STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	08/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COLUMBUS TRANSITIONAL CARE AND REHABILITATION	2100 MIDWAY ST COLUMBUS, IN 47201

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 16, 17, 18, 19, and 22, 2022. Facility number: 000058 Provider number: 155133 AIM number: 100283340 Census Bed Type: SNF/NF: 56 Total: 56 Census Payor Type: Medicare: 4 Medicaid: 44 Other: 8 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 30, 2022.	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-			

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

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	(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to prevent facility acquired pressure ulcers (Residents 255 and 30) and to follow the physicians' orders and infection control (Resident 20) related to pressure ulcers for 3 of 4 residents reviewed for pressure ulcers. Findings include: 1. During an observation on 08/18/22 at 1:16 P.M., the ADON (Assistance Director of Nursing) changed the dressing to Resident 255's left foot. The wound was on the resident's left heel with the wound bed was purple with dark purple around the outer edges and measured 4.8 cm (centimeters) x (by) 4.0 cm. There was no odor or drainage noted. The clinical record for Resident 255 was reviewed on 08/18/22 at 2:00 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 07/06/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, anemia, heart failure, hypertension, Alzheimer's dementia, anxiety, depression, and respiratory failure. The resident required total assistance of two or more staff with bed mobility, transfers, dressing, toileting, and bathing. The resident was at risk for developing pressure	F 0686	F686 Requires the facility to prevent facility acquired pressure ulcers and to follow physician's orders and infection control. 1. Resident #255, #20 and #30 pressure ulcer interventions were reviewed and residents were compliant with interventions. Areas were noted to be improving. Resident #20 anti-fungal cream was discontinued by wound center physician as the wound is almost healed and does not require this treatment. 2. All residents have the potential to be affected. An audit was conducted ensuring all necessary pressure prevention interventions were in place at this time. Physician orders were reviewed to ensure treatmentsare applied per physican's order. An inservice was conducted to ensure staff was aware on how to perform a clean technique dressing No concerns were noted. See below for corrective measures. 3. The Pressure Ulcer Prevention policy and procedure and Clean	09/09/2022

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	ulcers. A "SWAT WOUND MONITORING" form, dated 06/01/22, indicated the resident was a new admission with pressure ulcers noted to his coccyx and left great toe. A "SWAT WOUND MONITORING" form, dated 06/08/22, indicated the resident's wounds were healing. The resident was active in bed and kicked the pillows out of place that were used to float his heels. The resident was repositioned every two hours. A "SWAT WOUND MONITORING" form, dated 07/27/22, indicated the resident had a new deep tissue injury (purple or maroon area of discolored intact skin due to damage of underlying tissue) to his left heel. A new order was in place for preventative boots while in bed. An "INITIAL PRESSURE ULCER ASSESSMENT", dated 07/25/22, indicated the resident had a Deep Tissue Injury to his left heel that was first identified on 07/25/22. The area measured 4 cm X 4 cm. There was no drainage and the wound bed was dark red. A Physician Progress Note, dated 07/25/22, indicated the resident had a necrotic (dead skin) left heel. The July 2022 Weekly Skin Assessments and Shower Sheets lacked any indication the resident had any new skin concerns. A physicians' order, dated 06/13/22, indicated the nursing staff were to apply house lotion to the extremities once a day.		Technique policy and Prevention were reviewed with no changes made. (See attachment A) The staff was inserviced on the above procedures. 4. The DON or her designee will conduct rounds daily ensuring pressure prevention interventions are in place for each resident to prevent facility acquired pressure ulcers. If a resident is non-compliant with an intervention, a behavior monitoring sheet will be documented and a care plan started. The DON or her designee will monitor two dressing changes a day ensuring physician orders are followed as well as ensuring clean dressing technique is being followed. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment C) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly 5. The above corrective measures will be completed on or before September 9, 2022.	

