STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155488	A. BUILDING 00 B. WING	03/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ROLLING HILLS HEALTHCARE CENTER	3625 ST JOSEPH RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00400647. Complaint IN00400647 - Federal/State deficiencies related to the allegations are cited at F600, F686, F690, and F725. Survey dates: February 27, 28, March 1, 2 and 3, 2023. Facility number: 000526 Provider number: 155488 AIM number: 100266970 Census Bed Type: SNF/NF: 104 Total: 104 Census Payor Type: Medicare:11 Medicaid: 89 Other: 4 Total: 104 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 11, 2023.	F 0000	Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required.	
F 0584 SS=E Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving			

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

Shamika Palmer | RN, RDCO | 03/30/2023

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

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	treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation and interview, the facility failed to ensure residents' rooms were clean and free of debris for 4 of 5 random observations of	F 0584	F-584 1. Resident 67,20,33,81, and 105 were not harmed by the	03/31/2023

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	the facility environment and for 5 of 104 residents that reside in the facility. (Residents 81, 105, 67, 20, and 33) Findings include: During an observation of Residents 81's and 105's room on 2/28/23 at 2:25 p.m., there was a heavy soiled area of food particles under and around both beds. During an observation of the 200 Hall on 3/1/22 between 2:30 p.m. and 2:45 p.m., in Resident 67's room there were three strips of bacon, a sausage patty, and a heavy accumulation of other unidentifiable food debris on the floor under the resident's night stand. In Resident 20 and 33's room there was a heavy buildup of food debris under the bed and a heavy buildup of brown debris built up on the floor near the walls throughout the room. During an observation of the 200 Hall on 3/2/22 at 2:50 p.m., in Resident 67's room there were three strips of bacon, a sausage patty, and a heavy accumulation of other unidentifiable food debris on the floor under the resident's night stand. In Residents 20's and 33's room there was a heavy buildup of food debris under the bed and a heavy buildup of brown debris built up on the floor near the walls throughout the room. During an observation on 3/3/23 at 10:50 a.m., in Resident 67's room there were three strips of bacon, a sausage patty, and a heavy accumulation of other unidentifiable food debris on the floor under the resident's night stand. In Residents 20's and 33's room there was a heavy buildup of food debris under the bed and a heavy buildup of brown debris built up on the floor near the walls		alleged deficient practice. Residents 67,20,33,81, and 105 rooms were cleaned in accordance with F-584 Safe/Clean/Comfortable/Homelike Environment. 2. All residents in the facility have the potential to be affected by the alleged deficient practice. All resident rooms will be evaluated for cleanliness. Any concerns will be immediately addressed and corrected. 3. The housekeeping supervisor/designee will complete in-service training with all housekeeping staff on policy and procedures as it relates to daily room cleanliness. Education will be completed by 3/24/2023. 4. The housekeeping supervisor/designee will conduct an audit of resident rooms to ensure a safe/clean environment on 5 resident rooms weekly for 1 month, then 3 resident rooms weekly for 1 month, then 5 rooms a month for 1 month. The Regional Housekeeping Supervisor/designee is responsible for the compliance. The results of these audits will be reviewed during the monthly Quality Assurance meeting for 6 months or until 100% compliance is achieved X 3 consecutive months. The QA committee will identify any trends or patters and make recommendations to revise the plan of correction as indicated.	

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	throughout the room. During a confidential interview, between 2/27/23 and 3/3/23, a resident's family member indicated. The room was so dirty they took everything out and cleaned it themselves. They did the mopping and pulled out the furniture. The facility was never clean. During an interview on 3/3/23 at 10:55 a.m., the Housekeeping Supervisor indicated all rooms were swept and mopped daily. They only had one shift of housekeeping services. A lot of days they would come in to work and have to play catch up, because there were two shifts where they did not have housekeeping. When the maintenance and house-keeping were not staffed, the task fell onto nursing staff. The Housekeeping Supervisor entered Resident 67's room and indicated he observed the food debris under the bed and it would need to be cleaned immediately. During an interview on 3/3/23 at 11:00 a.m., Housekeeper 5 indicated Resident 67's room was cleaned on 3/2/23, but they did not pull everything out and clean under it daily. They should have swept under the night stand. 3.1-19(a)			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or			

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	chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, record review, and interview, the facility failed to protect the resident's right to be free from physical abuse by another resident for 3 of 4 residents reviewed for abuse. (Residents B, H, and J) Findings include: 1. The clinical record for Resident B was reviewed on 2/28/23 at 1:42 p.m. The diagnoses included, but were not limited to, schizoaffective disorder, dementia with agitation, paranoid personality disorder, anxiety disorder, depression, and cognitive communication deficit. The social services note, dated 8/10/22 at 2:40 p.m., indicated the resident's cognition assessment indicated her cognition was severely impaired. There were no behaviors at that time. The incident note, dated 10/21/22 at 9:12 a.m., indicated Resident B was observed with abrasions or scratches on her chest and below her right eye area. Upon investigation, the resident indicated another resident allegedly made contact with her, causing the areas. This was not witnessed by any staff members. The resident was assessed by a licensed nurse with no other areas identified. The family and nurse practitioner were notified with treatment orders in place and the care plan was updated. The resident would have a follow up	F 0600	**F600-D** **Corrective action for the residents found to have been affected by the deficient practice:** Resident B could not be identified as they were part of a complaint survey. Resident H could not be identified as they were part of a complaint survey. Resident J could not be identified as they were part of a complaint survey. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents in house have the potential to be affected by this alleged deficient practice. Residents able to be interviewed related to abuse were interviewed for any concerns, and those who were not able to be interviewed had skin assessments complete to ensure no issues were identified. **Measures/systemic changes put**	03/31/2023

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	with psychiatric, social service, and the nurse practitioner as indicated. The incident report, dated 10/21/22, indicated Resident B informed the facility of an altercation between her and Resident G after Resident B entered Resident G's room. Resident B had abrasions to her face and neck. An assessment was completed on both residents and they were both separated. Resident B was placed on one-on-one (one staff to one resident) observation until a psychologist could assess the resident. Resident G had no injuries. The care plan, dated 10/21/22, indicated the resident's psychosocial well-being was at risk for decline due to alleged negative interaction with a peer on 10/21/22, 1/2/23, and 2/13/23. The interventions, dated 10/21/22, indicated to allow the resident time to answer questions and to verbalize feelings, perceptions, and fears, assist, encourage, and support the resident to set realistic self-initiated goals, consult with pastoral care, psychiatric services, and or support groups, when a conflict arose, and to remove the residents to a calm safe environment and allow them to vent or share their feelings. The care plan lacked documentation of new or altered interventions after each incident of negative interactions with a peer or behaviors after 10/21/22. The social service note, dated 10/21/22 at 9:18 a.m., indicated the resident had no recollection of the event. The skin and wound note by the wound nurse practitioner, dated 10/22/22 at 11:17 a.m., indicated the skin and wound were evaluated for the scratch		**into place to ensure the deficient practice does not recur:** DON/Designee educated staff on facilities policy “Indiana Abuse & Neglect & Misappropriation” with emphasis on maintaining resident’s rights to be free from abuse. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON and/or Designee will audit 5 resident’s daily x’s 4 weeks, then 5 resident’s weekly x’s 4 weeks, then 5 resident’s monthly x’s 4 months to ensure residents are free from abuse. The DON and/or Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	marks to the resident's face and chest. The resident was scratched by another resident in the facility. The behavior note, dated 1/5/23 at 5:36 p.m., indicated the resident had continued behaviors of opening the back door and exit seeking. She was wandering the hallways restlessly. The nurse's note, dated 1/23/23 at 5:30 p.m., indicated while the nurse was in the hallway, Resident B randomly came out of her room yelling at staff. She was indicating that staff always do this to her and that it's always their fault. When the resident was asked what's wrong, she indicated it's always their fault and they blame everything on her. The resident then went into her room and slammed the door. The resident was very tearful and agitated for no apparent reason. No one else was in the hallway or in her room. 2. The incident report, dated 11/2/22, indicated Resident B was observed making contact with Resident H and showing an inappropriate hand gesture. The residents were separated immediately. Resident B was sent out for a psychiatric evaluation. During the investigation, Housekeeper 6, indicated she witnessed Resident B make contact with Resident H with her hand to the right side of Resident H's neck. Resident B indicated she hit her. Resident B indicated it felt good and she would do it again. Resident H had a 3-centimeter-long scratch to the right side of her neck. The nurse's note, dated 11/2/22 at 2:30 p.m., indicated Resident B was observed by a housekeeper, walking towards her roommate. Resident B then came in contact with Resident H on the right side of their neck. No injuries were			

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	observed to either party. Neither resident could recall any additional details of the altercation. Resident B was sent to a local hospital ER (emergency room) for psychiatric evaluation and clearance. 3. The incident report, dated 1/31/23, indicated Resident B had a physical altercation with Resident J. The residents were separated, and Resident B was placed on one one one observation. LPN 7's statement, dated 2/1/23, indicated she was walking down the hall on the unit, when Resident K waved her into his room. Resident B was standing with her back to the door. Resident J was kneeling on her knees and Resident B was pulling her. The two were immediately separated and escorted out of Resident K's room. A head-to-toe assessment was completed. The Behavior note, dated 1/31/23 at 5:30 p.m., indicated Resident B made physical contact with Resident J, causing Resident J to fall on the floor. No injuries were observed upon assessment. The MD was notified and a new order to send the resident to the ER for evaluation and treatment and one-on-one supervision immediately was received. The nurse's note, dated 1/31/23 at 10:53 p.m., indicated Resident B returned from the local hospital ER. No distress was observed, and the resident was not at risk for harm to herself or others. The nurse's note, dated 1/31/23 at 11:08 p.m., indicated the psychiatric nurse practitioner was notified of Resident B's return and that she was no longer at risk for harm to others or herself at this time. A new order to discontinue the			

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	one-on-one supervision was received. The nurse's note, dated 2/15/23 at 3:18 p.m., indicated Resident B was moved to another room. Resident L and her new roommate asked for the move. During an observation of the resident on 2/28/23 at 9:27 a.m., the resident was walking in her room. She had her pajamas laid on her bed and was waiting for her shower. During an observation on 3/1/23 at 2:11 p.m., the residents were outside sitting under the shelter. Resident B was sitting with the other residents. The staff were going in and out of the exit doors to bring other residents outside. During a confidential interview between 2/27/23 and 3/3/23, Staff C indicated there had been one episode of abuse between Resident B and Resident H. The two were separated by a room change. Resident B did not like loud people. She needed calm people to be around. The new roommate, Resident L, had been good for her to be around. The interventions to prevent altercations with other residents was to bring Resident B to activities. She especially liked prayer. Resident B would buddy up with Resident L to go to activities. Staff explained to Resident B they were fine and everything was alright. Resident B's hand was swollen one time, but Staff C was unsure how the resident's right hand became swollen. During a confidential interview between 2/27/23 and 3/3/23, Staff K indicated the first altercation for Resident B was with Resident H. Resident H and Resident B were not compatible. Resident B reacted to Resident H being in her face. The			

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	second incident was with Resident J. Their rooms were diagonal from each other. Resident B liked a male resident and was jealous that Resident J had gone into his room. Resident B tried to get Resident J out of the male resident's room by pulling Resident J by her hair. The third altercation the staff could not remember. The interventions were to redirect Resident B. The resident liked to keep to herself and liked a calm environment. Things were less hectic on the front of the hall. The current Indiana Abuse & Neglect & Misappropriation of property policy, was provided by the ED (Executive Director) on 2/27/23 at 9:30 a.m. The policy included, but was not limited to, "... Cases of physical or sexual abuse, for example by facility staff or other residents, always require corrective action... This coordinated effort would allow the QAA Committee to determine... Whether the resident is protected... Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about...Measures to verify the implementation of corrective actions and timeframes, and tracking patterns of similar occurrences." This Federal tag relates to Complaint IN00400647 3.1-27(a)(1)			
F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment,			

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	involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Based on record review, interview, and observation, the facility failed to ensure misappropriation of a resident's property had not occurred, related to a missing narcotic card for 1 of 3 residents reviewed for misappropriation. (Resident 71) Findings include: The review of the Incident Report, dated 1/29/23, indicated the facility discovered Resident 71's card of Hydrocodone-APAP, 10-325 mg, was missing. A pain assessment was completed, and the resident denied pain. RN 8 indicated he worked Friday, 1/27/23, on the 200-Hall from 6:00 p.m. to 6:30 a.m. The RN received a card of Hydrocodone 10-325 mg, containing 30 tablets, from the pharmacy delivery at approximately 8:00 p.m. It was the only narcotic card he had received. The card was for Resident 71. He locked the card in the narcotic cart. Then he put the sheet in the narcotic book and added the narcotic to the Control/Shift change count book. LPN 9 (Licensed Practical Nurse) was scheduled to work the 6:00 a.m. to 6:00 p.m. on the 400- Hall. The LPN arrived at the facility at 6:07 a.m. Another nurse came to LPN 9 and handed her the narcotic keys to the 200-Hall cart. LPN 10 indicated, between 7:30 a.m. and 8:00 a.m., she clocked in and went to the 200-Hall. There was a note on the cart which indicated LPN 9 had the keys to the narcotic medication cart. She went to the 400-Hall and LPN 9 gave her the keys. She started passing her morning medications. RN 11 came to work at 6:00 p.m. and they started counting the narcotics. LPN 10 indicated she noticed the Control/Shift change book was not in the narcotic book. She informed	F 0602	**F602-D** **Corrective action for the residents found to have been affected by the deficient practice:** Resident 71 was not harmed by alleged deficient practice. Resident 71 had pain assessment complete and was noted to have no pain. All notifications were made per facility policy. Residents narcotics that were unaccounted for were replaced at facility cost. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who receive narcotics have the potential to be affected by this alleged deficient practice. All full house audit was complete to ensure all narcotics were accounted for. All residents who are able to be interviewed were interviewed for concerns related to misappropriation & exploitation. Those not able to be interviewed has pain assessments complete to ensure pain was not noted. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated staff on facilities policy “Abuse & Neglect	03/31/2023

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	RN 11 she did not know what to do so when she returned in the a.m. she would inform the supervisor the book was missing. She wrote on a piece of paper the number of cards, then she dated and initialed the paper. RN 11 initialed and signed the paper and then she left the building. The nurse's note, dated 2/7/23, indicated an investigation was completed and the medication card was not located. An audit was conducted on all residents with narcotic medication and no other concerns were observed. The other residents were interviewed and did not voice any concerns about not getting medications when they requested pain medication. The resident's medication was replaced at the facilities expense. During an observation on 3/2/23 at 10:30 a.m., a narcotic count was completed on the 200-Hall, 300-Hall, and the 400-Hall. There were no missing narcotics, narcotic sheets and pharmacy card sheets. During an interview on 3/2/23 at 10:35 a.m., LPN 4 indicated if a narcotic was missing, she would inform the DON immediately and then the pharmacy would be notified. Management would look at the narcotic sheets cards and do a narcotic count. They would call whoever was on that shift and start an investigation. The narcotics should be counted at the beginning and end of every shifts. If she passed her keys to another nurse, due to leaving the building, she would do a narcotic count when she returned to the floor. Anytime the keys were passed from one nurse to another nurse a narcotic should have been done. During an interview on 3/2/23 at 1:00 p.m., the RDCO (Regional Director of Clinical Operations) indicated if a narcotic was missing the incident		& Misappropriation of Property" **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON and/or Designee will audit 5 resident's daily x's 4 weeks, then 5 resident's weekly x's 4 weeks, then 5 resident's monthly x's 4 months to ensure no issues are noted with misappropriation of property. The DON and/or Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required	

