 mg on 2/13/23 and 2/17/23.

During a record review, on 3/1/23 at 11:03 a.m., the resident did not receive the following medication due to the medication was unavailable.
a. ascorbic acid (a supplement) 500 mg tablet on 12/18/22.
b. hydrochlorothiazide (a blood pressure medication) 25 mg tablet on 12/18/22.
c. montelukast (an anti-inflammatory) 10 mg tablet on 12/20, 12/21, 12/23, 12/24/22.
d. Zetia 10 mg tablet on 12/17, 12/18, 12/19, 12/20, 12/21, 12/22, 12/23, 12/24, 12/25, 12/26 and 12/30/22.
e. triamcinolone acetonide cream 0.1% (used to treat skin rashes) on 12/6, 12/17 and 12/18/22.
f. cefpodoxime (an antifungal) 200 mg on 12/19/22.

A physician's order, dated 12/17/22, indicated to give cefpodoxime 200 mg (milligram) tablet, give 2 tablets at 8:00 p.m., for 2 days.

During an interview, on 3/0/23 at 4:55 p.m., the

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	Clinical Support Nurse indicated the resident did not receive one dose of cefpodoxime when she returned from the hospital and the resident should have received both doses. 7. Resident J filed a grievance, dated 12/15/22, for not receiving a shower in over one week. The record for Resident J was reviewed on 3/7/23 at 4:32 p.m. Diagnoses included, but were not limited to, anxiety disorder, depression, atrial fibrillation, hypertension, congestive heart failure, anxiety disorder, and depression. Resident J was missing 10 showers or bed baths from 1/1/23 through 2/28/23. During an interview, on 3/7/23 at 2:55 p.m., Resident J indicated she was very upset with the staff for not getting her showers when they were scheduled. The residents were paying a lot of money to live here, and it was not too much to ask. The residents could not get a shower anymore because only one CRCA was working and they did not have time. The CRCAs tell the residents they were too short staffed. Resident J's showers were scheduled for Thursday and Sunday on day shift. It was very important to the resident a shower was given. 8. During a Resident Council Meeting, on 3/1/23 at 1:20 p.m., Resident K, Resident L, Resident M were present. The concerns addressed in the meeting were as follows: a. Showers not being given. b. Medication given late. During an interview, Resident K indicated her showers were scheduled on Tuesday and			

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	Saturday. The resident was required to stay up late to get her shower. The resident's showers were very important, and she looked forward to them and did not like to receive showers late at night. The facility did not have enough staff. During an interview, Resident M indicated the nurse provided 6 wash clothes for the resident to wash and dry off on. The resident indicated it was hard and she made it work. During an interview, on 2/28/23 at 3:44 p.m., Resident N's family member indicated there were concerns about the consistency of the nursing staff. The facility was mostly short staffed, and this made it hard to give good care.9. The record for Resident B was reviewed on 03/01/23 at 10:25 a.m. Diagnoses included, but were not limited to, hypertensive heart and chronic kidney disease with heart failure, chronic diastolic heart failure, end stage renal disease, acute embolism and thrombosis of right femoral vein, acute embolism and thrombosis of deep veins of right upper extremity, saddle embolus of pulmonary artery without acute cor pulmonale, severe protein calorie malnutrition, mitral valve insufficiency, left bundle branch block, thrombocytopenia, hypotension, and a pacemaker. During the record review, the resident received the following medications late: a. levothyroxine (a hormone supplement) was administered late on 10/2/23. b. cholecalciferol (a supplement), colchicine (an anti-inflammatory) and omeprazole (to treat heartburn) were administered late on 10/23/22. c. Cholecalciferol, omeprazole, potassium (a supplement) and colchicine were administered late on 12/12/22. d. warfarin (a blood thinning medication) 3			