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	An Avoidability Evaluation of Pressure Ulcer for the left heel, dated 07/25/22, indicated the resident had 2 or more risk factors of chronic bowel incontinence and continuous urinary incontinence or chronic dysfunction. The resident had a serum albumin less than 3.4 mg (milligrams), and the resident ate less than 50% of meals at times. The attempts at preventative measures included, but were not limited to, the resident was receiving routine preventative skin care currently and before the breakdown occurred, the care plan reflected all preventative measures, and the resident was non-compliant with preventative interventions. The care plan reflected the non-compliance. The pressure ulcer was unavoidable and signed by the Nurse Practitioner. There was no indication in the resident's clinical record to indicate he refused to float his heels or the application of house lotion to the extremities. A "Rejection of Care" Care Plan, dated 06/01/22, lacked any indication of what care the resident rejected. An open ended physicians' order, dated 06/22/22, indicated to ensure the resident's heels were floated while in the bed or the chair, as tolerated, and to document any refusals. The July and August 2022 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) was provided by the DON (Director of Nursing) on 08/22/22 at 9:22 A.M., the EMAR/ETAR lacked documentation the resident's heel were floated until 08/08/22. The nurses' progress notes and behavior monitoring forms lacked indication the resident			

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	had refused for his heels to be floated. During an interview on 08/19/22 at 9:26 A.M., CNA (Certified Nurse Aide) 5 indicated Resident 255 required staffs total assistance with all care and he used a mechanical lift for transfers. The resident recently started wearing soft boots to his foot. When a resident took a shower, she would document on the shower sheet if they had any new skin concerns and let the nurse know. She would always check under skin folds, coccyx, and heels for any discolorations. During an interview on 08/19/22 at 2:10 P.M., CNA 6 indicated the resident usually didn't refuse any care. If a resident had refused care, then they would document it on a behavior sheet that would go to Social Services. During an interview on 08/19/22 at 2:19 P.M., the ADON indicated the resident had admitted to the facility with an open area to his buttocks that had since healed. He also developed a new pressure ulcer in July 2022 on his heel. She would assume the new area had developed from pressure. The staff should have found something sooner before it was noticed as a deep tissue injury. During an interview on 08/22/22 at 8:48 A.M., the DON indicated the facility had not done anything regarding the resident's low albumin level because there wasn't really anything that could be done due to it being related to his liver function. 2. During an interview on 08/17/22 at 10:24 A.M., the DON indicated the resident had two suspected deep tissue injuries to the back of her heels. It was determined the wounds resulted from the resident wearing her shoes while in bed.			

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	The clinical record for Resident 30 was reviewed on 08/19/22 at 1:23 P.M. A Quarterly MDS assessment, dated 07/11/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, stroke and anemia. The resident required extensive assistance of one staff for bed mobility, transfers, dressing, and toileting. The resident was at risk for developing pressure ulcers. An "Initial Pressure Assessment, dated 07/29/22, indicated the resident had a suspected deep tissue injury to the right heel that measured 2 cm X 2 cm. The wound bed was purple with no drainage. An "Ongoing Assessment of Pressure Ulcer", dated 08/15/22, indicated the wound to the right heel was 2 cm X 2 cm. The wound bed was purple with no drainage. An "Initial Pressure Assessment, dated 07/29/22, indicated the resident had a suspected deep tissue injury to the left heel that measured 1 cm X 1 cm. The wound bed was purple with no drainage. An "Ongoing Assessment of Pressure Ulcer", dated 08/15/22, indicated the wound to the left heel was 1 cm X 1 cm. The wound bed was purple with no drainage. The weekly skin assessments and shower sheets for July 2022 lacked any indication of any skin concerns until 07/29/22. The resident lacked a care plan for rejection of removing shoes while in bed. The behavior monitoring logs for Resident 30			