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	would be reported to the DON and then she would report to the Executive Director. The RDCO, police, physician, pharmacy, and the resident's family would be notified. An investigation would be initiated. Anytime anyone leaving or returning to the building, a narcotic count should have been done. The Abuse and Neglect and Misappropriation of Property Policy and Procedure, last revised 7/25/18, included, but was not limited to, " ...Misappropriation of resident funds or property: In Indiana, the deliberate misplacement, exploitation, or wrongful, temporary or permanent us of a resident's property or money without the resident's consent. Resident's property included all resident's possessions, regardless of their apparent value since it may hold intrinsic value to the resident. This includes any medication dispensed in the name of the resident. This does include medications from an EDK [Emergency Drug Kit] that have not been charged to the resident..." 3.1-28(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives			

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	necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on record review and interview, the facility failed to ensure preventative interventions were implemented for 3 of 4 residents reviewed for pressure ulcers. (Residents E, O, and F) Findings include: 1. The clinical record for Resident E was reviewed on 2/28/23 at 12:00 p.m. The diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and homonymous bilateral field defects of left side. The admission assessment, dated 2/2/22, indicated the resident had no skin areas observed. The Braden scale indicated the resident was chairfast, had slightly limited mobility, adequate nutrition, had a potential problem with friction and shearing, and was identified as a potential risk for skin breakdown. Suggested interventions included explain risk versus benefits to resident/family and the importance of changing positions for prevention of pressure ulcers, encourage small frequent position changes, turning and repositioning at least every 2 hours when in bed as resident will allow, use of pillow to separate pressure areas, with special attention of off-loading contracted joints, elevation of heels off bed, and use of wedges to help maintain positioning. The baseline care plan, dated 2/2/22, indicated the resident required extensive assistance of two staff members with bed mobility, was totally dependent for transfers. Bowel and bladder interventions	F 0686	**F686-D** **Corrective action for the residents found to have been affected by the deficient practice:** Resident 92 was not harmed by alleged deficient practice, resident had skin assessment and Braden complete, preventative interventions put into place per findings, plan of care updated. Resident 34 was not harmed by alleged deficient practice, resident had skin assessment and Braden complete and preventative interventions put into place per findings, plan of care updated Resident 18 was not harmed by alleged deficient practice, resident had skin assessment and Braden complete and preventative interventions put into place per findings, plan of care updated **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by this alleged deficient practice. The DON and/or Designee have completed entire house skin assessments and Braden's. All residents identified at risk for pressure ulcers have	03/31/2023

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	included to check and change every 2 hours and provide frequent positional changes. He was provided a pressure relieving mattress. The baseline care plan did not include any indication of interventions to float or offload the resident's heels. The care plan, initiated on 2/9/22 and last revised 5/18/22, indicated the resident was at risk for altered skin integrity related to CVA (Cerebral Vascular Accident), decreased mobility, and poor vascularity. The interventions included, but were not limited to, administer medications as ordered, complete weekly skin checks, encourage the resident to allow staff to turn and reposition every 2 hours, ensure residents are turned and repositioned, float heels while in bed, monitor vital signs, provide off-loading mattress, diet as ordered, and provide peri-care as needed to avoid skin breakdown during incontinence. The NP (Nurse Practitioner) note, dated 1/5/23 at 12:15 p.m., indicated the resident had left sided hemiplegia and hemiparesis. He was unable to transfer without maximum assistance and a Hoyer lift. He was fully dependent upon others for functioning. He had difficulty moving his extremities, left lower and upper extremity weakness. The January 2023 MAR (Medication Administration Record) indicated the resident had no behaviors of resisting care. The clinical record lacked documentation of encouraging the resident to turn and reposition and floating his heals on 1/25/23, day shift. The Annual MDS (Minimum Data Set) assessment, dated 2/1/23, indicated the resident was severely cognitively impaired, he exhibited no		had preventative interventions put into place and plan of care updated as indicated. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON and/or Designee educated staff on facilities policies “Plan of Care Overview Policy” and “Skin and Wound Management Overview Policy” with emphasis on implementing preventative interventions for residents identified to be at risk for pressure ulcer development and updating plan of care. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON and/or Designee will audit 5 resident’s daily x’s 4 weeks, then 5 resident’s weekly x’s 4 weeks, then 5 resident’s monthly x’s 4 months to ensure preventative measures in place for residents identified to be at risk and plan of care updated with interventions. The DON and/or Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine	

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	rejection of care behaviors, required extensive assistance of 2 staff members with bed mobility, and had no current pressure ulcers, but was at risk for developing pressure ulcers. The February TAR (Treatment Administration Record), on 2/23/23, lacked documentation of any behaviors of refusal of care or daily wound assessment completion. The clinical record lacked documentation of encouragement to reposition and float his heels on 2/23/23, day shift. The February 2023 CNA (Certified Nurse Aide) Documentation lacked documentation of turning and repositioning (T&R) the resident on the following dates: - On 2/1/23 there was no documentation of T&R from midnight to 4:00 a.m. - On 2/2/23 there was no documentation of T&R from 6:00 p.m. until 6:00 a.m. on 2/3/23. - On 2/3/23 there was no documentation of T&R from 2:00 p.m. until 6:00 p.m. - On 2/4/23 there was no documentation of T&R from 6:00 a.m. until 6:00 p.m. - On 2/5/23 there was no documentation of T&R from 6:00 a.m. until 4:00 p.m. - On 2/6/23 there was no documentation of T&R from 6:00 p.m. until 6:00 a.m. on 2/7/23. The only documented resident refusal on the CNA documentation for February 2023 was on 2/1/23 from 6:00 a.m. to 6:00 p.m. The clinical record lacked documentation of any attempts to address the resident's refusal on that date. The NP note, dated 2/1/23 at 1:06 p.m., indicated the resident did not get out of bed. He had contractions to his hands and feet from his stroke.		when 100% compliance is achieved or if ongoing monitoring is required.	

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	The weekly skin assessment, dated 2/7/23, indicated the resident had no skin impairment. The skin grid pressure assessment, dated 2/8/23 at 1:11 p.m., indicated the resident had a new pressure area to the right outer ankle, which measured 1.7 cm (centimeters) in length by 1.7 cm in width. It was classified as unstageable and had no depth listed. The edges were distinct, attached, clearly visible and even with the wound base. There was no description of the color or appearance of the wound bed. There was no exudate. The peri-wound was dark red or purple and non-blanchable. There was no pain associated with the wound and the care plan was reviewed and revised. The skin/wound note, dated 2/8/23 at 1:20 p.m., indicated the resident had a new unstageable pressure area to the left outer ankle measuring 1.7 cm by 1.7 cm. The wound base was sloughy (necrotic tissue). There was no drainage or odor observed. The peri-wound was red but blanchable. The wound nurse, dietician, Director of Nursing, and Executive Director were notified of the wound with treatment orders given cleanse the area with normal saline and pat dry, apply medihoney to the wound bed and cover with a dry dressing daily. New orders also given to start resident on a multivitamin along with zinc and vitamin C for 60 days. Pressure reduction boot were provided to elevate the resident heels and ankles from the bed. The resident stated to nursing staff that he did not like to be turned and re-positioned and preferred to keep his feet crossed at the ankles causing the left outer ankle to rest against the bed majority of the time. The dietary progress note, dated 2/8/23 at 2:02 p.m., indicated the resident had frequent refusals			

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	of care and crossed his legs routinely as well. The care plan, initiated on 2/8/23 and last revised 2/27/23, indicated the resident had actual impaired skin integrity that included an unstageable to the left outer ankle. The interventions included, but were not limited to, enhanced barrier precautions when providing care to the wound, evaluate area characteristics, wound care to evaluate and treat, measure area at regular intervals, monitor area for signs of infection, monitor area for signs of progression or declination, moon boots to bilateral feet while in bed, notify provider if no signs of improvement on current wound regimen, and provide wound care per treatment orders. The clinical record lacked documentation of any non-compliance with turning and repositioning or any intervention to address non-compliance with pressure reducing interventions prior to the wounds development. The IDT (Interdisciplinary Team) note, dated 2/9/23 at 9:39 a.m., indicated the resident had a new unstageable pressure area to the left outer ankle. The resident kept his feet crossed and his left left ankle resting against bed frequently. He refused to be turned and repositioned. Pressure reducing boots were provided. The Wound Assessment, dated 2/28/23, indicated the resident continued with an unstageable pressure ulcer to the left lateral ankle. The wound measured 2.14 cm in length, 1.87 cm in width, and did not have a depth measurement. There was 40% granulation tissue and 60% slough tissue. Treatment continued the same. During an interview on 3/2/23 at 1:59 p.m., LPN (Licensed Practical Nurse) 12 indicated the			

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	resident had developed the wound a couple weeks prior. He had been refusing to get up and take his bed baths for quite some time. The crossing of his legs and refusing to turn and reposition had been going on as long as she could remember and she admitted him. He had been crossing his legs and refusing to turn and reposition since he admitted. When a resident was refusing preventative measures it was supposed to be charted on. CNAs could chart on the refusal. If the resident was refusing she would let the Nurse Practitioner and the family know. During an interview on 3/3/23 at 11:44 a.m., the Regional Director of Clinical Operations (RDCO) indicated there were a couple of refusals of care charted on the resident by the CNAs on 2/1/23 and 1/20/23. Some of the CNAs were charting "No" on turning and repositioning for the resident because they thought that was what they were supposed to chart when a resident refused. If there was a blank spot on the CNA documentation it was where documentation of turning and repositioning was lacking. During an interview on 3/3/23 at 8:53 a.m., the Wound NP indicated on her first assessment of the wound it was an unstageable pressure injury. All she could see was slough. It measured 1.95 cm in length, 1.64 cm in width, and 0.2 cm in depth when she first saw it on 2/10/23. On 2/14/23 at 9:04 a.m., the wound slough was starting to soften up for removal, the measurements were 1.71 cm in length, 1.81 cm in width, and 0.1 cm in depth. On 2/21/23 she debrided the wound and it was 1.54 cm in length, 1.89 cm in width, and 0.2 cm in depth. It was still unstageable because she couldn't see enough to stage it. On 2/28/23 the wound was 2.14 cm in length and 1.87 cm in width. The resident was in a different position and that could change			

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	the measurement. The wound was improving. The last assessment it was still unstageable but there was 40% granulation with 60% slough. She was told that he was a leg crosser and was constantly crossing his legs over the ankles and that was what they had said was the cause of it. He still did it even now. She would hope they had some kind of pillow or something to off load it. They were supposed to document refusals and education. There should be some form of documentation when a resident is refusing to turn and reposition. 2. The clinical record for Resident O was reviewed on 2/27/23 at 1:58 p.m. The diagnoses included, but were not limited to, Alzheimer's, dementia, diabetes mellitus, weakness, and schizoaffective bipolar disorder. The care plan, dated 8/17/22 and revised on 9/6/22, indicated the resident was at risk for altered skin integrity. The interventions included, but were not limited to, complete a skin at risk assessment upon admission/readmission, quarterly, and as needed, complete weekly skin checks, encourage and assist the resident to turn and reposition, nutritional consult on admission, quarterly, and PRN, obtain laboratory and diagnostic testing as ordered by medical provider, provide an appropriate off- loading mattress, and provide a diet as ordered. The care plan, dated 1/10/23 and revised on 2/13/23, indicated the resident had actual impaired skin integrity that included a Stage 3 (full thickness tissue loss) to the right outer ankle. The interventions included , but were not limited to, enhanced barrier precautions when dressing/bathing/showering/transferring/personal hygiene, changing linens, toileting, peri-care and providing wound care, evaluate area characteristics, float heels as resident allows,			

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	wound care agency to evaluate and treat, measure areas at regular intervals, monitor area for signs of progression or decline, monitor areas for signs of infection, notify the provider if no signs of improvement on the current wound regimen and provide wound care per treatment orders. The nurse's note, dated 1/10/2023 at 2:33 p.m., indicated the resident stated that she was blind, could not feed herself and was asking for assistance with eating. She had scattered bruising to her bilateral arms and to her left leg. The resident's right leg had a bruise with a knot. She had an open area on outside of right ankle and the wound nurse would assess the right ankle wound. The skin/wound care note, dated 1/10/23 at 3:51 p.m., indicated the wound care nurse was called to resident's room by the floor nurse to evaluate the bruising and area to the resident's right outer ankle. The bruising to the RLE (right lower extremity) was observed to be a purple/blue area with a knot observed. The resident reported no pain at the site of bruising. An open area was observed to the right outer ankle. The peri wound was observed to be red, but blanchable, the area appears to be a blister that had popped. A cushion was provided to elevate the heels and feet off the bed. The NP was notified of both new areas, orders given to monitor bruising, area to ankle to be cleaned with normal saline and patted dry, apply Medi honey to the wound bed and cover with a dry dressing daily. The Skin Grid Pressure Wound note, dated 1/10/23 at 4:09 p.m., indicated the pressure wound to the right ankle was a facility acquired wound. The right outer ankle pressure wound measured 2.1 cm in length, and 2.3 cm in width and unstageable. The resident was to receive a MVI			

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	(multivitamin) daily to aid in wound healing. If weight loss became excessive, the resident would be reassessed for additional nutritional supplementation at that time. She would continue to be monitored weekly in NAR (nutritional at risk) as well. The dietary progress note, dated 1/11/23 at 8:08 a.m., indicated the resident had a new unstageable pressure wound to her right ankle. The wound nurse assessed the wound on 1/10/23 and the wound NP would assess the wound on the next visit. The IDT follow up note, dated 1/11/23 at 2:58 p.m., indicated a new pressure and non-pressure area was observed to the right ankle and right lower extremity. Care was being performed on the resident when the areas were observed. The resident preferred to lay on her back with her right leg pulled up and resulted in the right ankle to lying flat on her mattress. Staff would reposition her leg, but the resident would move it back. The wound care NP note, dated 1/13/23 at 10:12 p.m., indicated the resident had a right lateral pressure wound to the ankle. The measurements were 2.4 cm in length, 2.13 cm in width and depth was 0.29 cm. There was 10 percent granulation tissue and 90 percent slough and eschar. The pressure wound was acquired in house and was unstageable. There was a moderate amount of serosanguinous drainage, no odor and the peri-wound had erythema. The interventions included, change the dressing, cleanse with normal saline Medi-honey, float heels and secure with a bordered foam dressing. The Quarterly MDS assessment, dated 1/30/23, indicated the resident was moderately cognitively			

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	impaired. The resident was at risk for developing pressure wounds. The physician orders, dated 2/16/23, indicated skin prep to the bilateral heels and elbows every shift for skin preventative maintenance, a pressure reducing and relieving cushion the her wheelchair, barrier cream to the buttocks and peri-area every shift and PRN after incontinent episodes, and may keep at the bedside, encourage the resident to allow staff to turn and reposition every 2 hours as tolerated and every shift for preventative measure. Encourage the resident to float her heels while in bed as tolerated and every shift for preventative measure, dated 2/16/23. Cleanse the area to the outer right ankle with normal saline and pat dry, collagen particles to wound bed, cover with a bordered foam daily and PRN for soilage or dislodgment every day shift and as needed, dated 2/14/23. The resident was on a pressure reducing and relieving cushion to wheelchair every shift, dated 2/16/23. Skin prep to the bilateral heels and elbows every shift for skin preventative maintenance, dated 2/16/23. The Wound Measurement for the resident's Right outer ankle were as followed: - On 1/17/23 the resident's right outer ankle wound measured 1.78 cm in length, 2.48 cm in width and depth was 0.98 cm. - On 1/24/23 the resident's right outer ankle wound measured 2.11 cm in length, 1.28 cm in width, and 0.4 cm in depth. The wound was unstagable (wound covered with slough or eschar). - On 1/31/23 the resident's right outer ankle wound measured 1.31 cm in length, 1.22 cm in width, and 0.3 cm in depth. The wound was a Stage 3. - On 2/14/23 the resident's right outer ankle wound measured 1.62 cm in length, 0.74 cm in width, and			