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	milligrams was administered late 12/15/22. e. Cholecalciferol, omeprazole, potassium, and colchicine were administered late on 12/17/22. f. Caltrate with vitamin d (a supplement) was administered late on 1/7/23. During the record review, the resident did not receive the following medication due to the medication was unavailable. a. magnesium oxide was not administered due to drug/item unavailable on 12/10/22 at 4:05 p.m., 12/11/22 at 4:15 p.m., and on 1/14/23 3:11 a.m. b. cholecalciferol was not administered due the drug/item not being available on 1/22/23 at 9:01 a.m., and on 1/23/23 at 7:57 a.m. During an interview, on 2/27/23 at 12:30 p.m., Resident B indicated there was 1 certified resident care assistant working on the unit today. Her medications were late sometimes, and she had not received magnesium and potassium due to the unavailability of the medications. During an interview, on 3/1/23 at 3:35 p.m., Resident B's family member indicated the resident went without magnesium for 3 days in a row and medications had been given late. During an interview, on 3/3/23 at 4:01 p.m., Resident B's family member indicated for a while they didn't have the resident's Caltrate or magnesium. During an interview, on 03/07/23 at 10:32 a.m., the Executive Director indicated staffing was based on acuity and the number of residents. During an interview, on 3/7/23 at 10:33 a.m., the Clinical Support Nurse indicated she ran a report for medications not administered on time and			

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	monitored if the medications were late or late charting. She looked for trends. She looked to see if there were too many medications administered at the same time and tried to space them out or add another medication pass person. She also monitored if the staff member was not able to complete their work. During an interview, on 3/6/23 at 11:42 p.m., RN 5 indicated medication was given late. The late or unavailable medications were charted in the Medication Administration Record (MAR). RN 5 had been the only nurse on the hall, and it took time to pass out all the medication and there were some days it was hard to get all the work done due to being short staffed. A medication should never be unavailable, if it was not in the medication cart, you would check the first dose (medication dispenser) and then call the pharmacy and order the medication. During an interview, on 3/6/23 at 11:45 a.m., RN 9 indicated charting was sometimes late. When a medication was given past 10:30 a.m., it was considered late. During an interview, on 3/6/23 at 11:50 a.m., CRCA 7 indicated they switched from night shift to day shift. The workload was impossible to get done and they had 38 residents with only one nurse. During an interview, on 3/7/23 at 2:26 p.m., CRCA 6 indicated the residents were scheduled to receive two showers a week. The shower book had a list of room numbers and shifts the showers were assigned. A recent policy, titled "Specific Medication Administration Procedures," dated 11/18 and received from the Clinical Support Nurse on 3/6/23			

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	at 12:08 p.m., indicated "...review 5 rights 3 times...." A recent policy, titled "Scheduling Standards Policy," dated 2/23 and received from the Clinical Support Nurse on 3/7/23 at 3:13 p.m., indicated "...schedules should be developed in a manner that promotes efficient staffing in each health campus area for all shifts, weekdays and weekends...consistent schedules for continuity of care is desired...." This Federal tag relates to Complaints IN00401817 and IN00402470. 3.1-17 (a)			
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 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;			

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	§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 prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, interview and record review, the facility failed to ensure residents with dementia who received psychotropic medications had documentation to show resident specific delusions or hallucinations, had documentation to show how the resident was distressed or not easily redirected and to provide a clinical rationale for the declination of a gradual dose reduction (GDR) for 2 of 5 residents reviewed for unnecessary medications. (Resident 42 and 51) Findings include:	F 0758	1. Residents 41 and 52 were affected by this alleged deficient practice. Resident 41 and 52, care plans were updated to include resident specific delusions and hallucinations and all psychotropic medication have clinical rational for Gradual dose reduction declination. 2. All residents who have the diagnosis of dementia and who receive psychotropic medications have the potential to be affected.	04/28/2023

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	1. During an observation, on 2/27/23 at 3:22 p.m., Resident 42 was sitting up on the edge of his bed. There was a plastic bin next to his bed with a backpack, winter hat, and some items under the hat on the top of the bin. During an observation, on 2/28/23 at 3:06 p.m., the resident was lying in bed, in his room, and his eyes were closed. The plastic bin remained next to his bed. The record for Resident 42 was reviewed on 3/1/23 at 3:12 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with behavioral disturbance, psychotic disorder with delusions due to a known physiological condition, depression, and anxiety disorder. A physician's order, dated 6/29/22, indicated to give risperidone (an antipsychotic) 0.25 mg (milligram) twice a day for psychotic disorder with delusions due to a known physiological condition. A care plan, dated 6/30/22, indicated the resident demonstrated altered behaviors including delusions. The resident believed he was going home, looked at different destinations to live and packed up items. The goal was for the delusions to be easily altered without adverse effects. The approaches included, but were not limited to, medications per orders, psychiatric services as needed and to monitor the resident's behaviors with all hands-on care. A care plan, dated 7/08/22, indicated the resident was at a risk for developing adverse effects related to receiving an antipsychotic medication. The approaches included, but were not limited to, administer the medication as ordered by the		Care plans and target behavior have been reviewed to be resident specific for delusions and hallucinations. Resident on a psychotropic medication have been evaluated for gradual dose reduction and clinical rational was provided or dose reduction completed. 3. DSS was educated regarding including specific delusions and hallucinations in the resident's care plan. All nurses and QMAs were educated on documenting an explanation of delusions or if they are distressing to the resident when noting targeted behaviors for delusions and hallucinations. Nursing leadership educated on gradual dose reduction protocol. 4. Audits will be completed by the SSD or designee to ensure specific delusions and hallucinations are documented in the resident's care plan for 5 alternating residents per week for 4 weeks, every other week x 2 months, and monthly x 3 months by reviewing resident's records in the Clinical Care Meeting. Findings of audits will be reported to the QAPI Committee for ongoing compliance. Audits will be completed by the DHS/ designee to ensure MARs contain an explanation of resident's delusions or hallucinations and if they are distressing to the resident when noting a targeted behavior for	

