STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation Complaints IN00438262 and IN00446463. Complaint IN00438262-No deficiencies related to the allegations are cited. Complaint IN00446463-Federal/State deficiencies related to the allegations are cited at F804. Survey dates: October, 28, 29, 30, 31, and Novermber 1 and 4, 2024. Facility number: 000095 Provider number: 155181 AIM number: 100290490 Census Bed Type: SNF/NF: 120 SNF: 23 Total: 143 Census Payor Type: Medicare: 14 Medicaid: 115 Other: 14 Total: 143 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on November 8, 2024.	F 0000	The plan of correction is to serve as Carmel Health & Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Carmel Health & living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations.	
F 0576 SS=D	483.10(g)(6)-(9) Right to Forms of Communication w/ Privacy			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alyssa Holliday	HFA	11/22/2024

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

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Bldg. 00	Based on interview and record review, the facility failed to ensure mail was delivered unopened for 1 of 1 resident reviewed for resident rights. (Resident 135) Finding includes: During a resident council interview, on 10/30/24 at 1:05 p.m., Resident 135 indicated an item of her mail from Medicaid had been opened by the facility prior to being delivered. She indicated she had not given permission and did not want anyone from the facility to open her mail. The clinical record for Resident 135 was reviewed on 10/30/24 at 3:08 p.m. The diagnoses included, but were not limited to, cerebral palsy, type 2 diabetes mellitus, chronic viral hepatitis, atherosclerotic heart disease, and noninfective gastroenteritis and colitis. Resident 135 signed a "Permission & Acknowledgment" form, on 9/30/24 at 7:20 p.m. She selected "NO" to "I authorize community personnel and/or volunteers to open the resident's mail and read it to the resident at times the resident is unable to do so" and "NO" to "If the resident applies for Medicaid, I authorize the designated community personnel to open the resident's Medicaid mail each month to access the Medicaid number for billing purposes." Resident 135 had signed an "Authorized Representative for Health Coverage" form which named the facility as her representative. The form was not dated. During an interview, on 10/30/24 at 02:00 p.m., the Business Office Manager (BOM) indicated the	F 0576	**F576 Rights to form of communication with Privacy: Based on interview and record review, the facility failed to ensure mail was delivered unopened for 1 of 1 resident reviewed for resident rights. (Resident 135)** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 135 suffered no ill effect due to this alleged ill practice. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; This was an isolated incident of this alleged deficient practice. Facility had already corrected this action. Facility will continue to maintain that all resident mail is delivered unopened. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The Admin/Designee will provide education to staff who receive/deliver mail to the residents, to maintain that all mail delivered to the residents is unopened.	11/14/2024

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	facility opened Resident 135's Medicaid approval letter, made a copy of her new Medicaid card, and then delivered it to the resident. She had opened the Medicaid mail under the direction of the corporate office due to other sister facilities had checks delivered to residents which were supposed to go to the facility for payment. During an interview, on 10/31/24 at 9:26 a.m., the Executive Director (ED) indicated the facility did not have a policy pertaining to mail delivery or mail services. A current facility policy, titled "Resident Rights," dated 6/6/19 and received from the ED on 10/31/24 at 9:26 a.m., indicated "...Exercise his or her rights as a resident of the facility and as a resident or citizen of the United States...privacy and confidentiality...communicate in person and by mail...with privacy...The unauthorized release, access or disclosure of resident information is prohibited...." 3.1-3(s)(1)		how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and All resident mail delivered to the facility will be taken to Activities Director to be distributed to the residents by her staff. Activities staff will be monitored while delivering mail to ensure that all resident mail is maintained unopened. by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Completed 11/14/24	
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments Based on interview and record review, the facility failed to ensure pre-admission screening and resident reviews (PASARR) were accurate and updated for 2 of 3 residents reviewed for PASARR. (Residents 87 and D) Findings include:	F 0644	F644 Coordination of PASARR & Assessment: **Based on interview and record review, the facility failed to ensure pre-admission screening and resident reviews (PASARR) were accurate and updated for 2 of 3 residents reviewed for**	11/22/2024

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	1. The clinical record for Resident 87 was reviewed on 10/30/24 at 8:49 a.m. The diagnoses included, but were not limited to, depression, borderline personality disorder, and age-related physical debility. A notice of PASARR Level I, dated 8/2/24, indicated Resident 87 did not take any mental health medications. A physician's order, with a start date of 9/23/24, indicated the resident was on Amitriptyline (an antidepressant medication) 50 milligrams once a day. During an interview, on 10/30/24 at 2:10 p.m., the Clinical Support nurse indicated Resident 87 was on Amitriptyline on admission. She should have had the medication listed on her Level I PASARR. During an interview, on 11/01/24 at 11:37 a.m., Social Services 14 indicated the social service department was responsible for the PASARRs and were the ones who made sure the Level I and Level II were up to date. PASARRs should be updated when someone received a new mental health medication. 2. The clinical record for Resident D was reviewed on 10/29/24 at 3:29 p.m. The diagnoses included, but were not limited to, major depressive disorder, anxiety, and bipolar disorder. Resident D was admitted to the facility with a diagnosis of bipolar disorder on 9/11/24. A PASARR Level I, dated 8/13/24, indicated Resident D did not have a serious mental health disability and it was determined no Level II screen was required.		**PASARR. (Residents 87 and D)** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 87 and D suffered no ill effect due to this alleged deficient practice. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. A complete audit of all residents PASARR will be conducted to verify all current PASARR are accurate and up to date. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Admin/Designee will provide education to Social Service Associates on the importance of verifying PASARR are accurate and up-to-date. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and All admissions PASARR will	