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	0.03 cm in depth. The wound remained a stage 3. Treatment included collagen particles with a secondary dressing border foam. - On 2/28/23 the resident's right outer ankle wound measured 1.3 cm in length, 1.2 cm in width and 0.01 in depth. The wound was a Stage 3. During an interview on 2/28/23 at 8:49 a.m., the Wound Care NP indicated the resident acquired her wound in the facility. She was not compliant with repositioning her ankles. She tended to keep her legs crossed at the ankles. While up in her chair she did wear her boots. The wound was an unstageable and developed to a Stage 3. She was unsure if it was unavoidable. The resident's wound had been debrided and it was healing out well. The resident's treatment included Collagen particles with a foam dressing daily. During an interview 3/3/23 at 9:03 a.m., the Wound Care Nurse indicated the resident would tuck her ankles underneath her. She was noncompliant with wearing boots while she was in bed. Her heels would be floated on pillows, and she was compliant with using the pillows. She would be turned and repositioned every 2 hours. She would monitor the wound for increase in size, drainage, odor, fever, redness, and edema. The peri wound had hard tissue approximately half the size of the wound. The NP would debride the wound next week. The center of the wound was soft and red in color. No drainage or foul odor was noted. The wound measured 1.5 cm x 1 cm. The treatment included collagen particles and a foam dressing daily. The wound was healing well and decreased in size. During an interview on 3/3/23 at 1:35 p.m., CNA 13 indicated the resident wasn't always compliant with turning and repositioning. She was			

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	noncompliant with wearing her pressure relieving boots while in bed. The clinical record lacked documentation of any non-compliance with turning and repositioning or any intervention to address non-compliance with pressure reducing interventions prior to the wounds development. 3. The clinical record for Resident F was reviewed on 3/2/23 at 9:07 a.m. The diagnoses included, but were not limited to, Parkinson's disease, bipolar disorder, type 2 diabetes mellitus with diabetic polyneuropathy, peripheral vascular disease, Alzheimer's disease, right and left above the knee amputation, and schizoaffective disorder of bipolar type. The nurse's note, dated 8/31/22 at 11:15 a.m., indicated the resident was admitted to facility from a rehabilitation center. Her skin was intact and the healed wound to the coccyx was intact. No open areas were observed on the skin. The care plan lacked documentation for being at risk for skin breakdown. The nurse practitioner note, dated 9/9/22 at 10:15 a.m., indicated during the inspection of the skin overall, there was redness to the buttocks with no open area. The orders indicated to apply a barrier cream to the coccyx twice daily, and as needed for soilage, to prevent skin breakdown. The care plan, dated 9/20/22, indicated the resident was at risk for altered skin integrity related to Parkinson's, diabetes mellitus, peripheral vascular disease, and bilateral below the knee amputation. The interventions, dated 9/20/22, indicated to complete the weekly skin checks,			

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	ensure the residents were turned and repositioned. The weekly skin assessments, dated 9/21/22 and 9/28/21, indicated no skin conditions or change, ulcer, or injuries. The skin wound note, dated 10/4/22 at 1:35 p.m., indicated during the wound rounds this morning, a CNA asked the nurse and wound nurse practitioner to look at the residents bottom. Upon assessment, the area to the sacrum, that was previously scabbed over, was observed to be open along with trauma areas to the left buttock. The staff reported that the resident had been attempting to scoot around in bed and also scooted while sitting in her wheelchair. Treatment orders were currently in place. The skin wound note, dated 10/4/22 at 5:47 p.m., indicated during the comprehensive skin and wound evaluation for the area to the sacrum ulcer was indicated to be a moisture acquired skin damage ulcer and she had left buttock multiple trauma wounds. The wound nurse practitioner ordered to continue the current management with a recommendation of an air mattress for pressure reduction. The care plan, dated 10/4/22 and last revised on 12/19/22, indicated the resident had actual impaired skin integrity that included a stage III to the sacrum and trauma to the left buttock, which healed on 11/1/22. The interventions, dated 10/4/22, indicated to apply enhanced barrier precautions when dressing, bathing, showering, transferring, personal hygiene, changing linens, toileting and peri-care, to providing care to the wound, a wound company would follow, apply a pressure redistribution mattress to the bed per			

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	manufacture guidelines, measure areas at regular intervals, monitor the areas for signs of infection, monitor areas for signs of progression or declination, provide wound care per treatment orders, PT (Physical Therapy) to screen for wheelchair cushion, and on 2/12/23, to evaluate the area characteristics. The care plan lacked documentation of non-compliance with turning and repositioning. The wound evaluation note, dated 10/5/22, indicated the shearing trauma wound to the left buttock measured 11.28 cm long by 3.14 cm wide. The dressing change was three times daily. The wound evaluation note, dated 10/5/22, indicated the unstageable wound to the sacrum measured 0.82 cm long by 0.77 cm wide by 0.1 cm deep. There was a moderate amount of serosanguinous drainage and 100% slough. The order was to cleanse with normal saline, an apply medihoney and a bordered foam dressing. The non-pressure skin grid, dated 10/18/22 at 1:26 p.m., indicated the left buttock wound had improved. The skin grid, dated 10/18/22 at 1:28 p.m., indicated the pressure ulcer to the sacrum, measured 0.6 cm long by 0.9 cm wide and was unstageable. The weekly skin check, dated 10/19/22, indicated there were no skin conditions or changes, ulcer, or injuries. In the skin wound note, dated 10/25/22 at 6:35 p.m., the wound nurse practitioner indicated the pressure ulcer to the sacrum was now stage III			

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	which was the normal and was an expected progression of the wound. The wound evaluation note, dated 10/25/22, indicated the pressure ulcer to the sacrum was now a stage III and measured 0.55 cm long by 0.85 cm wide by 0.10 cm deep with 100% slough. No change to the drainage or the treatment order. The weekly skin assessment, date 10/26/22, indicated no skin conditions or change, ulcer, or injuries. The wound evaluation note, dated 11/1/22, indicated the trauma to the left buttock healed. The nurse practitioner note, dated 11/3/22 at 9:01 a.m., indicated during the inspection of the skin overall, there was no redness to the buttocks and no open area. The wound nurse practitioner note, dated 11/8/22 at 1:28 p.m., indicated the stage III to the sacrum was improving. The skin wound note, dated 11/15/22 at 11:25 a.m., the wound nurse practitioner indicated the area to the sacrum was improving with the current treatment orders. No new orders were given. The resident was continued on a pressure redistribution mattress and was encouraged to allow staff to turn and reposition. The skin wound note, dated 11/22/22 at 1:04 p.m., indicated the wound nurse practitioner had not assessed the resident due to the resident just getting out of bed and refusing to lay back down for evaluation. The nurse would obtain measurements when the resident returned to bed this shift.			

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	The wound evaluation note, dated 11/29/22, indicated the stage III pressure ulcer to the sacrum measured 0.9 cm long by 1.04 cm wide by 0.1 cm deep with a moderate amount of serosanguineous drainage and 100% slough. No change in the treatment order. The wound evaluation note, dated 12/13/22, indicated the stage III pressure ulcer to the sacrum measured 0.84 cm long by 1.09 cm wide by 0.1 cm deep. The order indicated to cleanse with normal saline, apply collagen and a bordered foam dressing. The nurse's note, dated 12/13/22 at 11:13 a.m., indicated the resident was seen by the wound nurse practitioner with new orders to change the treatment from medihoney to collagen for the sacrum. The clinical record lacked documentation of a weekly skin assessment for 12/14/22. The Quarterly MDS assessment, dated 12/29/22, indicated the resident was severely cognitively impaired. She required extensive assistance of 2 staff for transfer, locomotion on unit, dressing, toilet use, eating, and personal hygiene. The weekly skin assessment, dated 12/31/22, indicated no skin conditions or change, ulcers, or injuries. The skin grid pressure note, dated 1/3/23 at 1:48 p.m., indicated a new stage III pressure area to the sacrum. The wound measured 0.3 cm long by 0.5 cm wide by 0.1 cm deep. The nurse practitioner note, dated 1/6/23 at 1:46			

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	p.m., indicated redness to the buttocks with no open area. The wound care treatment was to cleanse the area to the sacrum with normal saline and pat dry, apply collagen to the wound bed and cover with a border foam daily, and as needed for soilage or dislodgment. The weekly skin assessment, dated 1/7/23, indicated no skin conditions or changes, ulcers or injuries. The wound evaluation note, dated 1/10/23, indicated the stage III pressure ulcer to the sacrum measured 0.44 cm long by 0.41 cm wide by 0.1 cm deep. The order change to cleanse the wound with normal saline and apply hydrocolloid every Tuesday and Friday. The wound nurse practitioner note, dated 1/10/23 at 9:25 a.m., indicated hospice had given a recommendation to change the treatment from collagen to a hydrocolloid two days a week. The wound nurse practitioner agreed to the new treatment order. The area to the sacrum was cleaned with normal saline and patted dry, a hydrocolloid was placed onto the sacrum. The wound evaluation note, dated 1/31/23, indicated the stage III pressure ulcer to the sacrum measured 0.41 cm long by 0.51 cm wide by 0.1 cm deep. The wound was stalled and there were no order change. The nurse practitioner note, dated 2/10/23 at 9:53 p.m., indicated the wound treatment was to cleanse the area with normal saline and pat dry, apply a hydrocolloid bandage to the sacrum on Tuesdays and Fridays and as needed for soilage or dislodgement.			

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	The wound evaluation note, dated 2/21/23, indicated the stage III pressure ulcer to the sacrum measured 0.37 cm long by 0.5 cm wide by 0.1 cm deep. The wound was improving and no changes to the orders were indicated. The weekly skin assessment, dated 2/21/23, indicated no skin conditions or changes, ulcers or injuries. During an interview on 2/28/23 at 8:48 a.m., the Wound Nurse Practitioner indicated Resident F currently had a stage III pressure ulcer to the coccyx, which developed at the facility. The resident followed commands, but she didn't like to be turned. She was unsure if the resident had an air mattress prior to the development of the pressure ulcer. She was on hospice care. The pressure ulcer was open before. It had healed and then reopened as a stage III. She had declined in health, had a bilateral amputation, and refused to turn. When a resident refused to turn and reposition, there wasn't anything that could be done. The wound evaluation note, dated 2/28/23, indicated the stage III pressure ulcer to the sacrum measured 0.26 cm long by 0.28 cm wide by 0.10 cm deep and was improving. No changes to the orders were indicated. During an observation on 3/3/23, at 9:03 a.m., the resident's wound was approximately the size of a nickel. The peri wound had hard tissue approximately half the size of the wound along the lower edge of the wound. The Wound Care nurse indicated the NP would debride the wound next week. The center of the wound was soft and red in color. No drainage or foul odor was observed. The wound nurse indicated the wound was 1.5 cm x 1.0			

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	cm in size. The treatment included collagen and a foam dressing daily. She indicated the wound was healing well and had decreased in size. During a confidential interview between 2/27/23 and 3/3/23., Staff member B indicated it depended on the resident's mood as to whether she would allow the staff to turn and reposition her. Yesterday, 3/2/23, she was not cooperative with care. She had not seen the wound, but was told it was doing better. During an observation of the wound on 3/3/23 at 9:40 a.m., the Wound Nurse indicated the dressing was changed yesterday, but she would pull it back for an observation. She applied gloves and entered the resident's room. The resident was rolled onto her right side. Upon removing the brief, the dressing was not present. It was not in the brief. The wound was closed with slough around the wound. The center of the wound was pink in color and approximately one eighth of an inch long. During an interview on 3/3/23 at 9:43 a.m., the Wound Nurse, indicated it was a toss up on her cooperation with turning and repositioning. During an interview on 3/3/23 at 1:35 p.m., the Wound Nurse, indicated the CNAs knew she was going to do an observation of the wound and they probably left the dressing off for that. If the dressing fell of during care, the staff should let the nurse know. During a confidential interview between 2/27/23 and 3/3/23, Staff member B indicated CNA 14 had not mentioned removing the dressing from the resident's wound. If it fell off they would have told her.			

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	The Plan of Care Overview policy, revised on 7/26/18, was provided by the RDCO (Regional Director of Clinical Operations) on 3/3/23 at 2:45 p.m. The policy included, but was not limited to, "... a. An interdisciplinary care team that participates in the planning and implementation of care may include but is not limited to... The 'MDS Coordinator' will oversee and coordinate the care team and PoC [plan of care] 2. Nurses are expected to participate in the resident plan of care for reviewing and revising the care plan of residents they provide care for as the resident's condition warrants..." The Skin & Wound Management Overview policy, effective 7/11/26, was provided by the RDCO on 3/3/23 at 2:45 p.m. The policy included, but was not limited to, "... Each resident/patient is evaluated upon admission and weekly thereafter for changes in skin condition. Resident/patient skin condition is also re-evaluated with change in clinical condition, prior to transfer to the hospital and upon return from the hospital... Implementation of preventions strategies to decrease the potential for developing pressure ulcers and/or... 4. Develop a care plan with individualized interventions to address risk factors..." This Federal tag relates to Complaint IN00400647. 3.1-40(a)(1)			
F 0689 SS=E 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			

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	remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure the residents' rooms were free of hazards related to multiple medications, including controlled substances, were found on the bedroom floors in 5 of 61 resident rooms. (Residents 15, 32, 86, 20, and 97) Findings include: 1. The clinical record for Resident 15 was reviewed on 3/2/23 at 8:19 a.m. The diagnoses included, but were not limited to, dementia with agitation and cognitive communication deficit, generalized anxiety disorder and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 12/7/22, indicated the resident was cognitively intact, had no mood or behavior issues, no hallucinations or delusions, had no swallowing issues, and was mobile in a wheelchair with no impairments in functional range of motion. During a random environmental observation of Resident 15's room on 3/1/23 at 2:40 p.m., on the floor in front of her nightstand there were 2 small white pills observed. During an interview on 3/1/23 at 2:45 p.m., LPN (Licensed Practical Nurse) 4 was shown both white pills and identified them as probably Resident 15's water pill and blood pressure pill. She indicated that she did not understand how they got on the floor as she had stood right there	F 0689	**F689- E** **Corrective action for the residents found to have been affected by the deficient practice:** Resident 15 was not harmed by alleged deficient practice, MD and RP were notified of medication on floor and any new orders implemented as result of notification, room was searched per resident/RP consent for any medications on floor. Resident 32 was not harmed by alleged deficient practice, MD and RP were notified of medication on floor and any new orders implemented as result of notification, room was searched per resident/RP consent for any medications on floor. Resident 86 was not harmed by this alleged deficient practice, MD and RP were notified of medication on floor and any new orders implemented as result of notification, room was searched per resident/RP consent for any medications on floor. Resident 20 was not harmed by this alleged deficient practice, MD and RP were notified of medication on floor and any new orders	03/31/2023

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	when the resident took her medication. LPN 4 then took the medications up to medication cart and identified the pills as buspar (an antidepressant) 5 mg (milligrams) and hydroxyzine (for itching) 25 mg. She indicated the resident did not like to take those medications and was surprised the resident's potassium pill was also not found. The March 2023 monthly physician orders indicated the resident had orders for busPIRone HCl (hydrochlorizide) Tablet 5 mg - 1 tablet by mouth three times a day for anxiety and for hydrOXYzine HCl Tablet 25 mg - 1 tablet by mouth in the morning for itching. 2. During an interview on 3/1/23 at 1:31 p.m., a resident's family member indicated she had made multiple complaints to the facility about findings pills on the resident's floor. During an observation and interview on 3/1/23 at 2:26 p.m., the family member indicated she had found a pill just then on the resident's floor. The pill was a small, round, white tablet with an imprint of EP 904 on one side and no imprint the other side. The family member indicated it had been on the floor just inside the door of the resident's room. Information was obtained, on 3/1/23 at 2:30 p.m., from medicine.com and drugs.com pill identifier resources. The information from both sites identified the tablet as lorazepam 0.5 mg. The clinical record for Resident 20 was reviewed on 3/2/23 at 2:31 p.m. The diagnoses included, but were not limited to, schizophrenia, anxiety disorder, bipolar disorder and major depressive disorder. The physician's order, dated 1/31/23, indicated the		implemented as result of notification, room was searched per resident/RP consent for any medications on floor. Resident 97 was not harmed by this alleged deficient practice, MD and RP were notified of medication on floor and any new orders implemented as result of notification, room was searched per resident/RP consent for any medications on floor. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by this alleged deficient practice. The DON and/or Designees have completed an entire house audit to ensure residents rooms were free from medications on floor. All residents noted with medications on floor staff retrieved medications and disposed of them per protocol, MD and RP notified and any new orders implemented as results of notification. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON and/or Designee educated staff on facility policy “Medication Controlled Drugs and Security Policy” with emphasis on during medication administration to observe for potential pocketing of	