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	physician, attempt to give the lowest dose possible and GDR at least twice a year unless contraindicated. A target behavior, dated 7/21/22, indicated the resident believed he was going home, looked for different destinations to live and packed up his items. A target behavior, dated 7/21/22, indicated the resident had sadness about being in a facility and wanted to go to his daughter's home. A pharmacy recommendation, dated 11/29/22 at 12:00 p.m., indicated the resident had received the psychotropic medications risperidone 0.25 mg twice a day and sertraline (an antidepressant) 50 mg daily. The doses had been in place since 6/29/22. A review of the resident's chart did not reflect a worsening of depression, anxiety, or psychosis. To reach the minimal effective dose, please consider a trial dose reduction to risperidone 0.25 mg at bedtime and continue the sertraline 50 mg as ordered. If the order for the risperidone was to be continued as written, please document the risk versus the benefits have been considered. A progress note, dated 12/1/22 at 11:15 a.m., indicated a GDR review was completed. The resident was on risperidone and sertraline and was recommended by the pharmacy to GDR the risperidone and leave the sertraline. A progress note, dated 12/2/22 at 1:47 p.m., indicated the hospice nurse was consulted regarding the GDR review and indicated it was recommended to keep the dosage the same as it was working for the resident.		delusions or hallucinations for 5 alternating residents per week for 4 weeks, every other week x 2 months, and monthly x 3 months by reviewing resident's records in the Clinical Care Meeting. Findings of audits will be reported to the QAPI Committee for ongoing compliance.	

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	The progress note did not include the rationale for keeping the resident on the risperidone or the risks versus the benefits. A Medication Administration Record (MAR) history, dated 12/01/22 through 12/31/22, indicated the resident had one targeted behavior of anxiety with asking about going home. An MAR history, dated 12/01/22 through 12/31/22, indicated the resident had one targeted behavior of going home, looking for different destination to live and packing up belongings which occurred on 12/7/22. An MAR history, dated 12/1/22 through 12/31/22, indicated the resident had one targeted behavior of sadness about being in a facility and wanting to go to his daughter's home which occurred on 12/28/22. During an interview, on 3/2/23 at 11:33 a.m., RN 4 indicated the resident did not go to activities and got anxious when he was out of his room. During an interview, on 3/2/23 at 4:17 p.m., the Executive Director (ED) indicated the resident self-isolated, preferred to be alone, and was not receiving psychiatric services at the facility. During an interview, on 3/6/23 at 4:05 p.m., the resident's family member indicated the resident had not been social outside of his family. The resident would be anxious if he was taken to the facility dining area and wanted to eat in his room. The resident kept western books in the tote by his bed packed with his other belongings. The resident did not need to be on a dementia unit, so she wanted him moved to this facility.			

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	The facility documentation and the interviews from the staff were conflicted. The documentation indicated the resident wanted to leave and the interviews indicated the resident wanted to stay in his room. The facility documentation of the resident's belongings being packed as a delusion and the family member's interview of the resident keeping his books and belongings close by the bed for his accessibility were also in conflict.2. During an observation, on 03/01/23 at 11:46 a.m., the resident was resting in the bed, on her right side, with the head of the bed elevated slightly. Her daughter was visiting in the room with an activity staff member. The resident had her eyes closed. The resident was not grimacing or restless. During an observation, on 03/01/23 at 4:05 p.m., the resident was resting in the bed, on her right side, with the head of the bed slightly elevated. The resident had her eyes closed. No restlessness or movement was observed. During an observation, on 03/02/23 at 11:01 a.m., the resident was resting comfortably in bed with a low air loss mattress in place. She was lying on her right side and her eyes were closed. The record for Resident 51 was reviewed on 03/01/23 at 11:50 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, delirium due to known physiological condition, hallucinations, and cerebellar stroke syndrome. A physician's order, dated 12/1/22, indicated lorazepam (an antianxiety medication) 0.5 milligrams at bedtime.			