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	The mental health diagnoses listed on the Level I PASARR were anxiety and depression/depressive disorder. The diagnosis of bipolar disorder was present on Resident D's admission Minimum Data Set (MDS) assessment. During an interview, on 11/1/24 at 2:13 p.m., Social Services 14 indicated the social service department should review the resident's diagnoses upon admission and if the resident triggered for a Level II screen, they would initiate the Level II screening process. Resident D's bipolar diagnosis was missed, and a Level II screening should have been initiated. During an interview, on 11/1/24 at 2:04 p.m., the Clinical Support nurse indicated the facility did not have a policy for PASARR. The facility followed the resident assessment instructions (RAI). 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)		be reviewed with the first 72 hrs of a resident admitting. An audit will be conducted daily M-F for 4 weeks, biweekly for 4 weeks, monthly for 9 months. The results of the audit will be reviewed at the monthly QAA until substantial compliance is achieved and maintained. Changes may be established to the auditing process based on the results of the audit. by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Completed 11/22/24	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on interview and record review, the facility failed to ensure a comprehensive person-centered care plan was developed for a resident diagnosed and treated for insomnia for 1 of 31 residents reviewed for comprehensive person-centered care plans. (Resident F) Finding includes: The clinical record for Resident F was reviewed on	F 0656	F656 Develop/Implement Comprehensive Care Plan: Based on interview and record review, the facility failed to ensure a comprehensive person-centered care plan was developed for a resident diagnosed and treated for insomnia for 1 of 31 residents reviewed for comprehensive person-centered care plans.	11/22/2024

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	10/29/24 at 3:23 p.m. The diagnoses included, but were not limited to, senile degeneration of the brain (dementia), diastolic heart failure, and insomnia. A physician's order, dated 6/18/24, indicated Resident F was to receive a melatonin 10 milligram (mg) tablet, once a day, before bedtime for insomnia. A physician's order, dated 8/29/24, indicated Resident F was to receive a trazodone (an antidepressant medication) 50 mg tablet, once a day, before bedtime for insomnia. A physician's order, dated 10/24/24, indicated Resident F was to receive a Seroquel (an antipsychotic medication) 50 mg tablet, once a day, before bedtime for insomnia. The comprehensive care plan did not include Resident F's diagnosis of insomnia or the use of melatonin, trazodone and Seroquel. During an interview, on 10/30/24 at 10:12 a.m., RN 10 indicated Resident F did not sleep well at night and was on several medications for insomnia. During an interview, on 11/1/24 at 2:13 p.m., Social Services 14 indicated it was the responsibility of the social service department to review the resident's diagnoses and medications to assure they were added to the care plans. Resident F's diagnosis of insomnia and the medications prescribed were not included in the care plan. During an interview, on 11/1/24 at 2:04 p.m., the Clinical Support nurse indicated the facility did not have a policy for care plans. The facility followed the resident assessment instructions		(Resident F) what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident F suffered no ill effect due to this alleged deficient practice. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. A complete audit will be conducted of all residents diagnoses to confirm all have been care planned. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/Designee will provide education to nursing staff on the importance of proper care planning for diagnoses. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and IDT will be responsible for verifying all resident diagnosis are care planned. IDT will ensure all	

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	(RAI) manual. 3.1-35(a)		care plans are in place. Audit will be conducted on 5 residents daily M-F for 4 weeks, bi-weekly for 4 weeks monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process based on the results of the audit. by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan Completed 11/22/24	
F 0684 SS=E Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure staff followed physician's orders to hold medications, administer as needed (prn) medications according to the parameters, obtain daily weights, and failed to communicate with a urologist and a hospice provider for 5 of 5 residents reviewed for quality of care. (Residents G, H, F, 33 and 105) Findings include:	F 0684	F684 Quality of Care: **Based on interview and record review, the facility failed to ensure staff followed physician's orders to hold medications, administer as needed (prn) medications according to the parameters, obtain daily weights, and failed to communicate with a urologist and a hospice provider for 5 of 5 residents**	11/22/2024

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	1. The clinical record for Resident G was reviewed on 10/30/24 at 11:05 a.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, essential primary hypertension, anxiety disorder, recurrent major depressive disorder, and moderate vascular dementia with psychotic disturbance. A care plan, dated 7/14/22 and edited 9/9/24, indicated the resident had the potential for hypoglycemia, hyperglycemia, and diabetic complications. The interventions included, but were not limited to, administer accuchecks and any insulin coverage per physician's order. A physician's order, dated 6/8/23, indicated to give 8 units of Humalog U-100 insulin solution subcutaneously three times a day with special instructions to hold the dose if the blood sugar reading was less than 150. A Medication Administration Record (MAR), dated 9/1/24 through 9/30/24, indicated the Humalog was administered: a. On 9/1/24, with a blood sugar of 127. b. On 9/8/24, with a blood sugar of 142. A MAR, dated 10/1/24 through 10/31/24, indicated the Humalog was administered: a. On 10/7/24, with a blood sugar of 148. b. On 10/13/24, with a blood sugar of 144 in the a.m., and a blood sugar of 141 in the p.m. c. On 10/25/24, with a blood sugar of 147. d. On 10/28/24, with a blood sugar of 143. e. On 10/30/24, with a blood sugar of 149. A physician's order, dated 6/5/24, indicated to give a 0.1 milligram (mg) clonidine tablet by mouth twice a day as needed upon rising and before bedtime with special instructions to give for a systolic blood pressure (SBP) greater than 160.		**reviewed for quality of care. (Residents G, H, F, 33 and 105)** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents (G, H, F, 33 and 105) had no ill effect due to this alleged deficient practice. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice's. Current residents who have a order for daily wights have the potential to be affected. Current residents weights were audited to ensure all weights are being obtained per order. Unit Managers will ensure residents who go out for appointments will have follow up paperwork or a follow-up phone call to the office will be made. All Hospice correspondence was reviewed to ensure any changes to resident orders/care is communicated/up-to-date. All resident medication administration records have been reviewed to ensure medication administration is being followed per physician orders	