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	were reviewed and lacked and refusals of taking her shoes off while in bed. During an interview on 08/19/22 at 9:23 A.M., CNA 5 indicated the resident was not able to get in and out of bed by herself. She was very unsteady on her feet. During an interview on 08/19/22 at 2:40 P.M., CNA Student 7 indicated the resident would sometimes refuse care such as taking her shoes of while in the bed. During an interview on 08/19/22 at 2:21 P.M., the ADON indicated she believed the staff had tried to get the resident to take her shoes off while in bed, but she refused. The resident should have had a non-adherence care plan for removing shoes while in bed. The areas should have been noticed before being identified as deep tissue injuries. The current facility policy titled, "Pressure Ulcer Prevention", dated 10/2014, was provided by the DON on 08/22/22 at 9:22 A.M. The policy indicated, "....To prevent pressure ulcers and promote healing...Personnel will identify those residents most likely to experience skin breakdown, and take precautions necessary to prevent breakdown..." 3. During an observation and interview on 08/16/22 at 11:45 A.M., Resident 20 was lying in bed on her side. The resident indicated she had a sacral wound and went to the wound care clinic. The wound care clinic sent dressing change and treatment orders back to the facility. She had to constantly remind the staff what the current treatment entailed. The wound treatment had been the same, but the wound center added more to the original treatment that included applying an			

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	antifungal cream around the wound. She sweated frequently putting her at risk for an infection. The antifungal cream was a daily treatment. The wound care clinic had sent a tube of the cream back to the facility with her. When the staff changed the dressing, they were supposed to put the antifungal cream around the wound. The dressing change was ordered for evening shift but LPN (Licensed Practical Nurse) 2 usually changed the dressing during the day. The wound dressing change to the resident's sacrum was observed on 08/19/22 at 10:53 A.M. An over the bed table looked damp and had already been prepared with the resident's wound care products when entering the resident's room. The resident was positioned on her left side. The DON and LPN 2 washed their hands with soap and water and donned clean gloves. The DON assisted the resident rolling her over on her left side and held her in place. The LPN pulled the resident's incontinence brief away from her buttocks leaving it tucked slightly under the resident's buttocks. The LPN removed the old dressing, then picked up the bottle of wound cleanser. The DON reminded him to sanitize his hands and change his gloves. The LPN removed his gloves, washed his hands with soap and water, donned clean gloves, opened the (Kerlix) package of rolled gauze, cut a piece of gauze from the roll, picked up the bottle of wound cleanser, sprayed the piece of gauze, and wiped the wound removing the gray remains of the previous treatment. The LPN cut the silver (Prisma) square paper-like piece of the wound treatment in half and applied the small rectangles to the resident's open wound bed. The LPN touched his mask with his left hand three times while holding the Maxorb Alginate (absorbing) dressing part of the treatment in his right hand, then applied the			

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	treatment to the resident's sacrum wound using both hands. He unrolled a strip of gauze, cut it off the roll, adjusted his mask with the back of his gloved hand, used both hands to roll and apply the gauze to the sacral area, took the glove off of his left hand, dated an ABD (abdominal) pad gauze dressing with his gloved right hand using a black marker, then removed his other glove. The resident asked about using the antifungal cream and the DON indicated she did not need it and that her skin looked good. The LPN washed his hands, donned clean gloves, cut strips of cloth tape, applied Skin Prep (a skin toughening agent) to the area around the dressing, applied the ABD pad to cover the dressing and secured the pad with cloth tape strips. The DON suggested changing the resident's brief. The LPN rolled up the brief, that had been under the resident's buttocks prior to the dressing change, with his gloves on, grabbed a new brief out of the package in the closet, and tucked it under the resident's buttocks area. The resident indicated she still had a lot of discharge and needed the brief (she currently had a colostomy). Both staff assisted the resident by pulling her up in the bed and positioning her on her left side. The LPN left his gloves on and cleaned the resident's over the bed table that had been used for the dressing change products, removed his gloves, and moved the resident's other over the bed table closer to her that had the resident's drinks, phone, and television remote on it. The LPN touched his mask with his bare hand then put the left-over dressing change products back in a set of plastic drawers in the resident's room. Then the LPN went into the bathroom and washed his hands. During an interview, immediately following the dressing change, on 08/19/22 at 11:18 A.M., LPN 2 indicated he thought he had used his forearm on			