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	A physician's order, dated 1/23/23, indicated Depakote sprinkles (a mood stabilizer) 250 milligrams three times daily. A physician's order, dated 1/23/23 indicated Seroquel (an antipsychotic medication) 25 milligrams three times daily. A physician's order, dated 2/27/23, indicated lorazepam 0.5 milligrams every four hours as needed. A Medication Administration Record (MAR), dated 1/1/23 to 1/31/23, indicated the target behavior was complaints of not falling asleep or staying asleep. There were no behaviors documented for these dates. A MAR, dated 1/1/23 to 1/31/23, indicated the target behavior was yelling, screaming, and disrupting the environment. There were three behaviors during these dates and were easily altered. A MAR, dated 2/1/23 to 2/28/23, indicated the target behavior was complaints of not falling asleep or staying asleep. There were no behaviors documented for these dates. A MAR, dated 2/1/23 to 2/28/23, indicated the target behaviors was hallucinations. There was one episode noted and was easily redirected between the dates of 2/1/23 to 2/16/23. A MAR, dated 2/1/23 to 2/28/23, indicated a new order dated 2/16/23 for the target behavior the resident demonstrated combative behavior with care as well as yelling at staff. No behaviors were documented from 2/16/23 to 2/28/23.			

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	A MAR, dated 2/1/23 to 2/28/23, indicated a new order dated 2/16/23 for the target behavior of yelling/screaming and disrupting the environment. There were three episodes which were easily directed between 2/16/23 to 2/28/23. A pharmacy recommendation, dated 6/21/22, indicated the resident received a rather extensive psycho active regimen of trazadone 50 milligrams for insomnia and Seroquel 25 milligrams twice daily for hallucinations. She was due for a dose reduction trial of the two agents. Review of the nurse's documentation on the behavior logs found no reports or observations of insomnia, however occasional hallucinations were reported. The recommendation was to decrease the trazadone to 25 milligrams at bedtime. A note on the recommendation, dated 7/26/22 at 9:44 a.m., indicated the interdisciplinary team reviewed the resident's medications trazadone and Seroquel. The interdisciplinary team agreed after talking with the nurse practitioner to decrease the trazadone to 25 milligrams. A pharmacy recommendation, dated 9/29/22, indicated the resident received hospice services with protocol order for as needed lorazepam. CMS required a specified stop date regardless of the resident's hospice status. The recommendation was to add a stop date of 14 days and re-evaluate. The response from the physician was the medication was only as needed and needed to be available when needed and the common sense stop date would be death. A pharmacy recommendation, dated 2/24/23, indicated the resident was receiving the following psychotropic medications which were due for gradual dose reduction evaluation: Depakote 250 mg three times daily. The dose of the medication			

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CUMBERLAND POINTE HEALTH CAMPUS	1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906

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	had been in place since 7/2022, and a review of the resident's chart did not reflect worsening behaviors. To reach the minimal effective dose, please consider a trial dose reduction of Depakote 250 milligrams every morning, 125 milligrams at noon, and 250 milligrams at bedtime. If the medications were to continue as written to document the risk versus benefits were considered. During an interview, dated 03/02/23 at 11:04 a.m., Registered Nurse 5 indicated the resident would occasionally talk non-sensical, but rarely. She did not always take her meds due to sleeping. She had behaviors of yelling out in the past. They have not changed the antipsychotic medications. During an interview, on 03/06/23 at 4:21 p.m., the Social Service Director indicated the gradual dose reduction recommendation from the pharmacy, dated 2/24/23, was not answered at this time. The physician was not good at responding to the gradual dose reduction recommendations. She tried to get the nurse practitioner involved when the physician did not respond. She was aware of the few behaviors documented. A recent publication of "PDR.net" indicated "...Seroquel was used in adults for the treatment of schizophrenia, mania associated with bipolar 1 disorder, bipolar depression, maintenance of bipolar one disorder...antipsychotics were not approved for treatment of dementia-related psychosis in geriatric patients and the use of quetiapine in this population should be avoided if possible due to an increase in morbidity and mortality in geriatric patients with dementia receiving atypical antipsychotics...." A recent publication of "PDR.net" indicated			