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	A physician's order, dated 7/24/24, indicated to obtain a blood pressure reading daily upon rising. A MAR, dated 9/1/24 through 9/30/24, indicated the as needed clonidine was not administered as ordered: a. On 9/1/24, for a systolic blood pressure of 173 in the a.m., or the p.m. b. On 9/3/24, for a systolic blood pressure of 182 in a.m., or 172 in p.m. c. On 9/7/24, for a systolic blood pressure of 185. d. On 9/16/24, for a systolic blood pressure of 165. e. On 9/18/24, for a systolic blood pressure of 177. f. On 9/20/24, for a systolic blood pressure of 181. g. On 9/25/24, for a systolic blood pressure of 169. h. On 9/27/24, for a systolic blood pressure of 172. i. On 9/28/24, for a systolic blood pressure of 173. A MAR, dated 10/1/24 through 10/31/24, indicated the as needed clonidine was not administered as ordered: a. On 10/6/24, for a systolic blood pressure of 168. b. On 10/9/24, for a systolic blood pressure of 167. c. On 10/17/24, for a systolic blood pressure of 174. d. On 10/21/24, for a systolic blood pressure of 171. A nurse practitioner progress note, dated 10/4/24, indicated the resident had chronic uncontrolled hypertension and to monitor closely. During an interview, on 11/4/24 at 10:30 a.m., the Clinical Support nurse indicated the Humalog doses were supposed to be held when the resident's blood sugar was less than 150. When the dose was held, there would be a 0 for the dose, a blank, or not given on the MAR.		what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/Designee will provide education to nursing staff on the importance of following physician's orders to holding meds, administration of PRN medications according to the parameters, obtaining daily weights, communication/follow up post resident appointments, and communication with hospice companies. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and IDT will be responsible to conduct audits daily of (daily weights, review of all residents on hospice binders, follow up to resident appointments, and review of MARs for correct medication administration) for 5 days a week mon-fri for 4 weeks, biweekly for 4 weeks, monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process based on the results of the audit.	

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	During an interview, on 11/4/24 at 12:15 p.m., Unit Manager 4 indicated the as needed clonidine was to be given with the morning and evening medications when the systolic blood pressure was greater than 160. The Humalog should be held according to the physician's hold orders.2. The clinical record for Resident H was reviewed on 10/29/24 at 3:25 p.m. The diagnoses included, but were not limited to, history of urinary tract infections, neuromuscular dysfunction of the bladder, and dementia. During an interview, on 10/29/24 at 1:57 p.m., the daughter of Resident H indicated she had concerns with the lack of communication at the facility. She indicated Resident H had an outpatient urology appointment on 10/18/24 and was diagnosed with a urinary tract infection (UTI). Resident H was supposed to be started on an antibiotic for the UTI, but when she called the facility to see if Resident H had started the medication, the nurse indicated the facility did not know anything about the antibiotic. A physician's order indicated if the resident had a positive urine culture, to fax the information to the Infection Disease (ID) provider or to call and speak with the staff. The physician's order included the ID provider's fax number and office telephone number. A progress note, dated 10/28/24, indicated Resident H's daughter called the facility inquiring if the antibiotic for the UTI had been started. The nurse did not find any information about the urinalysis testing or prescribed antibiotics. The nurse asked Unit Manager 18 if he had any information on the matter. Unit Manager 18 indicated he had not received anything.		by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Completed 11/22/24	

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	During an interview, on 10/30/24 at 2:42 p.m., the Administrator indicated Resident H returned from her outpatient appointment without paperwork. During an interview, on 11/1/24 at 9:58 a.m., RN 9 indicated if a resident returned from an appointment without paperwork, she would first check with the transportation driver to see if the paperwork was left in the vehicle. If the paperwork was not in the vehicle, she would then call the office the resident returned from. During an interview, on 10/31/24 at 11:29 a.m., Unit Manager 8 indicated the standard of practice for the facility was to reach out to the provider within 24 hours if a resident returned from an outside appointment without paperwork. During an interview, on 10/31/24 at 3:07 p.m., a staff member from the outside provider indicated Resident H had an appointment, on 10/18/24, for a urinary catheter change and a urinalysis sample was obtained. The positive urine culture results were faxed to the ID provider's office and to the facility on 10/25/24 at 8:00 a.m. She received a fax confirmation indicating the fax was sent successfully. She sent the fax again, on 10/30/24 at 2:00 p.m., after the resident's daughter came into the office indicating the resident had not received the antibiotic. There was a 6-day delay in Resident H receiving treatment for the UTI. 3. The clinical record for Resident F was reviewed on 10/29/24 at 3:23 p.m. The diagnoses included, but were not limited to, anxiety and insomnia. A physician's order, dated 6/18/24, indicated Resident F was receiving hospice services.			

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	155181	A. BUILDING 00 B. WING	11/04/2024

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	An entry in the hospice communication log, dated 10/21/24, indicated hospice nurse RN 12 communicated new orders to discontinue melatonin (a medication to treat insomnia), discontinue the scheduled nighttime lorazepam (a medication to treat anxiety) and to start Seroquel (an antipsychotic medication) 25 milligram (mg) for insomnia with the facility. During a review of the physician's orders: a. an order for Seroquel 25 mg was not found. b. there was an active order for melatonin 10 mg, to be given before bedtime, indicating staff was administering the medication. c. there was an active order for lorazepam 0.5 milliliter (ml), to be given before bedtime, indicating staff was administering the medication. An entry in the hospice communication log, dated 10/24/24, indicated to increase the Seroquel from 25 mg to 50 mg. A physician order, dated 10/24/24, indicated Seroquel 50 mg was started. During an interview, on 10/30/24 at 11:25 a.m., the Director of Nursing (DON) indicated the hospice nurse would give the order to the nurse in the facility or the unit manager. The hospice nurse would then enter the order in the matrix or write the order on the order sheet. Unit manager 8 checked the binders for anything new added by hospice. While reviewing the Medication Administration Record (MAR), on 10/30/24 at 11:25 a.m., the DON indicated the melatonin, and the lorazepam had been administered from 10/21 to 10/29.			