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	his mask while doing the dressing change. During an interview on 08/19/22 at 11:21 A.M., the Resident indicated the staff were supposed to use an adhesive remover wipe called Tack away. She had held the box of tack away up prior to the dressing change and asked the staff if they needed it and they just progressed with the dressing change and pulled the tape off. She indicated it was in her orders to use the adhesive remover. She used the tack away to remove her ostomy dressing as well. She changed her own ostomy bags. She had asked them during the dressing change if they needed the antifungal cream. The DON indicated her skin looked fine and she had not need it. The resident indicated she sweated a lot and that her backside stayed wet often. At the wound clinic they indicated to put the antifungal cream on the skin surrounding the wound. Wound care sent a tube of the cream back with her for the facility to use during dressing changes. She knew they were doing things differently during the dressing change today. The hand washing and changing gloves frequently was not a normal process for the staff. The nurse touched his mask all the time. She thought it was a nervous habit for him. The clinical record was reviewed on 08/19/22 02:06 PM. An Admission MDS assessment, dated 07/07/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, pressure ulcer to the sacral region, stage 4 (bone and/or tendon visible), neurogenic bladder, diabetes, and paraplegia. The resident was totally dependent and required the assistance of two or more staff for bed mobility, toileting, bathing, and transfers. The resident was admitted to the facility on 06/30/22.			

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	The "Wound Care Report" records from the wound clinic were provided by the ADON on 08/19/22 at 3:15 P.M. and included the following: - a record, with a service date of 07/05/22, indicated the resident had an adhesive tape allergy causing a rash. The resident's wound on her sacrum had irritation around the wound from "tape/moisture". The wound care instructions indicated to cleanse the wound with wound cleanser with each dressing change, apply antifungal cream to affected areas, Prisma, Maxorb alginate, gauze bolster, ABD pad, change daily and as needed. Please try to keep the ABD pad in place with the patient's brief instead of tape. - a record, with a service date of 07/12/22, indicated the wound care instructions were to cleanse the wound with wound cleanser with each dressing change, apply antifungal cream to affected areas, Prisma, Maxorb alginate, gauze bolster, ABD pad, change daily and as needed. Please try to keep the ABD pad in place with the patient's brief instead of tape. - a record, with a service date of 08/09/22, indicated the wound care instructions were to cleanse the wound with wound cleanser with each dressing change, apply antifungal cream to affected areas, Prisma, Maxorb alginate, gauze bolster, ABD pad, change daily and as needed. Please try to keep the ABD pad in place with the patient's brief instead of tape. - a record, with a service date of 08/17/22, lacked wound care instructions. The EMAR/ETAR for July 2022, was provided by the DON on 08/22/22 at 3:16 P.M. The record lacked documentation the physician's order for			

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	the antifungal cream had been transposed from the wound clinic reports into the resident's record. The EMAR/ETAR for August 2022, was provided by the DON on 08/22/22 at 11:23 A.M. The record lacked documentation the physician's order for the antifungal cream had been transposed from the wound clinic reports into the resident's record. During an interview on 08/22/22 at 3:51 P.M., the DON indicated the resident said she had not used the antifungal cream in a while. There had been some excoriation around the wound, but it had healed. The wound clinic left the orders as they were in the beginning and just added things to the orders. The current "DRESSING - CLEAN TECHNIQUE" policy, dated 10/2014, was provided by the DON on 08/22/22 at 1:34 P.M. The policy indicated, "...A clean dressing technique is used to provide an appropriate environment conducive to wound healing...Remove soiled dressing and discard...Remove gloves, wash hands, and put on a pair of clean gloves...Cleanse wound...Apply dressing as specified by physician, touching only the outer part of dressing. Remove gloves. Apply tape sparingly, if necessary..." 3.1-40(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to store medications appropriately for 1 of 6 residents reviewed for accidents (Resident 43) and 3 of 6 medication carts observed (Generations and Harmony Way). 1. During an observation and interview on 08/18/22 at 9:16 A.M., Resident 46 was lying in his bed on his right side. An overbed table was sitting beside the bed and contained a medication cup with four pills inside. The resident indicated he was unsure when the medications were brought into the room. During an interview on 08/18/22 at 9:20 A.M., QMA (Qualified Medication Aide) 3 indicated she had watched the resident take his morning medications and had not left them in the resident's room. During an interview and observation on 08/18/22 at 9:31 A.M., the DON (Director of Nursing) indicated the resident did not have a self-administration physician's order or care plan to have medications at his bedside. The medication cards were observed, and the medication cup contained Plavix (anti-platlet medication), Eomeprozole (a GERD [Gastroesophageal Reflux Disease] medication), Xarelto (a blood thinner medication), and Lyrica (a nerve pain medication). The clinical record for Resident 43 was reviewed on 08/18/22 at 1:08 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 07/20/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not	F 0689	F689 Requires the facility to store medications appropriately. 1. Resident 46 medications that were on his bedside table was removed and destroyed. Rounds were conducted to ensure medication carts were locked. 2. All residents have the potential to be affected. Rounds conducted to ensure medications are not left at bedside unless resident has an order for may self administer medications. Rounds conducted to ensure medications carts were locked. An inservice was immediately given to staff on medication storage. No concerns were noted. See below for corrective measures. 3. The Storing Drugs policy and procedure and Medication Administration policy and procedure were reviewed with no changes made. (See attachment D and E) The staff was inserviced on the on the above procedure. 4. The DON or her designee will conduct rounds twice daily ensuring that medications are not at bedside unless a resident has an order for self administration. The DON or designee will conduct rounds twice daily ensuring medication carts are locked. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly	09/09/2022