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	resident received lorazepam 0.5 mg tablet, one tablet by mouth, four times daily for anxiety. 3. During an observation on 3/1/23 at 2:35 p.m., a white pill was observed on the floor in Resident 97's and 86's room. The pill was imprinted on one side with 91, and an F on the other side. Information was obtained on 3/1/23 at 2:50 p.m., from medicine.com and drugs.com pill identifier resources. The information from both sites identified the tablet, found on the floor, in Resident 97's and 86's room, as ondansetron hcl 4 mg (an antinausea medication). The clinical record for Residents 97 and 86, lacked documentation of either of the resident's being prescribed ondansetron hcl 4 mg. 4. During an observation on 3/1/23 at 2:40 p.m., there were two blue oblong tablets on the floor under Resident 32's room labeled with an A on one side and 17 on the other side. Information was obtained on 3/1/23 at 2:55 p.m., from medicine.com and drugs.com pill identifier resources. The information from both sites identified the tablet as Zoloft 50 mg. During an interview on 3/1/23 at 2:45 p.m., LPN 15 indicated there were two pills on the floor behind resident 32's bed. There should not be any medications on the floor. Staff should stay with the resident until the medication was taken and if dropped they should pick it up and dispose of it. The clinical record for Resident 32 was reviewed on 3/1/23 at 3:00 p.m. The diagnoses included, but were not limited to, dementia with agitation, major depressive disorder, and impulse disorder.		medication and with any noted dropped medication to retrieve and dispose of per facility protocol. Each licensed nurse or QMA has had medication observation clinical competency complete to ensue in compliance with facility protocol. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON and/or Designee will audit 5 resident's daily x's 4 weeks, then 5 resident's weekly x's 4 weeks, then 5 resident's monthly x's 4 months to ensure residents room is free of medications on floor. The DON and/or Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	The physician's order, dated 11/23/22, indicated the resident received sertraline 75 mg tablet, 1 tablet by mouth in the morning for depression. The Medication Controlled Drugs and Security policy was provided on 3/2/23 at 1:00 p.m. by the RCDO (Regional Clinical Director of Operations). The policy included, but was not limited to, "... Safety is a primary concern for our residents... For this reason narcotics will be kept under double lock..." On 3/3/23 at 11:45 a.m., the RCDO presented a copy of the facility's current policy titled Storage of Medications with a revision date of 8/2020. Review of this policy included, but was not limited to, "Policy: Medications and biologicals are stored safely, securely and properly, following manufacture's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel,...or staff members lawfully authorized to administer medications..." 3.1-45(a)(1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-			

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	(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, record review, and interview, the facility failed to provide proper perineal and catheter care for 2 of 3 residents reviewed for bowel and bladder. (Residents M and D) Findings include: 1. The clinical record for Resident M was reviewed on 3/1/23 at 11:31 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, hyperosmolality and hypernatremia. The Annual MDS (Minimum Data Set) assessment, dated 2/2/23, indicated the resident was severely cognitively impaired. The infection note, dated 12/5/22 at 2:09 p.m.,	F 0690	**F690-D** **Corrective action for the residents found to have been affected by the deficient practice:** Resident M and D could not be identified as they were part of a complaint survey. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents who require catheter care and perineal care have the potential to be affected by this	03/31/2023

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	indicated the hospice company called and a new order was received to start Ciprofloxacin 500 mg (milligrams) twice daily for 7 days related to a UTI (urinary tract infection). The nurse's note, dated 12/9/22 at 1:27 p.m., indicated the resident continued to receive Ciprofloxacin for a UTI. No signs or symptoms of urinary issues were observed. His temperature was 98.3 degrees. During a confidential interview between 2/7/23 and 3/3/23, Staff B indicated it had been a while since the resident has had a UTI. He was not cooperative with perineal care at times. During an observation of perineal care on 3/3/23 at 9:00 a.m., with CNA 16 and the Social Service Director, CNA 16 applied hand sanitizer and then gloves. She obtained 4 wipes and laid them on the clean brief while she unfastened the brief. She applied peri cleanser and swiped down the creases and across the groin, folding the wipe with each swipe. She obtained 2 wipes, applied peri cleanser and cleaned the shaft, folded the wipe and with 5 swipes of the same area of the wipe, and cleaned around the penis. She obtained wipes, pulled back the foreskin and cleaned the tip of the penis with 2 swipes of the same area of the wipe. The resident was rolled onto his left side. His scrotum was cleaned with 2 swipes of the same area of the wipe. She obtained wipes and with a back and forth motion cleaned the resident's rectum. She folded the wipe and with a back and forth motion she swiped over the reddened area of the coccyx with 4 swipes of the same area of the wipe. She exited the room and requested a barrier cream to apply to the reddened area of the coccyx. She returned with zinc oxide and applied it. The brief was applied and fastened.		alleged deficient practice. All staff who provide direct care, Aides, QMA's and Nurses were educated on perineal and catheter care with pre and post testing to ensure proper understanding of clinical skills was noted. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated staff on facilities policy "Perineal Care Male/Female" and "Catheter Care". **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON and/or Designee will audit 5 staff member's daily x's 4 weeks, then 5 staff member's weekly x's 4 weeks, then 5 member's monthly x's 4 months to ensure proper catheter and peri-care is being provided. The DON and/or Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	During an interview on 3/3/23 at 9:15 a.m., CNA 16 indicated for perineal care she would use hand sanitizer or perform hand washing. She would obtain supplies and apply gloves. She would then provide privacy, obtain wipes and de-brief the resident. She would obtain wipes and clean down the creases, on top of the penis and then clean down the shaft of the penis. She would clean around the head of the penis, folding the wipe or washcloth or obtaining a fresh wipe. She would use a circular motion around the penis. She would clean the scrotum, then the rectum and clean the whole back side of the cheeks. She would then pat dry, not that the wipes were that wet and apply a clean brief, fastening it. She would use a front to back motion. 2. The clinical record for Resident D was reviewed on 2/28/23 at 1:50 p.m. The resident's diagnoses included, but were not limited to, urinary tract infections, need for assistance with personal care, and benign prostatic hyperplasia. The nurse's note, dated 6/7/22 at 5:42 p.m., indicated the resident was a new admission and had an indwelling urinary catheter. The nurse's note, dated 6/16/22 at 12:57 a.m., indicated the resident's catheter was draining dark yellow urine to his bedside drainage bag. The urinalysis report, dated 6/27/22, indicated the resident had greater than 100,000 CFU/mL (colony forming units per milliliter) pseudomonas fluorescens/putida and greater than 100,000 CFU/mL of Escherichia Coli (E. Coli) The NP's (Nurse Practitioner's) note, dated 6/28/22, indicated the resident was seen for a UTI follow-up. A u/a (urinalysis) was collected and			

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	was positive for E. Coli. The resident was started on Levaquin for 5 days. The nurse's note, dated 7/3/22 at 10:25 p.m., indicated the resident had completed his antibiotic for the UTI. His Foley catheter was draining dark yellow urine. The behavior note, dated 7/18/2022 at 6:09 p.m., indicated the resident was having behaviors of demanding to be sent home, he was unable to answer where he was or what year it was. The NP's note, dated 7/19/22, indicated the resident had increased confusion. His catheter was draining dark yellow urine. Orders were given to obtain a urinalysis with culture and sensitivity if indicated. The urinalysis report, dated 7/23/22, indicated the resident had greater than 100,000 CFU/mL of E. Coli. The nurse's note, dated 7/23/22 at 4:58 p.m., indicated the resident had blood-tinged urine and small clots in his catheter bag. He appeared to be pale. His u/a culture was still pending. New orders were received to irrigate the catheter and monitor for excessive bleeding and to notify hospice when the culture was finalized. The nurse's note, dated 7/23/22 at 7:14 p.m., indicated staff informed hospice of the positive results of the u/a and received new orders for Macrobid 100 mg. The hospice nurse would be out to change the catheter. The nurse's note, dated 7/23/22 at 8:20 p.m., indicated the hospice nurse changed the resident's catheter.			

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	The nurse's note, dated 9/19/22 at 11:00 a.m., indicated the resident's catheter had been removed while he was at the hospital. Supporting diagnoses was obtained from his urologist to obtain an indwelling urinary catheter to be placed to ensure comfort and decrease incontinent episodes. The nurse's note, dated 11/1/22 at 10:36 a.m., indicated the resident had increased confusion and agitation as well as refusal of care. The resident's POA (Power of Attorney) indicated he got this way sometimes when he had a UTI. The NP gave orders for a u/a with culture and sensitivity if indicated via straight catheter if necessary. The nurse's note, dated 11/2/22 at 4:31 p.m., indicated the nurse attempted to straight catheterize the resident for his u/a with no urine return. Staff would attempt again later in the shift. The nurse's note, dated 11/3/22 at 2:56 p.m., indicated the resident continued with behaviors. The u/a sample was successfully obtained and ready for lab pick up. The urinalysis report, dated 11/6/22, indicated the resident had greater than 100,000 CFU/mL of E. Coli) The NP note, dated 11/8/22 at 11:24 a.m., indicated had a history of UTIs and had a positive urine culture for E. Coli. He was started on Augmentin 875/125 mg twice daily for 7 days for a UTI. The nurse's note, dated 11/16/22 at 3:48 p.m., indicated a new order was given for a urinalysis. May straight catheterize if needed.			

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The nurse's note, dated 11/16/22 at 5:08 p.m., indicated the resident had increased behaviors and hallucinations. The resident's urine was obtained, and he had labs to be drawn in the morning.

The urinalysis report, dated 11/19/22, indicated the resident had greater than 100,000 CFU/mL of proteus mirabilis.

The NP's note, dated 11/22/22, indicated the resident's urinalysis was positive for proteus mirabilis and he was started on Bactrim 160 mg twice daily for a UTI.

The care plan, initiated on 2/13/23, indicated the resident had an indwelling urinary catheter related to obstructive uropathy. The interventions included, but were not limited to, position the catheter bag and tubing below the level of the bladder and provide privacy bag, observe, record and report to physician any signs of a UTI, including but not limited pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, or change in eating patterns, and provide catheter care every shift and as needed.

During an interview on 2/27/23 at 1:22 p.m., Resident D indicated he'd had several urinary tract infections. He got hallucinations when he had them. Staff did not perform catheter care on him. They were not cleansing the perineal area or the catheter insertion site. It was always full when they emptied it.

During an observation on 3/2/23 at 8:20 a.m.,

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	Resident D was lying abed wearing a brief. He indicated he had soiled himself. He had pushed his call light around 8:00 a.m., someone answered it and indicated they'd be back to change him but had not yet been back. He was afraid he was going to get a UTI. He pushed his call light again. During an observation on 3/2/23 at 8:28 a.m., the Wound Nurse entered the resident's room to change him. She donned an N95, gown, and gloves, but was not observed to wash her hands prior. As she was gathering supplies, she knocked the resident's cup off his table. She picked the cup up off the floor and placed it on the resident's nightstand per his request. She then grabbed the wipes and a clean brief from his bed side table. She removed his blanket and opened his brief. She picked up the resident's catheter with her gloved hand and repositioned it. She informed the resident she was going to clean his catheter. She cleansed the resident's penis and catheter tubing with disposable wipes. She then rolled the resident to his side. The resident had a small, formed bowel movement. She cleansed the rectal area and buttocks using disposable wipes. She then cleansed the remaining barrier cream from the resident's sacral area and indicated she was going to apply fresh cream. The skin was not broken down but had scarring from previously healed wounds. She applied a fresh layer of barrier cream. The cream remained on her gloves. She then grabbed the resident's leg and rolled him back onto his back. Barrier cream was observed to transfer to the resident's leg in the shape of her fingers where she had touched him. She repositioned his catheter tubing once more for the resident's comfort. She then covered the resident with a blanket and indicated she would be going to get assistance to lift him up in the bed. She did not at any point during the observation change			

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	her gloves or wash her hands. During an observation on 3/2/23 at 8:30 a.m., the Wound Nurse and LPN 12 re-entered the room and donned PPE (personal protective equipment). They rolled the resident to his right side and tucked his draw sheet under him. They then rolled him to his back and lifted his catheter bag in the air approximately 2 feet above the resident's body and passed it to the other side. Urine was observed to flow backwards in the tubing back towards the resident's body. They rolled the resident to his right side and the Wound Nurse repositioned his draw sheet. They then rolled the resident on his back and again passed the catheter back over the resident in the same manner with the bag being lifted in the air approximately 1 foot this time above the level of the resident's bladder. Urine was again observed to flow backwards in the tubing towards the resident's body. The bag was replaced on the bedside hook below the level of the bladder. LPN 12 indicated the resident's catheter bag was full and needed to be emptied. During an interview on 3/3/23 at 1:56 p.m., the IP (Infection Preventionist) indicated when performing catheter care and perineal care, staff should wash their hands prior to care. They should also change their gloves and wash their hands after performing the perineal care, before moving to the rectal area, and again after cleansing the rectal area prior to applying any creams and new briefs. They should change gloves and wash hands any time the gloves are soiled. They should maintain the catheter bag below the level of the kidneys and ensure no urine backwashes into the tubing. Urine flowing back into the tubing and into the resident's bladder could lead to a urinary tract infection.			