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	During an interview, on 10/30/24 at 2:13 p.m., Unit Manager 8 indicated she was not aware the medications had been discontinued. She indicated hospice would give the order to the nurse and if the unit manager was not there, a copy of the order would be placed under the unit manager's office door. Unit Manager 8 indicated she checked the hospice binders for information added by hospice and had missed the entry regarding discontinuing the melatonin and lorazepam. During an interview, on 10/30/24 at 2:51 p.m., hospice nurse RN 12 indicated the protocol for a new order would be to write the order on the order sheet and give the sheet to the facility nurse. To ensure the facility nurse was aware of what the order was, she would have the facility nurse repeat the order back to her. RN 12 indicated she did this with the facility nurse but was unable to recall the name of the nurse she gave the orders to. She indicated she did not have access to the electronic medical record the facility used and was unable to verify if the orders had been placed. A review of the MAR indicated Resident F had been administered melatonin 10 mg, from 10/21-10/29, after the order by hospice to discontinue the medication. A review of the MAR indicated Resident F had been administered lorazepam 0.5 ml, from 10/21 to 10/29, after the order by hospice to discontinue the medication. 4. The clinical record for Resident 33 was reviewed on 10/30/24 at 2:31 p.m. The diagnoses included, but were not limited to, hypertensive heart disease, hyperlipidemia (high cholesterol), and diabetes. A care plan, initiated on 8/21/18, indicated Resident 33 had a potential for abnormal blood			

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	pressures due to hypertension. One intervention, dated 8/21/18, indicated to administer medications per physician's orders. A physician's order, initiated on 6/28/24, indicated to give metoprolol tartrate (a medication for high blood pressure) 25 milligrams, twice a day. The order indicated to hold the medication if the resident's systolic blood pressure was less than 110 or if the pulse was less than 60 beats per minute. The October 2024 Medication Administration Record was reviewed and indicated the blood pressure results were outside of the physician's hold parameters, but the medication was administered: a. On 10/5/24, the resident had a blood pressure reading of 106/63. The blood pressure medication was administered between 7:00 a.m. and 11: 00 a.m. b. On 10/17/24, the resident had a blood pressure reading of 105/59. The blood pressure medication was administered between 7:00 a.m. and 11: 00 a.m. c. On 10/24/24, the resident had a blood pressure reading of 107/69. The blood pressure medication was administered between 7:00 a.m. and 11: 00 a.m. d. On 10/26/24, the resident had a blood pressure reading of 99/62. The blood pressure medication was administered between 7:00 a.m. and 11: 00 a.m. During an interview, on 11/1/24 at 10:32 a.m., Unit Manager 8 indicated the nursing staff were not supposed to give the blood pressure medication, metoprolol, based on the blood pressure reading. They should have held the medication.5. The clinical record for Resident 105 was reviewed on 10/30/24 at 1:03 p.m. The diagnoses included, but were not limited to, unspecified edema, acute kidney failure, and unspecified fluid overload.			

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	A current care plan, with a start date of 10/04/23 and last revised on 9/9/24, indicated the resident had a potential for fluid volume excess/exacerbation related to congestive heart failure. Administer medications as ordered. A physician's order, with a start date of 10/4/24, indicated to obtain and record a daily weight upon rising before breakfast. Please give as needed Lasix (a diuretic) for a weight gain of 3 pounds in a day and 5 pounds in a week. A physician's order, with a start date of 6/13/24, indicated to give Lasix 40 mg once a day as needed for a 3-pound weight gain in a day or 5 pounds in a week. The Medication Administration Record (MAR) indicated daily weights were not obtained on 10/4/24, 10/14/24, 10/21/24, and 10/24/24. The MAR indicated Lasix was not administered per the physician's order for weight gains on 10/7/24, 10/12/24, and 10/29/24. During an interview, on 10/31/24 at 2:14 p.m., the Director of Nursing (DON) indicated she did not see where it was charted as the resident refused weights for those specific dates. There were missing as needed Lasix administrations and missing daily weights. During an interview, on 11/1/24 at 3:08 p.m., the Assistant Director of Nursing (ADON) indicated the resident was missing some daily weights and she was not sure why the Lasix had not been given. The staff should chart any refusals. During an interview, on 11/1/24 at 2:05 p.m., the Corporate Support Nurse indicated the facility did			

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	not have a policy for following physician's orders. The facility was unable to provide a policy related to follow up communication with outside providers when a resident returned to the facility without paperwork. A facility document, titled "NURSING FACILITY AND HOSPICE SERVICES AGREEMENT," updated July 2020 and received upon entrance, indicated "...Hospice and facility shall develop a process by which to exchange information between Hospice IDG and Facility staff regarding...updating of the Coordinated POC...Facility Plan of Care...Plan of Care, Medications and Orders. The most recent Coordinated POC, medication information and physician orders specific to each Hospice Patient...." 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview and record review, the facility failed to ensure a resident did not have smoking articles in their room for 1 of 7 residents reviewed for accident hazards. (Resident 241) Finding includes: During an observation, on 10/28/24 at 12:00 p.m., Resident 241 had an electronic cigarette (e-cigarette) or vape in his room on his bedside table. During an observation and interview, on 10/28/24 at 12:05 p.m., CNA 20 walked in the resident's	F 0689	F689 Free of Accidents Hazards/Supervision/Devices: **Based on observation, interview and record review, the facility failed to ensure a resident did not have smoking articles in their room for 1 of 7 residents reviewed for accident hazards. (Resident 241)** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 241 had no ill effect	11/22/2024

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	room with the resident's lunch. The resident slowly grabbed the vape and brought it towards his abdomen as CNA 20 came in the door. The vape was still visible in the resident's hand as the CNA placed his lunch tray down on the table. CNA 20 indicated she was not sure if residents could have vapes stored in their rooms or not. The clinical record for Resident 241 was reviewed on 10/30/24 at 10:57 a.m. The diagnoses included, but were not limited to, opioid dependence, drug induced constipation, unspecified pain, and anxiety disorder. During an interview, on 10/28/24 at 12:11 p.m., Unit Manager 4 indicated he did not believe residents could have a vape in their room. It was a smoke free facility. He would check with the Executive Director (ED). During an interview, on 10/28/24 at 12:19 p.m., the ED indicated residents should not have vapes in their room. A current facility policy, titled "SMOKING POLICY," dated 6/6/19 and received from the Executive Director on 10/28/24 at 12:30 p.m., indicated "...Residents are not permitted to give smoking articles to other residents and personal smoking articles must be secured to prevent access by other residents. 14. Residents without independent smoking privileges may not have or keep any smoking articles, including cigarettes, tobacco, etc., except when they are under direct supervision...." 3.1-45(a)(1)		of this alleged deficient practice. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged practice. Residents are provided with the Facility Non Smoking Policy upon admission, and a copy of the policy is also placed in each new admissions room. If smoking articles are found in residents rooms, it will be removed from the room and family member of the resident will be asked to take the smoking article home. Education will then be given to resident/family at that time. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Facility smoking policy will be reviewed at the next resident council meeting. Admin/Designee will educate staff of Facility non-smoking policy. Staff will also be educated if they see smoking articles in resident rooms, to remove those items and take them to the unit manager. how the corrective action(s) will be monitored to ensure the deficient practice will not recur,	