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	limited to, dementia, anemia, GERD, heart failure, hypertension, renal insufficiency, diabetes, anxiety, depression, and psychotic disorder. The current facility policy titled, "Medication Administration" with a revision date of 4/2017 was provided by the Corporate Clinical Nurse on 08/19/22 at 1:19 P.M. The policy indicated, "...To safely administer medications as per physicians' orders...Licensed or qualified personnel shall be responsible to follow accepted practices of medication administration as per physicians' orders...Always observe the resident taking their medication(s). Never permit medication to remain in the resident's room. Residents may not self-administer medications unless specifically authorized in writing by the attending physician, and then only in accordance with facility procedures for self-administration..." 2. During an observation on 08/16/22 at 10:26 A.M., the Harmony Way Medication Cart was unlocked and unattended. One visitor and three residents passed by the unlocked medication cart. On 08/16/22 at 10:28 A.M., the Scheduler came to the medication cart and indicated it should not have been unlocked while being unattended. During an observation on 08/16/22 at 2:04 P.M., The Harmony Way Medication Cart was unlocked and unattended. The Registered Dietitian walked by the unlocked cart. The ADON (Assistant Director of Nursing) walked to the unattended cart, locked it, and indicated medication carts should not be left unlocked. During an observation on 08/22/22 at 11:05 A.M., the Generations Medication Cart was unlocked and unattended. Three staff members were sitting at the nurse's station. The medication cart was not		times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment C) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before September 9, 2022.	

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	visible from a sitting position at the nurses station. Licensed Practical Nurse (LPN) 2 returned to the medication cart, placed an insulin pen in the top drawer, and indicated the medication cart should not have been left unlocked. The current facility policy titled "STORING DRUGS", dated 12/2017, was provided by the Corporate Clinical Nurse on 08/16/22 at 1:38 P.M. The policy indicated, "...When a permitted person is not in a drug storage area, the drug storage areas and devices must be kept locked..." 3.1-45(a)(2)			
F 0732 SS=E Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows:			

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	(A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to post nurse staffing daily for 5 of 7 days during the survey period. Findings include: During an observation on 08/16/22 at 10:00 A.M., the nurse staffing was posted by the main entrance and dated for 07/25/22. During an observation on 08/17/22 at 3:12 P.M., the nurse staffing was posted by the main entrance and dated for 08/16/22. During an observation on 08/18/22 at 3:08 P.M., the nurse staffing was posted by the main entrance and dated for 08/17/22. During an observation on 08/19/22 at 8:35 A.M., the nurse staffing was posted by the main entrance and dated for 08/17/22. During an observation on 08/19/22 at 3:23 P.M., the nurse staffing was posted by the main entrance and dated for 08/17/22.	F 0732	F732 Requires the facility to post nursing staffing daily. 1. Nursing staffing was immediately posted. 2. All residents have the potential to be affected. The nursing staffing was posted. An inservice was provided to the QMA who is in charge of the posting to ensure she was aware the nursing hours should be posted prior to the shift starting. No concerns were noted. See below for corrective measures. 3. The Posting policy and procedure was reviewed with no changes made. (See attachment F) The staff was inserviced on the above procedure. 4. The DON or her designee will conduct rounds daily ensuring that the nursing staffing is posted daily. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then	09/09/2022