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	During an interview on 3/3/23 at 2:27 p.m., the Wound Nurse indicated she performed care, on 3/2/23, for Resident D. She indicated she should have washed her hands between going from dirty to clean. She should have washed her hands after performing his catheter care, when she cleaned his bowel movement, and then again after applying cream prior to repositioning him. She didn't realize they lifted the bag as high as they did. She understood the risk of lifting it that high, it should be kept barely above the resident to keep it at a good level. Guidance for E. Coli Prevention was obtained on 3/3/23 from the CDC (Centers for Disease Control) website. The guidance included, but was not limited to, "... Escherichia coli (abbreviated as E. coli) are bacteria found in the environment, foods, and intestines of people and animals... Most E. coli are harmless and are actually an important part of a healthy human intestinal tract. However, some E. coli can cause diarrhea, urinary tract infections... Practice proper hygiene, especially good handwashing. Wash your hands thoroughly after using the bathroom and changing diapers..." Guidance on Proteus Mirabilis infections was obtained on 3/3/23 from the National Center for Biotechnology Information Library of Medicine branch website. The guidance included, but was not limited to, "... Proteus mirabilis, part of the Enterobacteriaceae family of bacilli, is a gram-negative, facultative anaerobe with an ability to ferment maltose and inability to ferment lactose... Proteus is found abundantly in soil and water, and although it is part of the normal human intestinal flora (along with Klebsiella species, and Escherichia coli), it has been known to cause			

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	serious infections in humans... Urinary tract infections (UTIs) occur as a result of bacterial migration along the mucosal sheath of the catheter or up the catheter lumen from contaminated urine... Proteus infection can be avoided with proper sanitation and hygiene, such as adequate sterilization of medical equipment and surfaces..." This Federal tag is related to Complaint IN00400647 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observations, record review, and interview, the facility failed to ensure residents	F 0692	**F692- D**	03/31/2023

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	were monitored for weight loss and provided with assistance for eating for 3 of 6 residents reviewed for nutrition (Residents 89, 59, and 70) Findings include: 1. The clinical record for Resident 89 was reviewed on 3/1/23 at 11:31 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, celiac disease, depression, anxiety disorder, hyperlipidemia, hyperosmolality, and hypernatremia. The resident was admitted on 11/27/21 with a weight of 182.4 pounds. The care plan, dated 11/29/21 and last revised on 1/26/23, indicated the resident was at risk for nutritional decline related to dementia, hyperlipidemia, weight loss, and gluten allergy. The interventions, dated 11/29/21, included but were not limited to, staff were to ensure dentures were utilized for meals; establish a baseline weight; identify the resident's food and beverage preferences; monitor his meal intake; notify the medical provider and resident representative of unplanned weight changes; observe for signs and symptoms of aspiration or dysphagia; obtain weekly weights if unplanned weight loss is identified, offer substitutions if the provided meal was declined; position the resident properly for eating and swallowing; provide assistance with meals as needed; provide meals per the diet order and provide snacks per facility protocol. The weight change note, dated 8/30/22 at 6:03 a.m., indicated a weight warning of 133 pounds with a body mass index at 19. This was a 10% (percent) weight loss over 180 days and a 3% weight loss since the last weight. A weight loss		**Corrective action for the residents found to have been affected by the deficient practice:** Resident 89 was not harmed by alleged deficient practice, resident was re-weighed to ensure weight monitoring and plan of care reviewed and updated as indicated per IDT for residents need for assistance with meals. Resident 59 was not harmed by alleged deficient practice, resident was re-weighed to ensure weight monitoring and plan of care reviewed and updated as indicated per IDT for residents need for assistance with meals. Resident 70 was not harmed by alleged deficient practice, resident was re-weighed to ensure weight monitoring and plan of care reviewed and updated as indicated per IDT for residents need for assistance with meals. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by this alleged deficient practice. All residents re-weighed to ensure weight monitoring and reviewed per IDT for need for assistance with meals, plan of care updated as indicated. **Measures/systemic changes put**	

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	was observed for 6 months. The resident received a gluten-free, dysphagia mechanical soft diet with thin liquids. His intake averaged less than 50% of meals. Hospice was notified of the weight changes and did not wish to initiate weekly weights at this time. Hospice continued to provide snacks for the resident. Staff were educated to continue to offer additional meals, snacks, and supplements as desired and tolerated by the resident. An order was received to begin ensure+ twice daily at 10:00 a.m. and at night. The weight change note, dated 10/7/22 at 5:50 a.m., indicated a weight warning of 130.8 pounds with a body mass index at 19. This was a 10% weight loss. The resident's weight was now stable over two months. A weight loss was observed for 6 months. The weight change note, dated 12/7/22 at 6:17 a.m., indicated a weight warning of 125.5 pounds with a body mass index at 18. This was a 10% weight loss over 180 days and was a 3% weight loss over 180 days. A weight loss was observed over 6 months. The Annual Nutritional Assessment, dated 1/27/23, indicated the weight was now stable over a six month period. The current weight was 130 pounds with a body mass index at 19. The resident received a gluten free, dysphagia mechanical soft diet with thin liquids. Ensure plus was ordered twice daily. The care plan, dated 2/7/22, indicated the resident was at risk for aspiration related to dysphagia. The interventions, dated 2/7/22, included, but were not limited to, observe for signs or symptoms of aspiration and dysphagia, such as coughing or choking, during meals or when		**into place to ensure the deficient practice does not recur:** DON/Designee educated staff including Registered Dietician on facilities policy “Resident Height and Weight” with emphasis on monitoring weight and providing assistance for meals for those identified who require assist. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON and/or Designee will audit 5 resident’s daily x’s 4 weeks, then 5 resident’s weekly x’s 4 weeks, then 5 resident’s monthly x’s 4 months to ensure weight monitoring and assistance provided for meals per residents need. The DON and/or Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	swallowing medications, holding food in mouth or cheeks or residual food in his mouth after meals, loss of liquids or solids from his mouth when eating or drinking, complaints of difficulty or pain when swallowing, position the resident properly for eating and swallowing, provide assistance with meals as needed, and provide sufficient time to chew and swallow. The monitoring of the resident's weight indicated the following: - 3/2/22 at 3:20 p.m. 155.8 Lbs (pounds) - 5/5/22 at 9:01 a.m. 146.2 Lbs - 6/3/22 at 2:41 p.m. 144.5 Lbs - 8/29/22 at 3:17 p.m. 133.0 Lbs - 9/8/22 at 8:00 p.m. 127.5 Lbs - 10/6/22 at 11:57 p.m. 130.8 Lbs - 11/16/22 at 1:46 p.m. 130.6 Lbs - 12/6/22 at 12:40 p.m. 125.5 Lbs - 1/5/23 at 1:48 p.m. 130.0 Lbs - 2/8/23 at 3:02 p.m. 124.5 Lbs During an interview on 2/27/23 at 12:01 p.m., Resident 89's family indicated that sometimes the meal portions were small. Sometimes the food was pureed, and sometimes it wasn't. It was mechanical soft most of the time. The resident was put on hospice care, because the social worker felt he needed more help with care. He was losing weight, so the family had started coming in recently for every meal to help feed him. During an interview on 3/3/23 at 10:20 a.m., the Registered Dietician indicated the resident had gained weight recently. He was admitted on hospice care. He was dependent for assistance with eating. The staff had helped him to eat since admission.			

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	2. The clinical record for Resident 59 was reviewed on 3/2/23 at 2:00 p.m. The diagnoses included cerebral infarction, Alzheimer's disease, vascular dementia with agitation, cognitive communication deficit, need for assistance with personal care, iron deficiency anemia, hyperlipidemia, adult neglect or abandonment, and deficiency of the B group of vitamins. The care plan, dated 6/26/19 and last revised on 2/24/23, indicated the resident was at risk for nutritional decline related to dysphagia, weight loss, and dementia; received a pureed diet with double portions. The resident was followed by palliative care with a decline anticipated. The interventions, dated 11/3/21, indicated to provide double portions, 10/6/20 to monitor for signs and symptoms of dysphagia, provide nectar thick liquids as ordered, no ice cream, sherbet, jello or thin liquids, 10/6/20 provide nectar thick liquids, 2/24/32 palliative care was to follow, 10/6/20 provide meals per physician diet orders, 10/6/20 monitor and evaluate the energy intake and or food and beverage intake via meal intake records and observations, 10/6/20 to encourage and provide intake of fluids throughout the day, 10/6/20 encourage family and significant others to visit at meal times, 10/6/20 provide feeding and dining assistance as needed, 10/6/20 monitor and evaluate his weight and weight changes, 10/6/20 notify the Registered Dietician, family, and physician of significant weight changes, 10/6/20 obtain biochemical data per the physician orders and evaluate. The weight change note, dated 8/30/22 at 2:05 p.m., indicated a weight warning of 135 pounds with a body mass index at 19. There was a 10% loss over 180 days and 3% loss since the last weight. There was a weight loss documented			

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	over the last two months. The resident would continue on a regular diet with double portions ordered. The intake continued to average greater than 50% of meals. An order was received to begin ensure plus twice daily and weekly weights to be obtained. The physician's order, dated 8/30/22, indicated to administer Ensure Plus two times a day 237 mL (milliters) as a supplement. The nurse's note, dated 9/5/22 at 12:56 a.m., indicated the resident refused meals and refused bedtime snacks and health shake that were offered tonight. The resident required staff assistance. The weight change note, dated 9/7/22 at 6:08 a.m., indicated a weight warning of 132.4 pounds. The resident was continued on a dysphagia mechanical soft diet with double portions ordered. Ensure plus was added twice daily on 8/30/22. The nurse's note, dated 9/7/22 at 1:59 p.m., indicated the resident was discussed at NAR (nutrition at risk) today. His weight was lacking at this time related to the recent weight loss. Ensures were added to promote weight gain. The nurse's note, dated 9/28/22 at 1:46 p.m., indicated the resident was discussed at NAR today. His weight was stable at this time. Will weigh the resident weekly and continue to monitor. The weight change note, dated 10/3/22 at 5:05 a.m., indicated a weight at 131.6 pounds. There were no additional recommendations at this time due to the weight stabilization. The weight change note, dated 11/1/22 at 6:21			

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	p.m., indicated a weight at 134.3 pounds. A recommendation to discontinue the weekly weights due to weight stabilization was made. Monthly weights would continue for monitoring. The nurse's note, dated 11/2/22 at 10:04 a.m., indicated the resident was to be discontinued from NAR. The weight change note, dated 12/7/22 at 12:18 p.m., indicated a weight at 130.6 pounds. The weight change note, dated 1/6/23 at 6:41 a.m., indicated a weight at 127 pounds. The nurse practitioner's note, dated 1/6/23 at 9:33 a.m., indicated the resident had another 3 lb weight loss that month, with monthly weights ordered. He was on double portions, and Ensure supplements. The weight change note, dated 2/8/23 at 11:11 a.m., indicated a weight at 121.9 pounds. Nursing did report increased difficulty with the current meal textures. The resident was referred to speech therapy per the Registered Dietician. An order was received to begin weekly weights, obtain reweight, and begin weekly monitoring in NAR. Staff were educated to continue to offer additional fluids and snacks between meals. The nurse's note, dated 2/9/23 at 1:55 p.m., indicated the resident had a weight loss after the monthly weight was obtained for February. The Registered Dietician was aware of the weight loss with recommendations for speech therapy to evaluate, and for the resident to be added to NAR. The nurse practitioner was aware of the weight loss and had referred resident to palliative care.			

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	The physician's order, dated 2/28/23, indicated the resident was admitted to hospice for palliative care. The monitoring of weights indicated the following: 8/30/22 135 pounds 1/4/23 127 pounds 2/20/23 120.7 pounds During an interview on 3/2/23 at 1:20 p.m., the Dietary Manager indicated the cook had a problem with the portion sizes to begin with, but the Dietary Manager worked with her and felt it had gotten better. During a confidential interview between 2/27/23 and 3/3/23, Staff B indicated the resident received assistance with feeding, due to his weight loss. He ate well when he was assisted to eat. During an interview on 3/3/23 at 10:22 a.m., the Registered Dietician indicated the resident gained weight last week. He had been provided palliative care since last week. He was changed to a pureed diet and staff assisted him to eat now. It had helped the resident to be provided staff assistance to eat. He was on NAR up until last week when he went palliative. 3. The clinical record for Resident 70 was reviewed on 2/27/23, at 1:14 p.m. The diagnoses included bur were not limited to, dysphagia following a cerebral infarction, diabetes mellitus, major depressive disorder, weakness, dementia, and Alzheimer's. The care plan, dated 1/6/20 and revised on 8/25/21, indicated the resident had a swallowing problem due to dysphagia following cerebral infarction. The interventions included, but were			

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	not limited to, the resident would have no choking episodes when eating, check the resident's mouth after meals for pocketed food and debris, diet to be followed as prescribed, instruct the resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly, and the resident was to eat only with supervision. The care plan, dated 10/6/20 and revised on 1/31/23, indicated the resident was at risk for nutritional decline related to dementia, diabetes mellitus, and heart failure. The interventions included, but were not limited to, receive a dysphagia mechanical soft diet with a history of weight changes, consume adequate energy to maintain weight, consume an average of 75 percent of food and beverages at meals, maintain hydration status, encourage snacks, and monitor and evaluate meal percentage intake via meal intake records and observations, provide and encourage feeding and dining assistance as needed, monitor and evaluate weight changes, notify the Registered dietician, and physician of significant weight changes. Resident Council Minutes were reviewed on 3/3/23 at 2:07 p.m., indicated on 7/19/22 residents had concerns related to the Dietary not following select menus and food portions were too small. Dated 12/20/22, the residents concerns were the residents' felt like they were not getting the care they needed. Some residents were not getting fed their meals that needed to be fed and small portions of food. The clinical record lacked documentation indicating the resident was monitored and interventions were implemented to prevent weight loss.			

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	The review of the resident's weights indicated the following: - 2/2/2022 148.2 - 3/9/2022 150.4 - 4/1/2022 150.8 - 6/2/2022 144.8 - 8/12/2022 145.0 - 9/7/2022 142.0 - 10/4/2022 140.6 - 11/5/2022 143.1 - 12/7/2022 136.4 - 1/5/2023 137.6 - 2/9/2023 135.0 The Quarterly MDS assessment, dated 2/7/23, indicated the resident was severely cognitively impaired. He required extensive assistance of one staff member with eating. During an observation on 2/27/23 at 1:15 p.m., the resident was observed sitting in the dining room in his wheelchair. The resident indicated he was hungry and did not receive a lunch tray. A CNA was informed, and she indicated she was not aware the resident did not receive a lunch tray. During an observation on 3/3/23 at 8:30 a.m., the resident was sitting at bedside eating his breakfast. No supervision or assistance from staff was observed. During an interview on 3/3/23 at 10:38 a.m., the RD indicated the resident was on a regular diet and he was changed to a dysphagia diet. He was able to feed himself and had a good BMI. She indicated he did not need to be on NAR at this time. He received no supplements, and the staff should offer him snacks.			

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	The Regional Director of Clinical Operations provided a current copy of the policy titled, Resident Height and Weight on 3/3/23, at 3:29 p.m., included, but was not limited to, " ...d) Unstable residents will be reviewed by IDT team to determine weekly or other i) Update Interdisciplinary Care Plan as needed... 9) Reweight Parameters: a) A plus or minus of 5 pounds of weight in one week will result in: (1) Validation with nurse for accurate weight (2) Notify IDT team/doctor/family, if indicated 10) Reporting Weights. a) Weight loss concerns will be discussed at the weekly clinical meetings ....i) Reweight within 24 hours..." 3.1-46(a)(1)			
F 0725 SS=F Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and			

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	(ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, record review, and interview, the facility failed to ensure adequate staffing which contributed to the lack of resident care, the distribution of fluids, and supervision. This deficient practice had the potential to affect 104 of 104 residents residing in the facility. Findings include: During an interview on 2/27/23 at 11:45 a.m., Resident N's family member indicated the resident did not get the help and care needed without having to wait a long time. The family member indicated in the morning, the resident would have brown rings from urine on the sheets. It took bleach to launder them. The night shift would just let the residents lay in bed unchanged. Family felt the need to stay with the resident from 10:30 p.m. to 2:00 a.m., to provide care for the resident. The family had to start feeding the resident at every meal, because of the resident's weight loss. During an interview on 2/27/23 at 11:45 a.m., Resident M's family member indicated she felt the staff wouldn't pay attention to call lights at times. The facility recommended hospice care for the resident to provide more help with ADL (activities of daily living). The resident had lost weight, so the family decided to provide assistance with feeding the resident during meals. During an interview on 2/27/23 at 12:04 p.m., the resident's family indicated that he was provided	F 0725	**F 725 Sufficient Nursing Staff** **Corrective action for the residents found to have been affected by the deficient practice:** Residents were not able to be identified as they were part of a complaint survey. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** The alleged deficient practice has the potential to affect 104 of 104 residents residing in the facility. As a result of this noted alleged deficient practice, there was no negative outcome. The facility staffing patterns have been reviewed to ensure adequate staffing is in place to meet the needs of the residents. The facility has incentives in place to promote hiring of nurses and CNAs. Further, the facility has contracted with agency groups to assist in staffing the facility adequately. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/DON/Designee	03/31/2023