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			i.e., what quality assurance program will be put into place; and Caring Hearts/IDT will be responsible for conducting audits daily on 5 residents for 5 days a week Mon-Fri for 4 weeks, biweekly for 4 weeks, monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of the audit. - by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Completed 11/22/24	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview and record review, the facility failed to ensure the correct amount of oxygen was administered as ordered by the physician for 2 of 3 residents reviewed for respiratory care. (Resident 10 and 37)	F 0695	F695 Respiratory/Tracheostomy Correct Suctioning: **Based on observation, interview and record review, the facility failed to ensure the correct amount of oxygen was**	11/22/2024

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	Findings include: 1. During an observation, on 10/28/24 at 3:36 p.m., Resident 10's oxygen concentrator (a device used to provide supplemental oxygen therapy) was set on 3 liters per minute (L). During an observation, on 10/29/24 at 10:25 a.m., Resident 10's oxygen concentrator was set on 3L. During an observation, on 10/30/24 at 2:24 p.m., Resident 10's portable oxygen concentrator was set on 3L. During an observation, on 10/31/24 at 3:10 p.m., Resident 10's portable oxygen concentrator was set on 3L. During an observation, on 11/4/24 at 9:56 a.m., Resident 10's oxygen concentrator was set on 3L. The clinical record for Resident 10 was reviewed on 10/31/24 at 9:05 a.m. The diagnoses included, but were not limited to, heart failure, vascular dementia with mood disturbance, type 2 diabetes mellitus, chronic pulmonary embolism, shortness of breath, and acute and chronic respiratory failure. A care plan, dated 7/31/24 and last edited on 10/8/24, indicated the resident was on oxygen therapy. Interventions included, but were not limited to, report signs of hypoxia and administer oxygen as ordered. A physician's order, dated 10/8/24, indicated the resident was to receive 2L of oxygen continuously. During an interview, on 10/30/24 at 2:24 p.m., CNA		**administered as ordered by the physician for 2 of 3 residents reviewed for respiratory care. (Resident 10 and 37)** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 10 & 37 had no ill effect due to alleged deficient practice. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents on Oxygen have the potential to be affected by this alleged deficient practice. All Oxygen orders will be reviewed for residents who are on Oxygen to verify the correct Liter Flow. Residents O2 equipment in rooms will be verified for the correct Liter Flow. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; The DON/Designee will provide education to nursing staff on the importance of verifying residents are on correct Liter Flow for O2 equipment. how the corrective action(s)	

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	2 indicated the resident's oxygen concentrator was set on 3L. She was unsure of the resident's ordered liter flow rate. During an interview, on 10/30/24 at 2:29 p.m., LPN 2 indicated the resident's ordered rate was for 2L. During an interview, on 11/4/24 at 9:58 a.m., the ADON (Assistant Director of Nursing) indicated the resident's order was for 2L and the resident's oxygen was set at 3L. 2. During an observation, on 10/29/24 at 9:11 a.m., Resident 37 was observed sitting up in bed. She was receiving oxygen, through a nasal cannula, at 5 liters per minute. A physician's order, initiated on 7/16/24, indicated to provide oxygen at 2 liters per minute continuously via nasal cannula A care plan indicated the resident required oxygen therapy due to hypoxia (a condition which occurred when the body did not have enough oxygen). An intervention, with a start date of 3/6/24, indicated the resident would receive oxygen therapy per the physician's order. During an interview, on 10/29/24 at 9:15 a.m., the Director of Nursing reviewed the order for the resident's oxygen and indicated it was to be at two (2) liters per minute. The nurse was responsible to set the flow rate of the oxygen. During an interview, on 11/1/24 at 11:09 a.m., RN 10 indicated the nurse was to set the oxygen levels for the resident and check the setting throughout the day. A current facility document, titled "OXYGEN ADMINISTRATION SKILLS VALIDATION," dated as revised on 3/4/24 and received from the		will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and DON/Designee will be responsible for conducting audits on 5 residents who are on O2 to verify they are on the correct Liter Flow daily for 5 days a week Mon-Fri for 4 weeks, biweekly for 4 weeks, monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of the audit. by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Completed 11/22/24	

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	Corporate Support Nurse on 11/01/24 at 2:00 p.m., indicated "...Verify physician's order for the liter flow...prior to administering oxygen...." 3.1-47(a)(6)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, interview and record review, the facility failed to ensure the on-coming and off-going staff signed the narcotic count books each shift for 2 of 3 medication carts reviewed for drug reconciliation. (700-unit and 400-unit) Findings include: 1. During an observation, on 10/31/24 at 3:15 p.m., with Unit Manager 4 present, the October 2024 narcotic log count sheets for the 700-unit were observed. Book 1 was found to be missing 31 of 93 possible opportunities to sign the narcotic log sheet when staff were off-going and 28 of 93 possible opportunities to sign the narcotic log sheet when staff were on-coming. Book 2 was found to be missing 34 of 93 possible opportunities to sign the narcotic log sheet when staff were off-going and 33 of 93 possible opportunities to sign the narcotic log sheet when staff were on-coming. 2. During an observation, on 10/31/24 at 3:38 p.m., with LPN 19 present, the October 2024 narcotic log count sheets for the 400-unit were observed. The book was found to be missing 39 of 93 possible opportunities to sign the narcotic logs sheet when staff were off-going and 30 of 93 possible opportunities to sign the narcotic log sheet when staff were on-coming.	F 0755	F755 Pharmacy Services/Procedures/Pharmacist/ Records: **Based on observation, interview and record review, the facility failed to ensure the on-coming and off-going staff signed the narcotic count books each shift for 2 of 3 medication carts reviewed for drug reconciliation. (700-unit and 400-unit)** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All residents had no ill effect of alleged deficient practice. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential of being affected of this alleged deficient practice. All narcotic count books were reviewed for drug reconciliation completion.	11/22/2024