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	"...Depakote was used for seizures, bipolar disorder and migraine prophylaxis...a black box warning...valproic acid and its analogs are hepatotoxic (liver toxicity) ...cases of life-threatening pancreatitis have been reported in patients...." A recent publication of "PDR.net" indicated "...lorazepam was approved for the diagnosis of anxiety...a black box warning...as with other benzodiazepines, lorazepam causes central nervous system depression which may lead to respiratory affects and should be used with extreme caution...." A current policy, titled "Psychotropic Medication Usage and Gradual Dose Reductions," dated 12/31/22 and received from the Clinical Support Nurse on 3/2/23 at 2:29 p.m., indicated "...to ensure every effort is made for resident receiving psychoactive medications to obtain the maximum benefit with minimal unwanted side effects through appropriate use evaluation and monitoring by the interdisciplinary team...residents shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support usage. The medical necessity will be documented in the resident's medical record and in care planning process...efforts to reduce dosage or discontinue psychotropic medications will be ongoing as appropriate...a gradual dose reduction would be attempted for 2 separated quarters per physicians recommendations...review of medication use would be conducted by the consultant pharmacy...as needed orders for psychotropic drugs are limited to 14 days...." 3.1-48(a)(2)			

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	3.1-48(b)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure a medication was not left on the top of the medication cart and the medication cart was locked for 2 of 4 carts and the temperature log for the 300-hall medication room was completed for 1 of 2 medication storage rooms reviewed for medication storage. (100 and 300 halls carts and 300 hall medication room).	F 0761	1. All residents have the ability to be affected with no negative outcomes. DHS or designee completed cart reviews to ensure medications are stored properly and temperature logs for medication rooms are complete. 2. All residents have the ability to be affected. All medication	04/28/2023

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	Findings include: 1. During an observation, on 3/6/23 at 3:40 p.m., the medication cart on the 100-hall next to Room 112 had a medication bottle left unattended on top of the cart. There were three residents sitting at the nurse's station across from the medication cart. 2. During an observation, on 3/6/23 at 4:04 p.m., the medication cart on the 100-hall close to Room 102 was unlocked and unattended. 3. During an observation, on 3/1/23 at 11:36 a.m., the medication refrigerator in the 300-hall medication storage room was missing five temperatures on the temperature log. During an interview, on 3/1/23 at 11:36 a.m., RN 2 indicated the temperature log should be filled out every night by the night shift staff. During an interview, on 3/6/23 at 3:43 p.m., the Assistant Director of Health Services (ADHS) was unaware the bottle was on the cart. The bottle should not have been left unattended. During an interview, on 3/6/23 at 4:04 p.m., the ADHS was unaware the medication cart was unlocked and indicated the cart should always be locked. During an interview, on 3/6/23 at 4:30 p.m., the Clinical Support Nurse indicated the medication should not be left out on top of the carts unattended, the carts should be locked, and the medication room refrigerators temperature logs should be filled out. A facility form, titled "[name of facility]		carts will be audited to ensure proper storage and temperature logs of refrigerators in the med room are completed. 3. Nursing staff educated on proper medication storage and medication refrigerator temperature guidelines. 4. As a measure of ongoing compliance, DHS or designee will 1 audit medication cart 5x weekly x4 weeks, 3x weekly x4 weeks, monthly x3 or until 100% compliance has been maintained.	

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	Temperature Log," was missing the following temperatures: 2/4, 2/5, 2/14. 2/15 and 2/26/23. A current policy, titled "Refrigerator," dated revised on 5/16/17 and received from the Clinical Support Nurse on 3/1/23 at 11:00 p.m., "...To assure that appropriate temperatures are maintained in the campus refrigerators for the health and safety of our residents...Refrigerators: a. Will have a functioning thermometer present in a visible location inside the unit. Will be monitored daily. Temperature checks will be documented on the refrigerator monitoring log daily...." 3.1-25(m)			
F 0804 SS=D 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, interview and record review, the facility failed to ensure the cook prepared pureed foods according to the recipes for 1 of 1 resident who was ordered a pureed diet. (Cook 1) Finding includes: During the observation of pureed foods, on	F 0804	1. No residents were affected for the alleged practice 2. All residents with a pureed diet order have the potential to be affected by this allegedly deficient practice. New measuring spoons were obtained for ease when calculating a smaller portion size often utilized for pureed	04/28/2023