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	During an observation on 08/22/22 at 8:35 A.M., the nurse staffing was posted by the main entrance and dated for 08/17/22. During an interview on 08/22/22 at 9:37 A.M., the Scheduler indicated the nurse staff posting was updated daily. She would change it out after the census was provided by the Business Office Manager. The nurse staffing should have been changed out daily. During an interview on 08/22/22 at 10:07 A.M., the Administrator indicated the facility would follow the federal regulations related to nurse staffing posting. The current facility policy titled, "Postings", with a revision date of 9/17, was provided by the Administrator on 08/22/22 at 10:07 A.M. The policy indicated, "...Staffing (Federal) The facility must post the following information on a daily basis: facility name, current date, total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered Nurses...(B) Licensed practical nurses or licensed vocational nurses...(C) Certified nurse aides...resident census...Posting Requirements: On a daily basis at the beginning of each shift..."		weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment C) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before September 9, 2022.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

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	§483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review, the facility failed to store medications appropriately related to presetting of medications for 1 of 4 medication carts reviewed. (Resident 4, 9, 13, 19, and 42) Finding include: During a random observation on 08/16/22 at 10:21 A.M., the following was observed in the top drawer of the Generations Medication Cart: A medication cup labeled with Resident 4's name and room number, contained the following six pills: - bisacodyl 5 mg (milligrams) 2 tablets - Calcium 600 + D(3) 600 mg-10 mcg - clopidogrel 75 mg - famotidine 20 mg	F 0761	F761 Requires the facility to store medications appropriately. 1. Resident 4, 9, 13, 19, 42 medications were destroyed that were preset in medication cart. 2. All residents have the potential to be affected. Rounds conducted to ensure medications were not preset. An inservice was conducted to ensure nurses and QMA were aware medications cannot be preset. No concerns were noted. See below for corrective measures. 3. The Medication Administration policy and procedure was reviewed with no changes made. (See attachment E) The staff was inserviced on the above procedure. 4. The DON or her designee will	09/09/2022

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	- fluoxetine 40 mg - iron 159 mg - oxybutynin 5 mg - senna 8.6 mg A medication cup labeled with Resident 9's name and room number, contained the following pills: - bisoprolol fumarate 10 mg - bisoprolol fumarate 5 mg - ferrous sulfate 324 mg - gabapentin 400 mg - Lasix 20 mg - pantoprazole 40 mg - potassium chloride 20 mEq (milliequivalent) - Probiotic 250 mg - sertraline 100 mg A cup labeled with Resident 13's name and room number, contained the following pills: - cetaminophen 500 mg 2 capsule - acidophilus 1 cap - adult Multivitamin 1 tab - amlodipine 10 mg - Colace 100 mg - esomeprazole magnesium 40 mg - ferrous gluconate 240 mg - hydralazine 50 mg - hydrocortisone 20 mg - memantine 10 mg - Proscar 5 mg - senna 8.6 mg 2 tabs - simethicone 180 mg - vitamin D3 125 mcg - Xarelto 20 mg A medication cup labeled with Resident 19's name and room number, contained the following pills:		conduct rounds twice daily ensuring that medications are not preset. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment C) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before September 9, 2022.	