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	During an interview, on 10/31/24 at 3:19 p.m., Unit Manager 4 indicated staff were supposed to sign on/off in the narcotic book. A current facility policy, titled "Policy and Procedure for Scheduled Drugs," dated March 2015 and received from the Corporate Support Nurse on 11/01/24 at 2:00 p.m., indicated "...At the beginning of an associate's shift they must count and account for all scheduled drugs...with the outgoing associate...At the end of an associate's shift they must count and account for all scheduled drugs...with the oncoming associate...At the conclusion of each shift the outgoing and oncoming licensed nurse should complete the Nurse's Narcotic Sign In/Sign Out sheet...." 3.1-25(e)(2) 3.1-25(e)(3)		what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/Designee will educate nursing staff on the importance of completing the In/Out take narcotic count books for all shifts. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The DON/designee will be responsible for auditing the Nurse's Narcotic Sign In/Sign Out sheet for completion. Audits will be conducted daily for 5 days a week Mon-Fri for 4 weeks, biweekly for 4 weeks, monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of the audit. by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to	

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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
			submit an amended plan of correction with the updated plan of correction date. Completed 11/22/24	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, interview and record review, the facility failed to ensure medications and supplements were labeled and dated, expired medications were removed from the cart and medications were stored safe and secured away from residents for 3 of 3 units and 2 of 2 residents reviewed for medication storage. (500-unit, 800-unit, 700-unit, Resident 80 and Resident 45) Findings include: 1. During an observation, on 10/31/24 at 11:55 a.m., with LPN 16 present, the 500-unit medication cart was found to have an open Lantus insulin pen, dated 9/24/24, without a resident name on the pen. An anesthetic oral gel was opened and stored alongside an opened bottle of ear drops. There was also a 30-ounce bottle of liquid protein found open and without a resident's name on the bottle. During an interview, on 10/31/24 at 11:55 a.m., LPN 16 indicated the insulin was expired. The oral gel and eye drops were not to be stored together. The liquid protein was used for whoever needed it. 2. During an observation, on 10/31/24 at 2:53 p.m., with LPN 17 present, the 800-unit medication cart was found to have a 30-milliliter bottle of liquid protein, opened and without a resident's name on the bottle. The 800-unit medication room refrigerator had a bottle of aplisol (a solution used	F 0761	F761 Label/Store Drugs & Biologicals: Based on observation, interview and record review, the facility failed to ensure medications and supplements were labeled and dated, expired medications were removed from the cart and medications were stored safe and secured away from residents for 3 of 3 units and 2 of 2 residents reviewed for medication storage. (500-unit, 800-unit, 700-unit, Resident 80 and Resident 45) what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 80, 45 had no ill effect from alleged deficient practice. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents on 500, 800 & 700 have the potential to be affect by this alleged deficient practice. All medications were reviewed, all expired meds were disposed of	11/22/2024

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	155181	A. BUILDING 00 B. WING	11/04/2024

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	in tuberculosis testing) with the seal broke. There was no open date on the bottle or box. 3. During an observation, on 10/31/24 at 3:19 p.m., with Unit Manager 4 present, the 700-unit medication refrigerator had a bottle of aplisol with the seal broke and no open date. At that time, Unit Manager 4 indicated the solution was to be dated when it was opened. During an interview, on 11/1/24 at 2:00 p.m., the Corporate Support Nurse indicated it was the expectation open dates were placed on medications when they were opened.4. During an observation, on 10/28/24 at 10:23 a.m., Resident 80 had Diclofenac Sodium topical gel 1% (typically used for arthritis pain relief) on his bedside table. During an observation, on 10/29/24 at 9:26 a.m., Diclofenac Sodium topical gel 1% was still on his bedside table. The clinical record for Resident 80 was reviewed on 10/30/24 at 2:35 p.m. The diagnoses included, but were not limited to, other skin changes, chronic kidney disease, and vitamin d deficiency. The resident did not have a physician's order for Diclofenac Sodium topical gel 1%. During an interview, on 10/29/24 at 9:44 a.m., Unit Manager 4 indicated he should not have the gel in his room especially since he did not have an order for it. 5. During an observation, on 10/28/24 at 10:44 a.m., Resident 45 had Diclofenac Sodium topical gel 1% on a table in his room with a label on it. The label did not look like a facility label.		and removed from carts. All medications were reviewed for proper labeling and dating. If meds are observed at bedside, medications will be removed and a comprehensive assessment will be conducted. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/Designee will provide education to nursing staff members to verify proper label and dating of all medications, proper disposal of expired medications, and removal of meds in resident rooms if resident does not have a current order to self-administer that medication and having a comprehensive assessment in place for the medication. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The DON/designee will be responsible to audit 5 resident rooms for meds at bedside, will review 1 med cart daily M-F for expired meds, meds not properly labelled/dated. Audits will be conducted daily for 5 days a week Mon-Fri for 4 weeks, biweekly for 4 weeks, monthly for 9 months. The results of the audit will be	

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	During an observation and interview, on 10/29/24 at 9:38 a.m., the Diclofenac Sodium topical gel 1% was still on the table. Unit Manager 4 indicated they should not have the arthritis gel out in his room. The label on the tube did not look like it was from their pharmacy. The clinical record for Resident 45 was reviewed on 10/30/24 at 10:09 a.m. The diagnoses included, but were not limited to, unspecified edema, unspecified pain, and unspecified vitamin deficiency. A current facility policy, titled " DRUG STORAGE," undated and received from the Corporate Support Nurse on 11/01/24 at 2:00 p.m., indicated "...All expired...medications are removed from resident care areas and stored separately from medications available for administration...Drugs with different routes of administration should...be stored individually in separate compartments...Discontinued and expired medications should be removed from medication carts, refrigerators...." A current facility policy, titled "BEDSIDE MEDICATIONS AND SELF-ADMINISTRATION OF MEDICATIONS," undated and received from the Director of Nursing (DON) on 11/4/24 at 1:40 p.m., indicated "...The DON instructs all staff to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage. All staff will also be instructed to give the unauthorized medications to the DON for return to the family or responsible party when necessary...." 3.1-25(j) 3.1-25(m) 3.1-25(o)		reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of the audit. by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Completed 11/22/24	