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	water sometimes. During a confidential interview between 2/27/23 and 3/3/23., Staff D indicated there was one CNA (certified nurse aide) and one nurse on the hall. The number of staff varied. On the night shift there was one CNA. The staff would call off or would no show often. The 200 Hall was the worst. The nurses had to pass the trays during the shift due to a lack of help. During the weekends, it was terrible. No one wanted to work and they would call in or no show. During a confidential interview between 2/27/23 and 3/3/23, Confident 7 indicated there was one CNA and one nurse for the 24 residents on the hall. During a confidential interview between 2/27/23 and 3/3/23., Staff H indicated there was no CNA since the beginning of the shift, but one was supposed to show up later in the day. There was usually one CNA and one nurse residing on the hall. During a confidential interview between 2/27/23 and 3/3/23., Staff E indicated it was normal for them to have one CNA and one nurse on the halls. During an observation on 3/2/23 at 8:38 a.m., there were one CNA and one restorative aide, who assisted to pass the trays on the 200 Hall. During a confidential interview between 2/27/23 and 3/3/23, Staff G indicated there was only one CNA on the hall and she had been pulled from another hall, because they had no one on this hall. During a confidential interview between 2/27/23		held an in-service for nursing staff to provide information as it relates to staffing of the facility, incentives offered, and agency use. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The Administrator/DON/Schedule Coordinator/Designee will review the daily schedules Monday through Friday to include weekend schedules to ensure adequate staffing is in place as an ongoing practice. This will occur for no less than 6 months and compliance is maintained. The DON/Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	and 3/3/23., Staff B indicated there was two CNAs and one Activities Director on the hall. One of the CNAs was going to leave during the shift. During a confidential interview between 2/27/23 and 3/3/23, Staff F indicated work was done alone, due to call ins. From 2:00 p.m. to 6:00 p.m., work would have to be performed alone due to a staff requesting to leave then. The management tried to fill the openings, but that didn't always happen. The Facility Assessment Tool, dated 10/2/22 to 9/30/23, indicated the facility required one licensed nursing staff for up to every 26 residents and two CNAs for up to every 20 residents for an average range of care. Review of the current facility census and resident room location indicated the following number of resident resided on each hall: - The 100 Hall had 37 residents. - The 200 Hall had 22 residents. - The 300 Hall had 21 residents. - The 400 Hall had 24 residents. Cross Reference F692 Nutrition/Hydration: Based on observations, record review, and interview, the facility failed to ensure residents were monitored for weight loss and provided with assistance for eating. During an observation on 2/27/23 at 12:25 p.m., Resident 70 was complaining of not being able to breath. The resident was moaning and indicated he could not stand much more. The resident's family member indicated she told the nurse the resident complained of shortness of breath and the nurse indicated she would bring the resident's			

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	medication. She never returned with the medication or to check on the resident, and that had been some time ago. Approximately 20 minutes later a CNA came into the resident's room to pick up lunch trays, but the resident did not have a lunch tray in his room. She observed the resident was short of air and checked his vital signs. At that time, she indicated the resident's 02 (oxygen) saturation was a little low and she would inform the nurse. The Resident Council Minutes were reviewed on 3/3/23 at 2:07 p.m. The minutes indicated the following: - Dated 7/19/22, resident concerns indicated due to the staff shortage it was causing fear in the residents. The call lights were not being answered. The nurses were working 2 floors during a shift. Dietary was not following select menus and food portions were too small. - Dated 10/18/22, the residents concern was the CNAs did not answer the call light. The CNAs were on their cell phones a lot. - Dated 12/20/22, the residents concerns were nursing and CNAs were on their cell phones. The residents' felt like they were not getting the care they needed. Some residents were not getting fed their meals that needed to be fed and small portions of food. During a confidential interview between 2/27/23 and 3/3/23., a resident's family member indicated due to low staffing the staff do not have time to feed the resident. He was losing weight so the family came in and fed him for all his meals. During the weekend, the unit only had one CNA.			

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	During an interview on 2/28/23 at 10:30 a.m., Resident 71 indicated she did not get a bedtime snack and she was a diabetic. Her roommate had to go get her a snack because she could not get one. She felt like there wasn't enough staff to pass the bedtime snacks. During an interview on 3/3/23 at 8:30 a.m., CNA 18 indicated she was the only CNA on the floor. Usually there would be two CNAs but today they were short one.Cross Reference F584 Clean Environment: Based on observation and interview, the facility failed to ensure residents' rooms were clean and free of debris for 4 of 5 random observations of the facility environment and for 5 of 104 residents that reside in the facility The facility failed to ensure cleanliness of resident rooms on multiple observations. Housekeeping staff indicated a lack of housekeeping staffing contributed to having to play "catch-up" on housekeeping duties. During an interview on 3/3/23 at 10:55 a.m., the Housekeeping Supervisor indicated they only had one shift of housekeeping services so a lot of times they would come in to work and have to play catch up. There were two shifts a day where they did not have housekeeping. When the maintenance and housekeeping were not staffed, the task fell onto nursing staff. During a confidential interview between 2/27/23 and 3/3/23, Staff E indicated the staffing had not been great. There were not enough staff. When she got to work she would be the only one on the hall. One day she had no aide. She was an agency staff member and she had no in person physical orientation to the facility. She had no education			

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	with the facility prior to onboarding with the facility. During a confidential interview between 2/27/23 and 3/3/23, a resident's family member indicated the facility could not keep staff. One night she called for two and a half hours straight and got no answer. No one ever answered the phone because no one was there. The room was so dirty they took everything out and cleaned it themselves. They did the mopping and pulled out the furniture. There were times when there were no aides, or only one aide. The Facility Assessment Tool dated 10/2/22 to 9/30/23, provided by the ED (Executive Director) on 2/27/23 at 9:30 a.m., included, but was not limited to, "... Staffing plan 3.2 Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of their residents at any given time... Staff training/education and competencies 3.4... Abuse, neglect, and exploitation - training that at a minimum educates staff on Activities that constitute abuse, neglect, exploitation and misappropriation of resident property... Infection control - a facility must include as part of its infection prevention and control program mandatory training that included the written standards policies, and procedures for the program... Include dementia management training and resident abuse prevention training... Required training of feeding assistance... Activities of daily living..." This Federal tag is related to Complaint IN00400647 3.1-17(a)			

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F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. Based on record review and interview, the facility failed to ensure appropriate interventions were implemented to prevent recurrent resident to resident aggressive behaviors for 1 of 3 residents reviewed for behaviors. (Resident 45) Findings include: The clinical record for Resident 45 was reviewed on 2/28/23 at 1:00 p.m. The diagnoses included, but were not limited to, dementia with agitation, major depressive disorder, and anxiety disorder. The care plan, dated 8/11/21, indicated the resident had a potential for alteration in mood and behavior related to dementia, depression, previous homelessness causing fight or flight behaviors, and previous inpatient stays. His behaviors included being verbally aggressive with staff. He had altercations with other residents on 12/7/18, 8/4/21,12/8/21, 9/15/22, and 12/22/22. The interventions included, but were not limited to, allow personal space and quiet time, anticipate and meet the resident's needs, assist the resident to his room as preferred, assist the resident to develop more appropriate methods of coping and	F 0740	**F740- D** **Corrective action for the residents found to have been affected by the deficient practice:** Resident 45 was not harmed by alleged deficient practice. Resident was reviewed per IDT including psych to ensure appropriate interventions in place related to behaviors, care plan and behavior monitoring orders updated as indicated. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by alleged deficient practice. All residents have been reviewed for aggressive behaviors per IDT team, those identified with aggressive behaviors had appropriate interventions put into	03/31/2023

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	interacting with others, have positive conversation with him, encourage him to express feelings appropriately, give time to talk, offer support, provide opportunity for positive interaction, attention, stop and talk with him as passing by, counsel and/or offer alternatives if refusal of care or referral, explain all procedures to the resident before starting and allow time to adjust to changes, intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, remove from situation and take to alternate location as needed, non-pharmacological interventions, allow resident to direct care as much as possible, change caregiver as needed, encourage activities, praise any indication of the resident's progress/improvement in behavior, provide a program of activities that is of interest and accommodates residents status, provide the resident an opportunity for involvement in his/her plan of care, psychiatric service to evaluate the resident next visit, and the resident enjoyed watching television in his room. The nurse's note, dated 7/11/22 at 11:38 a.m., indicated the resident was screaming and yelling at the nurse that he did not want any medication. The behavior note, dated 7/31/22 at 6:40 p.m., indicated the resident had been refusing care and being aggressive towards staff. If staff asked the resident a question the resident would raise his hand, tried to hit someone, and yelled at them. Staff attempted to call the resident's POA (Power of Attorney), as she would like to be notified of these behaviors, and the calls would not go through. The nurse's note, dated 8/6/22 at 5:30 p.m., indicated the nurse overheard the resident yelling		place per IDT team and plan of care and behavior monitoring orders updated as indicated. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated staff on facilities policy “Behavior Management General Policy” with emphasis on reviewing residents noted with aggressive behaviors and initiating interventions for prevention. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON and/or Designee will audit 5 resident’s daily x’s 4 weeks, then 5 resident’s weekly x’s 4 weeks, then 5 resident’s monthly x’s 4 months to ensure residents noted with aggressive behaviors are reviewed per IDT and appropriate interventions for prevention are in place and plan of care and behavior monitoring update as indicated. The DON and/or Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring	

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	in the dining room. Upon entering the dining room staff observed another resident yelling at Resident 45 that if he ever touched him again he would "kick his a**". The first resident explained Resident 45 had kicked at him. The residents were separated. No contact was made between the two residents. No injuries were observed to either resident. Staff assisted Resident 45 to his room and helped him to bed. The NP was notified with no new orders given. A message was left for the POA. The IDT (Interdisciplinary Team) follow-up note, dated 8/8/22 at 8:04 a.m., indicated the resident had a negative interaction with another resident. The new intervention was for psychiatric services to see the resident on 8/8/22. The psychiatric evaluation note, dated 8/8/22, indicated no new orders or interventions were given. The plan of care indicated to continue to monitor the resident. The clinical record lacked documentation of any further new interventions related to the resident's behaviors towards other residents. The nurse's note, dated 9/14/22 at 1:58 p.m., indicated the resident was heard yelling from common area. Upon entering the common area, the nurse observed the resident grabbing another resident's arm. The resident had increased agitation but staff were able to redirect him. The resident was removed from the area and was able to be calmed down but talking with the resident. The NP (Nurse Practitioner) was made aware. Staff left a voice the message for the resident's POA. The NP's note, dated 9/30/22 at 11:35 a.m., indicated the resident was seen for his monthly		is required.	

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	evaluation and had no new issues. Staff reported no complaints. The resident was stable and the plan of care would be continued. The clinical record lacked documentation of any new intervention related to the incident on 9/14/22 with another resident. The nurse's note, dated 10/3/22 at 1:11 p.m., indicated the resident was seen by the psychiatric NP. Orders were given to decrease the resident's buspirone to 5 mg three times daily related to a gradual dose reduction. The resident's family was notified of new orders and voiced understanding. Nursing staff would continue to monitor and treat the resident. The nurse's note, dated 12/5/22 at 9:30 a.m., indicated the nurse attempted to administer medications to the resident. The resident screamed and tried to get out of bed refusing his medication and becoming very agitated. The nurse was not able to administer the morning medications. The NP note, dated 12/6/22 at 10:08 a.m., indicated the resident was refusing his medications. He was on buspar 5 mg three times daily and Depakote 250 mg (milligram) twice daily and Risperdal 0.5 mg daily. New orders were given to decrease the resident's buspirone to twice daily to limit medication passes and decrease refusals. The behavior note, dated 12/15/22 at 10:39 a.m., indicated the nurse attempted to administer morning medications and the resident got very agitated stated he was not taking his medication and to get out of his room. Staff were monitoring for behaviors.			

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	The nurse's note, dated 12/17/22 at 9:55 a.m., indicated the resident became very agitated when the CNA (Certified Nurse Aide) tried to change the sheets on the bed. After talking to the resident, he calmed down and took his morning medicine. The nurse's note, dated 12/22/22 at 4:24 p.m., indicated the resident was wheeling himself up to the common area in his wheelchair when another resident backed into his wheelchair by accident. The resident made contact with said resident. The residents were immediately separated. Resident 45 was placed on one-on-one care (one staff to one resident observation). A full head to toe assessment was completed with no injury noted. The NP, ED (Executive Director), DON (Director of Nursing), and family were notified. The nurse's note, dated 12/23/22 at 3:18 p.m., indicated a telehealth visit was completed with the psychiatric nurse practitioner. New orders were given to clear the resident of one-on-one and increase the resident's Depakote to 250 mg three times daily from twice daily. The nurse's note, dated 12/24/22 at 8:07 p.m., indicated the resident had an explosive incident where he was screaming at the staff and trying to grab staff. He was calm the rest of the day. The nurse's note, dated 12/28/23 4:14 p.m., indicated new orders were received from the psychiatric NP to increase the resident's buspirone to 7.5 mg twice daily. The behavior note, dated 1/18/23 at 3:08 p.m., indicated the resident had increased behaviors and was easily agitated. He was verbalizing to staff that he would hit other residents. Staff			

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	intervened and attempted to redirect the resident. The resident was given the chance to smoke and allowed one-on-one conversation with staff. All attempts had failed at the time. Staff took the resident to his room to reduce environmental stimuli, and asked the resident if he would like to lay down. The resident was agreeable at the time to lay down. Staff assisted the resident to bed where he continued to verbalize the desire to hit other residents. CNAs on the hall were to conduct frequent checks on the resident. The psychiatric NP was notified and staff were awaiting call back for new orders. They attempted to contact the POA with no answer. The behavior note, dated 1/18/23 at 4:43 p.m., indicated the psychiatric NP gave new orders to increase the resident's Depakote to 350 mg three times daily and to look for a short term psychiatric facility to accept the resident due to behaviors. The SSD (Social Service Director) was notified and staff were awaiting a call back from a behavioral facility for a bedside visit. The nurse's note, dated 1/23/23 at 1:38 p.m., indicated the resident was seen by the psychiatric NP. New order was received to increase the resident's buspirone to 10 mg three times daily. The clinical record lacked any new interventions when the resident's medication pass times were increased to three times a day from twice a day, related to the prior NP order to limiting medication passes to decrease refusals. During an interview on 3/3/23 at 11:48 a.m., the Regional Director of Clinical Operations (RDCO) indicated on 8/6/22 when the resident made contact with another resident they had him seen by psychiatric services, but there were no new			

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	orders related to the incident. The only intervention was to have him seen by psychiatric services. On 9/14/22 when he grabbed the resident, it was the same thing. They had him seen by psychiatric services and there were no new orders listed. There were no new interventions. They had him seen by psychiatric services and they didn't recommend anything. On 12/22/22 he got the medication increase of the Depakote and the buspar. On 1/18/23, when he verbalized wanting to hit another resident, the Depakote was increased and they had an order to send him out to a behavioral facility. During an interview on 3/3/23 at 11:52 a.m., the Infection Preventionist indicated she had called the behavioral facility and they had called back and said since the resident was not aggressive and had not made any contact with another person they would not conduct the bedside evaluation. They had staff conducting frequent checks on him. Psychiatric services followed up the next day and increased his medication and he had been stable since. During an interview on 3/3/23 at 4:32 p.m., the RDCO indicated when a resident had behaviors they would notify the doctor, the representative, the social worker, psychiatric services, and the NP. Then they would come together as an IDT and look at the incident and develop an intervention pertaining to the behavior that occurred and update the plan of care according to the behavior that they had and then they would update the intervention as well. They should create interventions specific to the incident. The Behavior Management General Policy, last reviewed 6/2/21, provided on 3/3/23 at 1:30 p.m. by the RDCO, included, but was not limited to, "... 2.			