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	2/28/23 at 11:12 a.m., Cook 1 was observed to do the following: a. He put a 4-ounce scoop of green beans into the Robo coupe (a machine to puree foods), added 1 and 1/2 teaspoons of melted unsalted butter and 3/4 teaspoon of thickener to the green beans and mixed to a pureed consistency. b. He then added an unmeasured piece of ham into the clean Robo coupe, added 1 tablespoon of water. He placed an additional unmeasured amount of water to the ham and mixed. The recipe called for 1 and 1/3 tablespoon of pineapple juice. He placed an unmeasured amount of pineapple juice in the Robo coupe, he added eight more tablespoons of water, mixed the ham, and added 3/4 teaspoon of thickener. He scooped the ham on the plate using a three and one-fourth ounce scoop. During an interview, on 2/28/23 at 11:12 a.m., Cook 1 indicated they did not have the materials to measure the ingredients correctly for the 1/3 tablespoon. During an interview, on 2/28/23 at 12:13 p.m., the Assistant Director of Food Services indicated Cook 1 should follow the recipes and use the correct measuring equipment. During an interview, on 2/28/23 at 12:20 p.m., the Executive Director indicated they have equipment to measure out food. The cook should have used the correct measurements. The recipe for green beans indicated for 1 serving of green beans, add 1/2 cup green beans, 1 and 1/4 teaspoon margarine and 3/8 teaspoon of thickener. Place cooked green beans in the food processor, add melted margarine and a food		foods.Recipes were obtained for pureed foods 3. Director of Food Service, Assistant Director of Food Service and cooks were provided re-education on 3.23.23 regarding the calculation and use of recipes for pureed food. 4. Observations will be completed by DFS or Designee to ensure pureed recipes are being followed for 5 alternating meals a week for 4 weeks, every other week x 2 months, and monthly x 3 months. Findings of audits will be reported to the QAPI Committee for ongoing compliance.	

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	thickener. Process briefly until mixed. The recipe for ham indicated for 1 serving of ham, add 3 ounces of ham, 1 and 1/3 tablespoon water, 1 and 1/3 tablespoon of pineapple juice and 3/4 teaspoon of thickener. Place the cooked ham in the food processor, add water, pineapple juice and food thickener. Process briefly until mixed. A current policy, titled "Pureed Food Preparation," dated as revised 7/2013 and received from the Clinical Support Nurse on 3/1/23 at 11:00 a.m., indicated "...Pureed foods will be prepared and served in a manner that maximizes quality of flavor and nutrient content...1. Foods pureed for a meal should follow the expanded menu for both regular and therapeutic diets. Leftover food items will not be used in pureed diets as the following meals...Pureed food should be consistency of applesauce or mashed potatoes...11. Pureed foods should be prepared as close to mealtime as possible...." 3.1-20(a)			
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			

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	gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure frozen food was securely covered, the refrigerator did not contain employee drinks and the thermometer used to temp food was cleaned between testing temperatures. The deficient practice had the potential to affect 62 of 62 residents who received food from the kitchen. Findings include: 1. During the kitchen observation, on 2/27/23 at 12:37 p.m., with the Dietary Manager (DM), the following were observed: a. The walk-in freezer had a large silver pan containing pulled pork and the plastic wrap over the top was not pulled tightly over the meat. The meat had ice formed over the top of the meat and the whole length of the pan. b. The refrigerator door had a large approximately 32 oz blue cup with a lid. The sticker on the cup indicated it was a staff member's cup. c. The thermometer to temp the food on the steam table was wiped off with a dirty rag from the Sani solution (a cleaning, sanitizing, and disinfecting solution) bucket. During an interview, 2/27/23 at 12:37 p.m., the DM indicated the frozen meat should have been securely covered and employee food and drinks	F 0812	F812 1. All residents had the potential to be affected by this practice. No residents had known ill effects. 2. All dining services staff will be re-educated by the Director of Food Services or designee on the guidelines related to proper food storage, labeling, dating and proper utilization of refrigerators as a single use only. Dining Services staff re-educated regarding Hot and Cold Temperature Holding Guidelines including proper sanitation of the thermometer probe. 3. The Director of Food Service or designee will randomly audit all dry, refrigerated, and frozen food storage 5 times a week for 4 weeks to ensure items are dated, labeled, or disposed of when warranted, 5 times a week for 2 weeks, 2 times a week ongoing. 4. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold	04/28/2023