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F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs Based on observation, interview and record review, the facility failed to ensure a resident received dental services to repair or replace partial dentures for 1 of 1 resident reviewed for dental services. (Resident 122) Finding includes: During an observation, on 10/29/24 at 3:26 p.m., Resident 122 was well groomed with make-up on including lipstick with missing front teeth. During an observation, on 10/30/24 at 2:21 p.m., the resident was again well dressed, her hair was styled and make-up carefully applied. The clinical record for Resident 122 was reviewed on 10/30/24 at 11:11 a.m. The diagnoses included, but were not limited to, repeated falls, bipolar disorder, oral phase dysphagia, Alzheimer's dementia with behavioral disturbance, anxiety, depression, and impaired memory. An admission assessment, dated 2/2/24, indicated the resident had upper partial dentures. A physician's order, dated 2/2/24, indicated the resident may receive dentistry services as needed. A nursing progress note, dated 7/1/24 at 7:51 p.m., indicated the resident was found in her room holding two of her front teeth when the aid entered to assist with her bedtime rituals. They had apparently just fell out, both were completely rotten. The aid came out to the nurse's station to tell the nurse and when they had returned to the room, the resident had flushed both teeth down	F 0791	F791 Routine/Emergency Dental Services in NF's: **Based on observation, interview and record review, the facility failed to ensure a resident received dental services to repair or replace partial dentures for 1 of 1 resident reviewed for dental services. (Resident 122)** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 122 had no ill effect for alleged deficient practice. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents who need dentures repaired/replaced have the potential to be affected by this alleged deficient practice. All residents who have an issue with their dentures will be reviewed. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Admin/Designee will educate Nursing and Social services when	11/22/2024

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	the toilet. A nursing progress note, dated 7/2/24 at 12:49 p.m., indicated the resident had no pain, infection, or bleeding noted in her mouth where the teeth had fallen out. A nurse practitioner note, dated 7/2/24, indicated per staff the resident's front teeth fell out with no incident. The unit manager was working on a dental consultation. A nursing progress note, dated 7/3/24 at 11:58 a.m., indicated the family was notified of the teeth falling out and the family wanted the resident to be seen by the in-house dentist. A speech therapy note, dated 7/8/24-8/6/24, indicated the resident had natural teeth but was missing a few upper teeth. A care plan, dated 8/26/24, indicated the resident desired to use the facility ancillary services, including dentistry. A speech therapy note, dated 10/26/24-11/24/24, indicated the resident had missing teeth. The electronic medical record did not include any dental visit notes or notes regarding any attempts at repairing or replacing the resident's partial upper dentures. During an interview, on 10/30/24 at 1:14 p.m., the Assistant Director of Nursing (ADON) indicated the teeth which fell out were partial dentures rather than natural teeth. The facility had contacted their dental provider to see if the dentures could be repaired but they had not heard back.		a resident's denture needs repaired, proper communication with ancillary service will be conducted and the facility will routinely track the repairs to ensure timely return of the denture to the resident. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and IDT will be responsible to audit residents who currently have dentures for proper function/usage of those dentures. Audits will be conducted daily for 5 days a week Mon-Fri for 4 weeks, biweekly for 4 weeks, monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of the audit. by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of	

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	During an interview, on 10/31/24 at 9:40 a.m., CNA 5 indicated the resident did not have her partial denture back. She thought they were getting fixed but had not heard anything about them in a long time. The resident was very put together, dressed very well, and always had her make-up and lipstick on. She did not think the resident would be comfortable not having all her front teeth if she did not have dementia. During an interview, on 10/31/24 at 10:00 a.m., Unit Manager 4 indicated the facility was working on getting her partial repaired or replaced, but he had not heard anything about them in a while. He did not know where things were in the process to get her partial dentures back. The resident had not had her dentures since the beginning of July. During an interview, on 10/31/24 at 1:45 p.m., the Administrator indicated the current social worker was new and the facility did not have any notes on any dental consult or dental visits for the resident. The facility could not provide any further notes regarding partial dentures or where things were in the process of getting them repaired or replaced. She thought the partial had been sent to the dentist but there was no documentation on where they were sent, when, or any further progress. The facility had no record of any dental visits arranged for the resident. She had no further paperwork to provide apart from the electronic medical record. A current facility policy, titled "Dental Services Policy," dated 6/6/19 and received from the Clinical Support nurse on 11/4/24 at 12:10 p.m., indicated "...will assist residents in making appointments...for routine...dental services and will refer residents with lost or damaged dentures		correction date. Completed 11/22/24	

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	for dental services within 3 days of said loss or damage...recognizing the importance of the dentures...to the resident self-esteem...When any member of the Community staff is informed that or notices that a resident's dentures are lost or damaged, that staff person will immediately complete the attached "Lost or Damaged Dentures Report" and submit the report to the Administrator...Within 3 business days of receiving the report, the Administrator or designee will ensure that the resident has been referred to the appropriate dental service provider for replacement or repair of the dentures. The Administrator or designee will also follow up to ensure that an appointment has been made...." 3.1-24(a)(3)			
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp Based on observation, interview and record review, the facility failed to ensure food was served at a safe and appetizing temperature for 1 of 1 room tray tested for food temperatures. (200 hall) Finding includes: During an interview, on 10/28/24 at 10:49 a.m., Resident E indicated the food was cold. During an interview, on 10/28/24 at 11:29 a.m., Resident D indicated the food was sometimes cold. During an interview, on 10/28/24 at 3:09 p.m., Resident B indicated the food was cold. During an interview, on 10/29/24 at 11:15 a.m.,	F 0804	F804 Nutritive Value/Appear, Palatable/Prefer Temp: **Based on observation, interview and record review, the facility failed to ensure food was served at a safe and appetizing temperature for 1 of 1 room tray tested for food temperatures. (200 hall)** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 200 Hall residents without ill effect of alleged deficient practice. how other residents having the potential to be affected by the	11/22/2024