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	Residents will be provided with a resident centered behavior management plan to safely manage the resident and others... 1. Assess for problematic/dangerous behaviors... 7. Complete a Care Plan a. Update with changes and/or new behaviors... d. Include resident specific interventions..." 3.1-37(a)			
F 0804 SS=F Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview, the facility failed to ensure meals were healthy and appetizing for residents, during 1 of 2 meal test trays. This had the potential to affect all 104 residents who ate meals at the facility. Findings include: During an interview on 2/27/23 at 9:38 a.m., Resident 63 indicated the food was bad and it was cold sometimes. During an interview on 2/27/23 at 9:40 a.m., Resident 211 indicated the food was not good. During a lunch meal test tray observation and	F 0804	F-804 1. Facility will ensure food served to residents is palatable, attractive and at a safe and appetizing temperature. The identified residents were assessed/interviewed. There was no negative outcome as a result of this deficient practice. 2. The DSM/designee will interview all residents to ensure all drinks and food are palatable, attractive and at a safe temperature. This interview will be completed on or before 3/25/2023. 3. The RD/designee will provide	03/31/2023

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	tasting on 3/2/23 at 11:26 a.m., the residents were served chicken salad sandwiches, broccoli salad, and potato salad. All 3 of the salads had mayonnaise in the recipe. The potatoes and the broccoli were undercooked. During an interview on 3/2/23 at 12:45 p.m., Resident 15 indicated the food was terrible today. The potatoes and broccoli were hard. If there was only one salad dish, it wouldn't have been so bad, but it was too many salads. The menu repeated all of the time. During an interview on 3/2/23 at 12:46 p.m., Resident 96 indicated she didn't like the potato salad. There was too many salad dishes on the tray. During an interview on 3/2/23 at 12:50 p.m., Resident 66 indicated he just had whatever soup they had, because he didn't like the usual meals. During an interview on 3/2/23 at 1:20 p.m., the Dietary Manager indicated she found the first batch of potatoes to be undercooked, so she had the cook prepare another batch of potatoes. She felt the test tray had the first batch of potatoes in the potato salad. She used both batches of potatoes for the residents. The salad dishes were only on the one menu. She indicated 4 jars of mayonnaise were used to prepare the lunch dishes. The menu repeated every 5 weeks. The resident council food committee meeting indicated the residents felt there was too much fish and ham dishes, so those would be removed from the menu for a while. During an interview on 3/2/23 at 1:10 p.m., Resident 11 indicated she did not eat her lunch today, because she did not want to eat it.		education to the culinary/nursing teams to ensure food temperatures are obtained at the start of the tray line and all meal trays served, stored and delivered safely and securely in order for all foods to maintain appropriate temperature and are palatable. 4. The RD/designee will audit 3 meals 5 days per week for 2 months and 3 days per week for one month. The DSM will attend the resident monthly Food Committee meeting to review the results of audits to ensure resident meal satisfaction. The results of these audits will be reviewed in the monthly QAPI meeting. The QA committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	155488	A. BUILDING 00 B. WING	03/03/2023

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	During an interview on 3/2/23 at 1:20 p.m., a resident's family member indicated the pureed texture was better, but she was wondering why the lunch meal was 3 different salads with each salad containing a lot of mayonnaise. During an interview on 3/2/23 at 1:40 p.m., Resident 87 indicated she ate her lunch, but she wasn't fond about having 3 different types of salad with mayonnaise. She felt like the meal could have been better. 3.1-21(a)(1) 3.1-21(a)(2)			
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			

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	Based on observation and interview, the facility failed to ensure the kitchen equipment was cleaned and in good repair, and food was stored properly in the dry goods room and refrigerator. This had the potential to affect all 104 residents who consumed meals at the facility. Findings include: During a tour of the kitchen on 2/27/23 at 9:12 a.m., the following concerns were observed: -There was a black loose charcoal substance on the bottom of the oven. -There was a black burned greasy area on the metal panel and plaster wall above the metal panel, to the left of the stove top burners. -There was a black greasy area to the right of the burners on the metal panel. -There was food debris and a build-up of a black charcoal substance on three of the aluminum lined drip pans under the burners. The drip pan on the left had grease under the aluminum. The fourth drip pan would not open. -In the dry goods storage room, the lid on the storage container, which had an open bag of dry milk, was ajar over half of the top. -the stand alone refrigerator had an internal temperature of 54 degrees Fahrenheit. Inside there was moldy greens in a box and a foul odor was observed. Also in the refrigerator was a box of cabbages and a box of apples. During an interview on 2/27/23 at 9:17 a.m., Cook 19 indicated the refrigerator would sometimes read 30 degrees and sometimes read 50 degrees. The cook removed the box of moldy greens from the refrigerator. During an observation on 2/27/23 at 11:03 a.m.,	F 0812	F-812 1. Facility will store, prepare, distribute and serve food in accordance with professional standards of foodservice safely. There was no negative outcome as a result of this alleged citation. 2. Concerned areas included: black loose charcoal substance on the bottom of the oven, black burned greasy area on the metal panel and plaster wall above the metal panel, black greasy area to the right of the burners on the metal panel, food debris and buildup of a black charcoal substance on 3 drip pans under burners, storage container ajar, standalone refrigerator internal temperature of 54 degrees Fahrenheit, moldy greens, brown dust above the serving counter vent. All areas have been addressed. The refrigerator was repaired during survey. 3. The Culinary Director /designee will educate culinary staff on the daily cleaning of equipment/areas, routine observation of food storage, and maintaining proper temperatures in refrigerators and freezers. Education will be completed by 3/24/2023. The administrator/designee will complete kitchen observation 5 days per week for 4 weeks, 3 days per week for 2 months, to ensure equipment and food are stored and prepared in accordance	03/31/2023

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	two vents above the serving counter were fully covered in a brown dust. The Dietary Manager indicated she had not noticed the dust on the vents. The Weekly Cleaning Schedule for the Cooks during the week of February 20, 2023 was provided by the Dietary Manager on 2/27/23 at 11:05 a.m. The daily equipment cleaned was initialed by the staff, indicating its completion. On Saturday night (2/25/23), the stove drip pans were initialed as cleaned. During an interview on 3/2/23 at 8:49 a.m., the Dietary Manager, indicated the kitchen stand alone refrigerator, has had problems for 3 months, and had food stored in it prior to the repair. The food had not been used, and was thrown out. During an interview on 3/2/23 at 11:10 a.m., the Dietary Manager indicated the Maintenance Director cleaned the equipment monthly. The review of the current Storage of Resident Food policy, included, but was not limited to, "... Unsafe foods... This may also include food that is expired, outdate or food that has been exposed to incorrect temperatures or other environmental contaminants..." The review of the Equipment policy, included, but was not limited to, "...All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials...All non-food contact equipment will be clean and free of debris..." 3.1-21(j)(3)		with professional standards of food service safety. The results of these audits/reviews will be reviewed in the monthly QAPI meeting. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required	

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;			

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	(iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure appropriate Infection Control practices related to transmission-based precautions (TBP) were implemented related to Aerosol-Generating Procedures (AGP's) for 2 of 2 random observations of care. (Resident 87)	F 0880	Rolling Hills # 155488 Rolling Hills Health Care maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit our capability to render adequate care. Please accept this plan of	03/31/2023

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	Findings include: 1. During an observation on 3/3/23 at 8:31 a.m., Resident 87 was observed in her bed in her room utilizing a nebulizer treatment. There was fine aerosol mist observed exiting the end of the nebulizer mouthpiece which she was utilizing. The resident's room door was open. The sign on the resident's door indicated she was in aerosol contact precautions. The sign indicated every one must wear a N95 or higher respirator, eye protection, gown, and gloves when entering and keep the door closed. During an interview and observation on 3/3/23 at 8:33 a.m., LPN (Licensed Practical Nurse) 20 indicated Resident 87 was receiving a breathing treatment which she had set up for her. She was not aware of the sign to keep the door closed. She thought since the resident was in the second bed it was ok. She then entered the room and closed the curtain in the room. She did not don a gown, or gloves. She then sat with the resident as her nebulizer was running. During an observation and interview on 3/3/23 at 8:35 a.m., CNA (Certified Nurse Aide) 21 indicated she was not aware of any PPE (Personal Protective Equipment) requirements during a breathing treatment. She was going in to change Resident 87's room mate. She entered the room without a gown and closed the door. During an interview on 3/3/23 at 8:38 a.m., The Divisional Nurse indicated if an AGP was going on and staff were in the room they needed to be gowned and masked. The door should be closed regardless of which bed it was. If the resident refused to close the door they would pull the curtain.		correction as the facility's written credible allegation of compliance such that all alleged deficiencies have been or will be corrected by 3-26-23. To remain in compliance with all federal and state regulation, the facility has taken or will take the actions set forth in the following plan of correction. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required. F-880 (D) Infection Prevention and Control The facility will ensure personal protective equipment is donned and doffed correctly and is consistently implemented to potentially prevent the spread of Covid-19 infections during aerosol generating procedures. Resident #87 was admitted to the facility and was in droplet precautions. Resident #62 was assessed by the DON on 5/24/2022 and did not have a negative outcome as a result of the deficient practice. On March 3, 2023 the facility	

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	2. During an observation on 3/3/23 at 12:10 p.m., Resident 87 was in her room on her bed. Her nebulizer was running and she was holding the nebulizer mouthpiece in her mouth and fine mist could be seen flowing out the other end of the mouth piece. There were no staff in the room. During an interview on 3/3/23 at 12:13 p.m., CNA 21 indicated resident's roommate had come out of the room and left the door open. CNA 21 then proceeded down the hall without attempting to close the resident's door or the curtain. The clinical record for Resident 87 was reviewed on 3/3/23 at 9:00 a.m. The diagnosis included, but was not limited to, COPD (chronic obstructive pulmonary disease). The physician's orders, dated 1/23/23, indicated the resident received albuterol sulfate 2.5 mg/3mL (milligrams per milliliters) every 8 hours as needed for wheezing, ipratropium-albuterol 0.5-2.5 mg/3 mL three times daily for COPD, and to don full PPE, which included the N95 mask with aerosolized treatments. The Guidance for Aerosol Generating Procedures policy, last revised 2/3/22, provided on 3/3/23 at 11:01 a.m. by the RDCO (Regional Director of Clinical Operations) included, but was not limited to, " ... The following steps are necessary when providing care during an aerosol generating procedure. An N95 mask, and full PPE must be worn with all aerosol generating procedures ... 3. If removing a room mate for 1 hour is not feasible, keep privacy curtain drawn around the resident receiving the treatment for duration of procedure and best practice is to keep the curtain closed for 1 hour after completion of treatment if it is safe to		tested resident # 87 and the roommate for COVID-19 via Binax both tests were negative. There were no negative outcomes as a result of the deficient practice. Employees # 20 and # 21 were given education immediately following the observation of the deficient practice. As a result of the deficient practice the facility will: · The DON/IP nurse will provide education to all staff regarding appropriate PPE, Donning and Doffing PPE per policy “Guidance for Aerosol generating procedures. Education will be completed by 3-26-23. The resources for education will be; the facility policy, “Guidance for Aerosol Generating Procedures, and the CDC guide for donning and doffing PPE. · The facility will conduct a root cause analysis with the assistance of the IP nurse, QAPI committee, and the Governing Body by 3-26-23. To assure continued compliance the facility will: · The DON/IP nurse will conduct rounds daily throughout the facility to ensure staff is donning appropriate PPE prior to entering a resident’s room who is receiving an aerosol treatment as per physician’s orders, doffing PPE upon exit, and performing	

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	do so ... 4. Close the door to the resident room before performing the treatment. 5. Keep privacy curtain drawn around the resident receiving the treatment for duration of procedure ..." 3.1-18(b)		hand hygiene appropriately for six weeks. · Results of the audits will be reviewed by the QAPI committee monthly for six months to determine of current interventions are adequate or if additional action is needed to ensure infection prevention and control procedure are implemented appropriately.	
F 0886 SS=E Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;			

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	(v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.			

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	Based on record review and interview, the facility failed to ensure the residents were COVID-19 tested in accordance with their policy for 6 of 12 residents reviewed for COVID testing. (Residents 80, 76, 89, 70, 87 and 92). Findings included: 1. The clinical record for Resident 76 was reviewed on 3/1/23 at 11:01 a.m. The diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease) and large-B-cell lymphoma. The Quarterly MDS (Minimum Data Set) assessment, dated 12/15/22, indicated the resident was severely cognitively impaired. On 6/9/22, the resident received new physician orders for Respiratory/COVID Screener: Any of the following S/Sx (signs/symptoms) of COVID-19 observed: If any S/Sx noted; complete the Respiratory/COVID Symptoms Evaluation, every shift, and for COVID-19 testing as needed; may use PCR (polymerase chain reaction) or POC (rapid viral test) testing as needed. A care plan, dated 6/13/22, indicated the resident had COPD with shortness of breath. The interventions included, but were not limited to, administer medications per medical provider's orders; observe for side effects and effectiveness; report abnormal findings to medical provider; monitor vitals and report abnormal findings to medical provider; observe for s/sx of COPD: increased shortness of breath, frequent coughing with and without mucus, wheezing, tightness in the chest and report any abnormal findings to medical provider; and monitor lab/diagnostic studies as ordered and report abnormal findings	F 0886	**F886-E** **Corrective action for the residents found to have been affected by the deficient practice:** Resident 80 was not harmed by alleged deficient practice. Resident had respiratory assessment complete per licensed nurse, and based on findings COVID-19 testing was implemented if indicated per MD order and plan of care and orders updated as indicated. Resident 76 was not harmed by alleged deficient practice. Resident had respiratory assessment complete per licensed nurse, and based on findings COVID-19 testing was implemented if indicated per MD order and plan of care and orders updated as indicated. Resident 89 was not harmed by alleged deficient practice. Resident had respiratory assessment complete per licensed nurse, and based on findings COVID-19 testing was implemented if indicated per MD order and plan of care and orders updated as indicated. Resident 70 was not harmed by alleged deficient practice. Resident had respiratory assessment complete per licensed nurse, and based on findings COVID-19 testing was implemented if indicated per MD	03/31/2023

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	to medical provider. A care plan, dated 6/13/22, indicated the resident was at risk for COVID-19. The interventions included, but were not limited to, lab/diagnostic testing per physician's orders, report results; observe for elevated temperature, s/s of respiratory distress, and s/s of COVID infection, and document and notify medical provider if occurs. The NP (Nurse Practitioner) progress note, dated 12/15/2022 at 11:31 a.m., indicated the resident complained of chest congestion, shortness of breath (SOB) and cough. Lung sounds were coarse throughout with diminished air movement and wet rales/crackles. Therapy reported the resident's O2 (oxygen level) was low in rehab and when put on 2 liters of oxygen via a nasal cannula, his O2 saturation levels went up to greater than 93% (percent). He also had complained of nausea. New orders were obtained for Azithromycin pak times 4 days and a chest X-ray for chronic cough and SOB. The SBAR (Situation Background Assessment Recommendation) Summary for Providers, dated 12/15/2022 at 1:34 p.m., indicated the resident was having shortness of breath, productive cough and new onset congestion. The Primary Care Provider responded with an order for a chest X-ray two views. The nurses note, dated 12/16/2022 at 9:19 a.m., indicated the chest X-ray obtained on 12/15/22 was negative. The results indicated the lungs were clear with no evidence of acute pulmonary disease. The Infection Surveillance Criteria Report, dated		order and plan of care and orders updated as indicated. Resident 87 was not harmed by alleged deficient practice. Resident had respiratory assessment complete per licensed nurse, and based on findings COVID-19 testing was implemented if indicated per MD order and plan of care and orders updated as indicated. Resident 92 was not harmed by alleged deficient practice. Resident had respiratory assessment complete per licensed nurse, and based on findings COVID-19 testing was implemented if indicated per MD order and plan of care and orders updated as indicated. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by this alleged deficient practice. All residents had respiratory assessments complete those found to have any abnormal symptoms were tested for Covid-19. Any positive results notifications were made per facility protocol and orders and care plan updated as indicated. **Measures/systemic changes put into place to ensure the deficient practice does not recur:** DON/Designee educated Licensed	