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	could be stored in the refrigerator. 2. During an observation, on 2/28/23 at 12:10 p.m., Cook 1 removed a white rag with multiple black stains from a bucket containing Sani solution. He wiped the thermometer off with the rag and placed the thermometer into a sweet potato. He took another white rag from the bucket and wiped off the end of the food thermometer and stuck it in the pan of green beans. He removed the thermometer from the green beans. He then used tongs and removed a hot dog from the steam table, wiped off the thermometer with the rag and stuck it into the hot dog. During an interview, on 2/28/23 at 12:45 p.m., Cook 1 indicated they were out of swabs used to clean off the thermometer and he thought using a rag from the sanitizing bucket would be fine. During an interview, on 2/28/23 at 12:19 p.m., the Assistant Director of Food Services (ADFS) indicated the cook should have used an alcohol swab to wipe off the thermometer and not a rag. During an interview, on 2/28/23 at 12:20 p.m., the Executive Director indicated they have signs on the refrigerators which indicate employees were not allowed to put their food or drinks in any refrigerators in the building. A current policy, titled "Refrigerator," dated as revised on 5/16/17 and received from the Clinical Support Nurse on 3/1/23 at 11:00 p.m., indicated "...Refrigerators will be single use only (medications, patients' food, staff food, specimen)...." A current policy, titled "Hot & Cold Temperature Holding Guideline," not dated and received from		of 95% is not achieved, an action plan will be developed, and ongoing monitoring will occur. 5. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing.	

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	the Clinical Support Nurse on 3/1/23 at 11:00 a.m., indicated "...The temperatures of all foods on the serving line will be measured prior to resident service and recorded at every meal...1. To take an accurate temperature reading, the food thermometer must be inserted into the food so that the notch toward the end of the probe is covered. 2. Hot food in the steam table should be at least 135 or higher degrees Fahrenheit and arrive approximately at greater than or equal to 120 degrees Fahrenheit when the resident is served. This is a guideline as certain foods like hot breads and eggs will not be this hot...." A current policy, titled "Food Labeling and Dating Policy," dated as revised 4/26/22 and received from the Executive Director on 2/27/23 at 3:00 p.m., indicated "...To provide knowledge and direction on how to properly label and date all food items and food products...Any food item must have a received-on label/received-on date, and or a label that indicates the production date and the use by date for the product...6. All food items must be properly covered (not exposed to air) prior to being labeled and dated...." 3.1-21(i)(1) 3.1-21(i)(3)			
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaints IN00402470 and IN00401817. Complaint IN00402470 - Federal/State deficiencies related to the allegations are cited at F725.	R 0000	The submission of this plan of correction does not indicate an admission by Cumberland Pointe Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the	

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	Complaint IN00401817 - Federal/State deficiencies related to the allegations are cited at F677 and F725. Survey dates: February 27, 28 and March 1, 2, 3, 6 and 7, 2023. Facility number: 000547 Residential Census: 47 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on March 15, 2023.		residents of Cumberland Pointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance	
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for			

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	every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure the staff on duty met the requirements of first aid training certification for 16 of 21 shifts reviewed for first aid training. Finding include: A review of the employee work schedule, dated 2/19/2023 through and including 2/25/2023, indicated the facility had 16 out of 21 shifts without a first aid certified staff member in the facility. During an interview, on 3/1/2023 at 5:05 p.m., the Executive Director (ED) indicated first aid trained certified staff members were not on duty at the facility for the 16 shifts indicated on the staffing schedule reviewed for 2/19 through and including 2/25/2023. A facility policy, titled "AL- Staffing Requirement Guidelines," dated as revised on 8/11/2016 and received from the DON on 3/1/2023 at 5:45 p.m., indicated "...1. The campus shall schedule staff sufficient in number, qualifications and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour schedule...."	R 0117	1. No residents were affected by the alleged deficiency. Facility to ensure at least one person per shift to be first aid trained certified. 2. Facility is in the process of identifying and obtaining the employees first aid training certifications. 3. Facility schedule will be audited daily to ensure one staff is first aid trained certified and continue for 4 weeks initially. 4. As a measure of ongoing compliance From audits it 3 times a week for another 4 weeks, once a week for 4 weeks, every other week for another 4 weeks, and monthly for another 3 weeks.	04/28/2023
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record	R 0273	1. All residents had the	04/28/2023