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	Resident C indicated the food did not have good flavor and it was cold. During a resident council meeting, on 10/30/24 at 1:05 p.m., the resident council indicated the food was sometimes cold, especially the room trays. During an observation and interview, on 10/31/24 at 11:46 a.m., a lunch tray was chosen at random to obtain food temperatures. The country fried steak temped at 100 degrees, the peas temped at 101 degrees, and the glazed carrots temped at 105 degrees. The Assistant Dining Services Supervisor indicated the hot food should be served at least 120 degrees or higher and she would need to reheat the food prior to serving it to the resident. A current facility policy, titled "Food Preparation and Safety Policy," dated 2020 and received from the Executive Director on 11/4/24 at 12:44 p.m., indicated "...Trays are delivered promptly to ensure that food is served at a preferable temperature and to preserve the quality of the food...Hot food, that is not served at a preferrable temperature to the resident, will be re-heated, to an internal temperature of 165°F for 15 seconds, or replaced..." This citation relates to Complaint IN00446463. 3.1-21(a)(2)		same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by this alleged deficient practice. Mangers will assist with passing room trays to ensure food is served at safe and appetizing temps. Managers will also temp food to verify food is being served at proper temps. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Admin/Designee will provide education to staff on the importance of always serving food at a safe and appetizing temperature. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and Dietary Supervisor/Designee will be responsible for conducting audits on 5 residents room trays 5 days a week Mon-Fri for 4 weeks, biweekly for 4 weeks, monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to	

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			the auditing process, based upon the results of the audit. by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Completed 11/22/24	
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation, interview and record review, the facility failed to ensure a safe, functional, sanitary, and comfortable environment was provided for 5 of 142 rooms reviewed for environment. (Rooms 314, 401, 428, 527, 719) Findings include: 1. During an observation, on 10/28/24 at 10:36 a.m., Room 314 had brown stains on 6 ceiling tiles and a telephone outlet without a cover exposing a white wire and a blue wire. During an observation and interview, on 10/29/24 at 10:16 a.m., the wires were still exposed in Room 314. Unit Manager 19 indicated he was not sure why the outlet cover would be off. It should be covered. He was not sure what type of wires were exposed.	F 0921	F921 Safe/Functional/Comfortable Environment: **Based on observation, interview and record review, the facility failed to ensure a safe, functional, sanitary, and comfortable environment was provided for 5 of 142 rooms reviewed for environment. (Rooms 314, 401, 428, 527, 719)** what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents who reside in rooms 314, 401, 428, 527, 719 had no ill effect from this alleged deficient practice.	11/22/2024

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	2. During an observation, on 10/29/24 at 2:15 p.m., Room 401 had a large brown stain on a dry wall ceiling by the patio door and a kitchenette sink faucet with a constant drip. 3. During an observation, on 10/28/24 at 2:49 p.m., Room 428 had an improperly fitted light switch cover, resulting in a visible hole between the light switch cover and the wall. 4. During an observation, on 10/28/24 at 2:41 p.m., in Room 527, Resident 33 was observed sitting up in bed eating a puree meal. The bed was positioned against a wall with a window. The wall below the window was observed to have drip stains, from food, below the window and on the window. During an observation, on 10/29/24 at 9:19 a.m., Resident 33 was up in the room eating breakfast. The window was noted to have dried debris stuck to it. The wooden windowsill was noted to be cracked with a milky white substance over it. During an observation, on 10/30/24 at 9:38 a.m., Resident 33's window was found to have dried debris stuck to it and the wooden windowsill remained unchanged. During an observation, on 10/30/24 at 12:57 p.m., Resident 33's window was noted to have brownish colored debris stuck to the window and the wooden windowsill remained unchanged. 5. During an observation, on 10/28/24 at 10:44 a.m., Room 719 had opened wound supplies on a table in his room. During an observation and interview, on 10/29/24		Room 314: cover was placed on telephone outlet, 6 ceiling tiles were replaced. Room 401: Ceiling was treated for water damage and painted, Sink faucet was replaced. Room 428: Light switch cover was replaced with on that fit the switch completely. Room 527: was deep cleaned and all debris was removed from the walls/window Room 719: Would Supplies were removed from the room and disposed of. how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All resident rooms have the potential of being affected by this alleged deficient practice. Complete check of all resident rooms will be completed and work orders filled out for repairs that need done. what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance Director/Designee will provide education to staff to submit work orders as soon as they notice repairs need made to residents rooms, ceiling tiles, floors, outlets,	

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	at 9:38 a.m., the wound supplies were still in the room and on the table. Unit manager 4 indicated opened wound supplies should be thrown away and not in the room. During an interview, on 10/31/24 at 10:00 a.m., an environmental tour was completed with the Maintenance Supervisor and the Administrator. They indicated the cover came from the telephone outlet and they did not know how long the cover had been missing. The stains on the ceiling tiles were from condensation when the air conditioning unit was running. When the electric company came to replace the light switch fixtures, they did not put the correct size cover on. They were not aware of the brown stains on the dry walled ceiling. A facility document, titled "Job Description ENVIRONMENTAL SERVICES SUPERVISOR," dated March 2004 and received from the Administrator on 10/31/24 at 2:54 p.m., indicated "...The Environmental Supervisor maintains the facility grounds and all equipment in good working order while providing a clean, safe, sanitary, and attractive living environment conducive to good health and pleasant living conditions for all residents and employees. Supervises the quality of environmental services...Makes rounds of all building areas to observe cleanliness, safety, and working conditions...Inspects and repairs all damage to hallways, walls, ceiling, floors, baseboards, doorjambs, handrails, etc... Supervises the scheduling and performance of housekeeping, laundry and maintenance staff to assure efficient delivery of services...." 3.1-19(f)(5)		or deep cleans that need completed. how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Maintenance Director/Designee will be responsible for completing audits on 5 resident rooms daily for 5 days a week Mon-Fri for 4 weeks, biweekly for 4 weeks, monthly for 9 months. The results of the audit will be reviewed at the monthly quality assurance meeting until substantial compliance is achieved and maintained. Changes may be established to the auditing process, based upon the results of the audit. - by what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date. Completed 11/22/24	