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	- aspirin 81 mg - diltiazem 180 mg 2 cap - Ferrex 150 Forte 1 tablet - Furosemide 20 mg - hydrocodone-acetaminophen 10-325 mg - isosorbide mononitrate 30 mg - Lexapro 20 mg - losartan 100 mg - Mucinex 600 mg - amlodipine 2.5 mg - multivitamin 1 tab - pantoprazole 20 mg - senna 8.6 mg 2 tabs - Vitamin C 500 mg - Vitamin D3 25 mcg (micrograms) A medication cup labeled with Resident 19's name and room number and 12:00 P.M., contained one white pill. A medication cup labeled with Resident 42's name and room number and 12:00 P.M., contained one white pill. During an interview on 08/16/22 at 10:21 A.M., QMA (Qualified Medication Aide) 3 indicated medications should not be pre set for residents. The current facility policy titled "MEDICATION ADMINISTRATION", with a revised date 04/2017, was provided by the Corporate Clinical Nurse on 08/16/22 at 1:38 P.M. The policy indicated, "...Never pre-pour medications..." 3.1-25(b)(5)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements.			

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	The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to follow infection control guidelines related to hairnet usage, mask usage, outdated foods, and cleaning schedules for 1 of 2 kitchen observations with the potential to effect 56 of 56 residents that resided in the facility and failed to store food appropriately in the residents' snack refrigerator for 1 of 1 snack refrigerators reviewed. Findings include: 1. The initial kitchen tour was conducted on 08/16/22 at 10:08 A.M., with the DM (Dietary Manager) and the interim RD (Registered Dietician). The DM, RD, and Cook 4 had strands of hair hanging out of their hair nets. The DM had hair	F 0812	F812 requires that the facility procure food from sources approved and or considered satisfactory by federal, state or local authorities. 1. The dietary staff were educated about the correct wearing of hairnets and masks. An in-service was provided to re-educate staff on the policy of hair restraints (see attachment G) and masks (see attachment H). 2. Cleaning schedules were posted and reviewed. Staff were educated on the completion of the cleaning schedules. (see	09/09/2022

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	protruding from her hair net around her temples. The RD had long wisps of hair hanging out from under her hair net and down to her chin, had her surgical mask under her nose, and pulled it up over her nose three times. Cook 4 had her surgical mask under her nose and left it there throughout the observation of the kitchen while preparing food for the residents. The walk-in freezer contained the following: - a four-quart container of leftovers labeled "vegetable soup" with a date of 04/25/22, - a two-quart container of leftovers labeled "vegetable soup" with a date of 04/25/22, - a seven-and-a-half-quart container of leftovers labeled "sloppy joe" with a date of 05/26/22, and - an open plastic bag of fish fillets with no open date and no received date. The bag was not sealed or clamped shut. The DM indicated the freezer items should be discarded after one month. The RD indicated they should not freeze cooked foods. The "Dishroom (AM) Cleaning Schedule", dated August 7 through 13, 2022, was posted in the dish room and provided by the DM on 08/16/22 at 10:27 A.M. - The schedule listed areas that needed cleaned daily that included the coffee carts, food carts, three tank sink, bus carts/tubs, trash bins, sweeping, mopping, and the dish machine. None of the boxes were checked indicating the items and areas had been cleaned. A coffee cart and two dish carts, that had stacks of clean dishes on them, had a sticky residue, some of which was black, on the shelves and upright supports of the carts that could be scratched off. A silver metal		attachment I) 3. The refrigerator on Generations was cleaned out and staff were in-serviced about the cleaning of the refrigerator along with labeling and dating of items in the refrigerator. (See attachment J) 4. The containers of leftovers in the freezer were disposed of and staff were re-educated about the cleaning schedules and carts. 5. The carts in the dish area were cleaned and the dietary staff were re-educated about the cleaning schedules and carts. 6. An in-service was provided to re-educate staff on the policy of hair restraints, cleaning, storage of leftovers; pantry storage and sanitation (see attachment L). The dietary manager or designee will complete round daily (Monday through Friday) for four weeks then twice weekly for four weeks, then weekly for two months then monthly to ensure continued compliance indefinitely (see attachment M) 7. The fining of the above audits will be reviewed during the facilities Quality Assurance meetings and the plan of action adjusted accordingly. 8. The above corrective measures	