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	12/16/22, indicated the resident had a respiratory infection, stuffy nose/nasal congestion and SOB. The Respiratory Surveillance Line List lacked documentation of the facility having performed a Rapid COVID Test on the resident when he experienced SOB, congestion and nausea. 2. The clinical record for Resident 80 was reviewed on 3/1/23 at 1:36 p.m. The diagnosis included, but was not limited to, COPD. The Quarterly Minimum Data Set assessment, dated 2/7/23, indicated the resident was cognitively intact. On 5/10/22, the resident received new physician orders for Respiratory/COVID Screener: Any of the following S/Sx of COVID-19 observed: If any S/Sx noted; complete the Respiratory/COVID Symptoms Evaluation, every shift, and for COVID-19 testing as needed; and may use PCR or POC testing as needed. New physician orders were obtained for Respiratory/COVID Screener. A care plan, dated 8/22/22, indicated the resident had COPD with shortness of breath. The interventions included, but were not limited to, administer medications per medical provider's orders; observe for side effects and effectiveness; report abnormal findings to medical provider; monitor vitals and report abnormal findings to medical provider; observe for s/sx of COPD, increased shortness of breath, frequent coughing with and without mucus, wheezing, tightness in the chest and report any abnormal findings to medical provider; and monitor lab/diagnostic studies as ordered and report abnormal findings to medical provider.		Nursing Staff on facilities policy "Criteria for Covid-19 Requirements" With emphasis on signs and symptoms that meet criteria for Covid-19 testing. **Corrective actions to be monitored to ensure the deficient practice will not recur:** The DON and/or Designee will audit 5 resident's daily x's 4 weeks, then 5 resident's weekly x's 4 weeks, then 5 resident's monthly x's 4 months to ensure with noted signs and symptoms that meet criteria for Covid-19 testing that residents were tested per facility policy. The DON and/or Designee will present the results of these audits monthly to the QAPI committee for no less than 6 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	A care plan, dated 8/22/22, indicated the resident was at risk for COVID-19. The interventions included, but were not limited to, lab/diagnostic testing per physician's orders; report results; observe for elevated temperature; s/s of respiratory distress; and s/s of COVID infection; and document and notify medical provider if occurs. The Nurse Practitioner's progress note, dated 1/26/23 indicated the resident complained of cough and shortness of breath but denied wheezing and difficulty breathing. Lung sounds had overall diminished air movement and expiratory wheezing. New orders were given for Mucinex 600 mg(milligrams) po (by mouth) BID (three times daily) for 10 days and a Chest X-ray for cough. A nurses note, dated 1/27/23 at 5:03 p.m., indicated the chest X-ray results were reviewed by the NP with new orders received to start Amoxicillin 875mg every morning and QHS (every night) times 7 days r/t (related to) a bacterial infection. The Respiratory Surveillance Line List lacked documentation to indicate the resident had been Rapid Tested for COVID when he experienced the shortness of breath and congestion. During an interview with LPN (Licensed Practical Nurse) 1 on 3/2/23 at 10:55 a.m., she indicated she would monitor the resident for fever, nausea, cough, respiratory issues as signs of COVID and would notify the NP/physician regarding the symptoms to see they wanted to order a COVID test. During an interview with QMA (Qualified			

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	Medication Aide) 2 on 3/2/23 at 11:20 a.m., she indicated that if she noticed any symptoms of possible COVID, she would immediately inform the LPN/RN who would then monitor for cough, respiratory issues, vitals, fever or vomiting. If symptoms were present, then nurse would call the NP/physician to inform them of the symptoms and obtain new orders. Resident would also be immediately placed into isolation and probably COVID tested. During an interview with the Infection Preventionist on 3/2/23 at 11:30 a.m., she indicated that she would monitor the resident for cough, congestion, fever, malaise, or change in mental status/condition, report the symptoms to the NP, and get orders for a chest X-ray and Rapid COVID test. 3. The clinical record for Resident M was reviewed on 3/3/23 at 9:12 a.m. The diagnoses included, but were not limited to, Asthma/COPD and Alzheimer's disease. The Quarterly MDS assessment, dated 11/3/22, indicated the resident had severe cognitive impairment. A care plan, dated 11/29/22, indicated the resident had Asthma/COPD with shortness of breath. Interventions included, but were not limited to, administer medications per medical provider's orders; observe for side effects and effectiveness; report abnormal findings to medical provider; monitor vitals and report abnormal findings to medical provider; observe for s/sx (signs/symptoms) of COPD, increased shortness of breath, frequent coughing with and without mucus, wheezing, tightness in the chest and report any abnormal findings to medical provider;			

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	oxygen therapy as ordered; and monitor lab/diagnostic studies as ordered and report abnormal findings to medical provider. A care plan, dated 11/29/22, indicated the resident was at risk for COVID-19 related to potential exposure with recent hospitalization. Interventions included, but were not limited to, lab/diagnostic testing per physician's orders, report results; observe for elevated temperature, s/s of respiratory distress, and s/s of COVID infection, document and notify medical provider if occurs. On 11/27/22, the resident received new physician orders for Respiratory/COVID Screener: Any of the following S/Sx of COVID-19 observed: If any S/Sx noted, complete the Respiratory/COVID Symptoms Evaluation - every shift and for COVID-19 testing as needed, may use PCR or POC testing as needed. The SBAR Summary for Providers, dated 12/10/2022 at 11:06 a.m. indicated the resident had a change in condition due to symptoms of nausea and vomiting and a temperature 100.0 Fahrenheit. Hospice was notified and gave new orders for Zofran PRN (as needed). The Respiratory Surveillance Line List lacked documentation to indicate the resident had been tested for COVID after presenting with symptoms of nausea and vomiting and a fever. 4. The clinical record for Resident 70 was reviewed on 2/27/23, at 1:14 p.m. The diagnoses included bur were not limited to, dysphagia following a cerebral infarction, diabetes mellitus, major depressive disorder, weakness, dementia, and Alzheimer's.			

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	The physician orders, dated 10/24/22, indicated staff were to observe for any of the following signs and symptoms for respiratory and Covid: fever/chills, shortness of breath, body aches, cough either dry/productive, diarrhea, nausea/vomiting, congestion, headache, loss of appetite/smell/taste, fatigue, sore throat. If any of the signs and symptoms were observed, complete the Respiratory/COVID Symptoms Evaluation every shift. The care plan, dated 8/25/20 and revised on 10/16/21, indicated Resident 70 was at risk for COVID-19. The interventions included, but were not limited to, the resident would remain free of complications of communicable disease, administer oxygen per physician's order, administer pharmacological interventions per physician's order, monitor for side effects and notify medical provider if occurs, confirm code status of the resident, respecting the resident's choice, educate the resident on proper and frequent hand washing, encourage fluids, Encourage the resident to report any new or worsening signs or symptoms as soon as possible, encourage the resident to cover his mouth and nose when coughing, give IV (intravenous) medications as ordered, hypodermoclysis per physician's order, isolation precautions as needed and as ordered, laboratory/diagnostic testing per physician's orders and report results, monitor for elevated temperature, monitor lung sounds, observe for signs and symptoms of respiratory distress, notify the physician if symptoms occurred, and remind the resident to avoid touching their face, eyes, and mouth when possible. The clinical record lacked documentation the resident was COVID-19 tested due to nausea and			

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	vomiting and shortness of breath. The Quarterly MDS assessment, dated 2/7/23, indicated the resident was severely cognitively impaired. He required extensive assistance with eating with one-person physical assistance. During an observation on 2/27/23 at 12:25 p.m., Resident 70 complained of not being able to breath. The resident was moaning and was breathing through his mouth. The resident's family member indicated she informed a nurse the resident was complaining of shortness of breath and the nurse indicated she would bring the resident medication. She indicated the nurse did not come back. Approximately 20 minutes later a CNA came into the room to pick up the lunch tray. She observed the resident short of air and checked his vital signs. At that time, she indicated the resident's 02 saturation was a little low and she would inform the resident's nurse. The nurse's note, dated 2/28/23, at 9:16 a.m., indicated the follow up from yesterday's nausea and complaints of shortness of breath. No nausea or shortness of breath observed. During an interview on 3/2/23 at 11:36 a.m., RN 17 indicated staff would monitor for signs and symptoms like cough, shortness of air, congestion, loss of smell or taste and fever. The resident would be tested for Covid if they had these symptoms. She would inform her Unit Manager and test the resident. She indicated the facility had an enough testing kits and PPE's. 5. The clinical record for Resident 87 was reviewed on 3/1/23, at 1:52 p.m. The diagnoses included, but were not limited to, COPD and muscle weakness. The Quarterly MDS assessment, dated			

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	2/3/23, indicated the resident was alert and oriented. The nurse's note, dated 1/6/23, at 10:54 a.m., indicated the resident complained of shortness of air and wheezing. A new order received to obtain CXR (chest x-ray)2 view. The nurse's note, dated 1/18/23, at 6:19 p.m., indicated the resident called the DON (Director of Nursing) into her room and complained of SOA (Shortness of Air). The resident was assessed and her lungs were CTA (clear to auscultation) bilaterally, Her 02 (oxygen) was observed to be 92 to 95% on NC (nasal cannula). No signs and symptoms of distress observed until the resident stated that she was terrified to be alone, and that something might happen to her. A small amount of yellow colored mucus was observed when the resident coughed. A CXR was ordered, but canceled due to her insurance, since her last CXR was less than 3 weeks ago. The resident stated itss all her anxiety that stems from not being able to breathe. The resident got very tearful when staff tried to exit the room. Staff encouraged the resident to drink fluids to help thin mucus at that time. The nurse's note, dated 1/19/23 a 4:24 a.m., indicated the resident requested to be sent to the hospital via ambulance. The medical company was contacted for permission to send her to the hospital. The physician orders, dated 1/23/23, indicated staff were to observe for any of the following signs and symptoms for respiratory and Covid: fever/chills, shortness of breath, body aches, cough either dry/productive, diarrhea, nausea/vomiting, congestion, headache, loss of			

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	appetite/smell/taste, fatigue, sore throat. If any of the signs and symptoms were observed, complete the Respiratory/COVID Symptoms Evaluation every shift. COVID-19 testing as needed and may use PCR or POC testing as needed for COVID 19 testing. The care plan, dated 1/23/23, indicated the Resident was at risk for COVID-19. The interventions included, but were not limited to, the resident would not exhibit signs and symptoms of COVID infection or a positive test result, laboratory and diagnostic testing per physician's orders and report the results, observe for an elevated temperature, signs and symptoms of respiratory distress, and signs and symptoms of COVID infection, document and notify medical provider if occurs. The clinical record lacked documentation indicating the resident was Covid-19 tested. 6. The clinical record for Resident 92 was reviewed on 3/1/23 at 11:31 a.m. The diagnoses included, but were not limited to congestive heart failure and personal history of pulmonary embolism. The Annual MDS assessment, dated 2/1/23, indicated the resident was severely cognitively impaired. The nurse's note, dated 2/26/23 at 7:13 p.m., indicated the resident had been repositioned frequently and complained and cried out that his muscles burned. The February TAR (Treatment Administration Record) lacked documentation of any symptoms of COVID-19. During an observation, on 2/28/23 at 11:17 a.m.,			

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	Resident 92 was observed to be visibly coughing. He indicated it had been going on for two days. He could be heard to be audibly wheezing. The resident could not stop coughing. His eyes were bloodshot. He indicated he had been up all night, his stomach muscles were sore from coughing. Staff had not said or done anything yet and he had not been covid tested. The resident was struggling to talk through the coughing and wheezing. During an interview on 2/28/23 at 11:19 a.m., Resident 61 (Resident 92's roommate) indicated Resident 92 had been coughing for a couple of days. The night prior he had gotten a nurse for his roommate because of his coughing. The clinical record lacked documentation of any assessment of respiratory symptoms including coughing or any COVID testing prior to 2/28/23. The nurse's note, dated 2/28/23 at 11:33 a.m., indicated the resident had a cough and congestion. The NP assessed him and gave new orders for albuterol nebulizer treatments as needed every 4 hours for SOB, Mucinex 600 mg twice daily for 10 days and a chest x-ray two view for cough and congestion. The nurse's note, dated 2/28/23 at 12:40 p.m., indicated the resident had a fever, cough, and congestion. Orders were received from the NP to perform a COVID test. The resident's COVID test was positive. The resident was placed into droplet precautions. During an interview, on 3/2/23 at 2:32 p.m., LPN 22 indicated the resident had been sitting up in his bed the night before he tested positive for COVID-19. They were watching a movie and she			

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	didn't see him in any distress. He wasn't coughing that much. She did recall him coughing a time or two like one would with allergies. She herself was coughing because of allergies, but it wasn't really "bad enough to notice." On 2/27/23 at 9:30 a.m., the Interim Executive Director presented a copy of the facility's current policy titled Facility Testing Requirements dated 3/24/22. Review of this policy included, but was not limited to:"...Definitions:...Swift identification of confirmed COVID-19 cases allows the facility to take immediate action to remove exposure risks to nursing home residents...Policy: The LTC facility must test residents...for COVID-19. At a minimum, for all residents..., the LTC facility must: 1. Conduct testing based on parameters set forth by the Secretary, including but not limited to:...1c. The identification of any individuals specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19:...3. Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; 4. For each instance of testing:...Document in the resident's record that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. resident and/or Resident Representative are notified of positive results in a timely manner...12. Regardless of the frequency of testing being performed or the facility's COVID-19 status, the facility should continue to screen...each resident (daily)...for signs and symptoms of COVID-19..." On 3/2/23 at 1:55 p.m., the Regional Clinical Director of Operations (RCDO) presented a copy of the facility's current policy titled Criteria for COVID-19 Requirements dated 9/23/22. Review of this policy included, but was not limited to,			

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	"...Policy: This policy is to assist with the guidance on how to manage...resident surveillance, a COVID-19 isolation room,...the criteria for admission into an isolation room...covid testing...The facility will isolate the resident in place and utilize Transmission-Based Precautions....Facility criteria including COVID-19 testing,...will follow the CDC and CMS requirements. Additionally, the facility will follow each state or local health department guidance...Residents:...b. Residents with symptoms of COVID-19 require the completion of the Respiratory/COVID Symptoms Evaluation at least daily...g. Residents who have symptoms of COVID-19 will be placed in quarantine and will be tested immediately. If the test is negative, the test is repeated in 48 hours. If the test is negative, quarantine can be discontinued...Consideration for COVID-19 Isolation Room: If symptoms are identified, place resident in isolation, obtain orders to test for COVID. Signs and symptoms of COVID-19: Fever greater or equal to 100.0, cough, shortness of breath, chest pain or pressure, Change in mental status, congestion, nausea and vomiting, increased care needs or increased fatigue..."			
F 9999 Bldg. 00	3.1-13(w) Administration and Management: In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, This State Rule was not met as evidenced by: Based on record review and interview, the facility failed to submit an Alzheimer's and dementia special care unit disclosure form on an annual	F 9999	F-9999 1. No residents were affected by the alleged deficient practice. 2. The Alzheimer's and Dementia Disclosure form was completed and submitted during the survey. 3. Education was provided to the facility by the Regional Director of Operations regarding the annual	03/31/2023

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	basis for the year 2022 to 2023. Findings include: During the initial Entrance Conference with the Interim Executive Director on 2/27/23 at 9:15 a.m., she was given a copy of the Annual Alzheimer's and Dementia Special Care Unit Disclosure form to complete. She indicated that she thought it had already been completed by the prior Executive Director but would have to look. On 3/1/23 at 9:00 a.m., the Interim Executive Director indicated Corporate office told her to go ahead and complete the Alzheimer's and Dementia Unit Application as it was not updated annually like it was supposed to. On 3/3/23 at 9:30 a.m., the Interim Executive Director indicated the application was uploaded to the State after being sent back to the Corporate office.		submission of the disclosure form to the state of Indiana. 4. The facility administrator will conduct an annual audit to ensure the Alzheimer's and Dementia Disclosure form is completed. The disclosure form will be reviewed in the monthly QAPI meeting. Any changes and or revisions to the disclosure will be submitted to the state per regulation.	