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	review, the facility failed to ensure frozen food was securely covered, the refrigerator did not contain employee drinks and the thermometer used to temp food was cleaned between testing temperatures. The deficient practice had the potential to affect 47 of 47 residents who received food from the kitchen. Findings include: 1. During the kitchen observation, on 2/27/23 at 12:37 p.m., with the Dietary Manager (DM), the following were observed: a. The walk-in freezer had a large silver pan containing pulled pork and the plastic wrap over the top was not pulled tightly over the meat. The meat had ice formed over the top of the meat and the whole length of the pan. b. The refrigerator door had a large approximately 32 oz blue cup with a lid. The sticker on the cup indicated it was a staff member's cup. c. The thermometer to temp the food on the steam table was wiped off with a dirty rag from the Sani solution (a cleaning, sanitizing, and disinfecting solution) bucket. During an interview, 2/27/23 at 12:37 p.m., the DM indicated the frozen meat should have been securely covered and employee food and drinks could be stored in the refrigerator. 2. During an observation, on 2/28/23 at 12:10 p.m., Cook 1 removed a white rag with multiple black stains from a bucket containing Sani solution. He wiped the thermometer off with the rag and placed the thermometer into a sweet potato. He took another white rag from the bucket and wiped off the end of the food thermometer and stuck it in the pan of green beans. He removed the thermometer from the green beans. He then used		potential to be affected by this practice. No residents had known ill effects. 2. All dining services staff will be re-educated by the Director of Food Services or designee on the guidelines related to proper food storage, labeling, dating and proper utilization of refrigerators as a single use only. Dining Services staff re-educated regarding Hot and Cold Temperature Holding Guidelines including proper sanitation of the thermometer probe. 3. The Director of Food Service or designee will randomly audit all dry, refrigerated, and frozen food storage 5 times a week for 4 weeks to ensure items are dated, labeled, or disposed of when warranted, 5 times a week for 2 weeks, 2 times a week ongoing. 4. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed, and ongoing monitoring will occur. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. As a quality measure, the ED or designee will review any findings and corrective action at least quarterly and ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155775	A. BUILDING 00 B. WING	03/07/2023

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	tongs and removed a hot dog from the steam table, wiped off the thermometer with the rag and stuck it into the hot dog. During an interview, on 2/28/23 at 12:45 p.m., Cook 1 indicated they were out of swabs used to clean off the thermometer and he thought using a rag from the sanitizing bucket would be fine. During an interview, on 2/28/23 at 12:19 p.m., the Assistant Director of Food Services (ADFS) indicated the cook should have used an alcohol swab to wipe off the thermometer and not a rag. During an interview, on 2/28/23 at 12:20 p.m., the Executive Director indicated they have signs on the refrigerators which indicate employees were not allowed to put their food or drinks in any refrigerators in the building. A current policy, titled "Refrigerator," dated as revised on 5/16/17 and received from the Clinical Support Nurse on 3/1/23 at 11:00 p.m., indicated "...Refrigerators will be single use only (medications, patients' food, staff food, specimen)...." A current policy, titled "Hot & Cold Temperature Holding Guideline," not dated and received from the Clinical Support Nurse on 3/1/23 at 11:00 a.m., indicated "...The temperatures of all foods on the serving line will be measured prior to resident service and recorded at every meal...1. To take an accurate temperature reading, the food thermometer must be inserted into the food so that the notch toward the end of the probe is covered. 2. Hot food in the steam table should be at least 135 or higher degrees Fahrenheit and arrive approximately at greater than or equal to 120 degrees Fahrenheit when the resident is served.			

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	This is a guideline as certain foods like hot breads and eggs will not be this hot...." A current policy, titled "Food Labeling and Dating Policy," dated as revised 4/26/22 and received from the Executive Director on 2/27/23 at 3:00 p.m., indicated "...To provide knowledge and direction on how to properly label and date all food items and food products...Any food item must have a received-on label/received-on date, and or a label that indicates the production date and the use by date for the product...6. All food items must be properly covered (not exposed to air) prior to being labeled and dated...."			