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	cart with clean dishes on the shelves had a two inch by one inch cream colored dried food splatter that contained small chunky pieces of food stuff. - The schedule listed areas that needed cleaned weekly and included bleaching the silverware, de-staining the tumblers and coffee mugs, and cleaning the chemical room. No items or areas on the schedule were checked off indicating they had been cleaned. No cleaning schedule was posted for the current week. The DM indicated the staff completed the tasks they just had not checked them on the schedule. 2. The single resident snack refrigerator currently in use was located on the Generations hall and was observed on 08/22/22 at 11:50 A.M., with LPN (Licensed Practical Nurse) 2. The refrigerator contained the following: - a Styrofoam cup with a lid and a straw, half full of red liquid with Resident 37's name written on it and dated 08/19/22. LPN 2 indicated it was probably red pop, - a brown paper sack laying on its side and torn open down one side with no name or date, containing a small open box with an open-faced roast beef sandwich that looked dry and crusty, and - a plastic sandwich container labeled with Resident 17 and Resident 14's first names, as identified by LPN 2, and dated 08/17/22. The label also listed the food items in the container which included, but was not limited to, salmon.		will be completed on or before September 9, 2022.	

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LPN 2 indicated foods brought in by families that were not prepackaged and sealed could be kept for 48 hours.

The freezer contained the following:

- an open box of egg sandwiches labeled with Resident 20's name but no date,
- an open box of sausage sandwiches with Resident 20's name but no date,
- a large 12" (inch) x 12" blue ice pack that LPN 2 indicated was from the therapy department,
- an eye mask labeled with Resident 254's name, and
- a 5" x 12" blue ice pack labeled with Resident 254's name.

LPN 2 indicated the ice packs had been on the resident's body at some time and ice packs should not be stored in the freezer with residents' foods.

During an interview on 08/22/22 at 4:10 P.M., the Corporate Clinical Nurse indicated they had not had any food borne illnesses in the facility in recent months.

During an interview on 08/22/22 at 4:22 P.M., the DON (Director of Nursing) indicated all 56 residents received food from the kitchen.

During an interview on 08/22/22 at 4:29 P.M., the DM indicated staff were supposed to wear their hairnets covering their entire head and all of their hair.

The current "Hair Restraints" policy, dated 05/2018, was provided by the DON on 08/22/22 at 4:36 P.M. The policy indicated, "...food employees shall wear hair restraints...that are designed and

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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
	worn to effectively keep their hair from contacting...exposed food...clean equipment, utensils..." The current "Cleaning Schedule" policy, dated 05/2018, was provided by the DON on 08/22/22 at 1:34 P.M. The policy indicated, "...It is necessary to ensure that equipment is cleaned and sanitized on a timely basis...A new cleaning schedule is posted weekly...Once the cleaning assignment is completed, it is initialed and dated by the employee who completed the job...the dietary manager inspects the item and works with the employee if cleaning is not satisfactory..." The current "REFRIGERATED FOODS / NOURISHMENT PANTRIES" policy, dated 10/2014, was provided by the DON on 08/22/22 at 11:58 A.M. The policy indicated, "...date mark all food items when opened ...potentially hazardous foods should be discarded thereby diminishing the risk of food borne illness...REFRIGERATED FOODS PROCEDURE...Food items that are opened and not totally consumed...shall be date marked with the date opened...Food items that require refrigeration...shall be maintained for 3 days...Food items that have not been date marked when placed in the refrigerator shall be discarded...NOURISHMENT PANTRIES PROCEDURE...Items kept in...refrigerators...should be dated..." The current undated "Refrigerator and Freezer Policy" that was taped to the outside of the resident snack refrigerator and signed by the Administrator was provided by the DON on 08/22/22 at 1:15 P.M. The policy indicated, "...This fridge and freezer are for Resident's [sic] food and/or drinks ONLY...Any item that is in this fridge or freezer must have either date it was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING 00 B. WING	08/22/2022

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	opened and the name of the resident it belongs to...Any food that is not labeled and dated is liable to be discarded..." The current "FOOD BROUGHT TO RESIDENTS BY FAMILY AND OTHER VISITORS" policy, with a revised date of 09/2017, was provided following the Entrance Conference. The policy indicated, "...facility staff shall offer assistance to ensure food items are stored in a safe and sanitary manner to include being sealed, labeled, date marked...to prevent potential foodborne illness..." 3.1-21(i)(3)			