STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155566	A. BUILDING 00 B. WING	08/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WARSAW MEADOWS	300 E PRAIRIE ST WARSAW, IN 46580

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00382515 and IN00381080. Complaint IN00382515 - Substantiated. Federal/State deficiencies related to the allegations are cited at F695 and F677. Complaint IN00381080 - Substantiated. Federal/State deficiencies related to the allegation are cited at F689. Survey dates: July 28, 29, 2022 and August 1, 2, 3, 4, 5 and 8, 2022. Facility number: 000359 Provider number:155566 AIM number: 100274920 Census Bed Type: SNF/NF: 60 Total: 60 Census Payor Type: Medicare: 1 Medicaid: 46 Other: 13 Total: 60 These deficiencies reflect State Findings cited in accordance with 140 IAC 16.2-3.1. Quality review completed 8/17/22.	F 0000		
F 0578 SS=D	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv			

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

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Bldg. 00	Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such			

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	information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on observation, interview, and record review, the facility failed to ensure an Advanced Directive was in place and signed by the physician for 1 of 24 charts reviewed for Advanced Directives. (Resident 18) Finding includes: A clinical record review was completed on 8/1/2022, at 11:28 A.M., and indicated Resident 18's diagnoses included, but were not limited to: heart failure, type 2 diabetes, cerebral infarction, intellectual disabilities and obstructive sleep apnea. A Physician Order and Care Plan, dated 12/15/2021, indicated the resident was to be a full code. During an interview on 8/3/2022, at 12:55 P.M., the Admissions Director indicated she could not find an advance directive for the resident in his chart. She located an advance directive form for Resident 18, dated 4/1/2022, in a file folder she kept for Resident 18, but it was not signed by the physician. The Admissions Director indicated it (the Advance Directive form) should have been signed and scanned into the resident's chart. On 8/3/2022 at 1:12 P.M., the Admissions Director provided a policy titled, " Advance Directives", dated 12/2016, and indicated the policy was the one currently used by the facility. The policy indicated "... 7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record...."	F 0578	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective September 9, 2022. We respectfully request paper compliance for this survey resolution. **F 578** It is the practice of this facility to assure that Advance Directives are in place for each Resident. The corrective action taken for those residents found to be affected by the deficient practice include: Resident #18 has an Advanced Directive on the medical record that is signed by the physician. Other residents that have the potential to be affected have been identified and corrective actions taken: All residents have the potential to be affected by the deficient practice. All resident medical records have been reviewed to ensure that Advance Directives are in place and signed	09/09/2022

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	3.1-4(f)(5)		by the physician. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been conducted for Admissions and Social Services to ensure Advanced Directives are present on the medical record after a change in directive or when a new admission arrives. The policy and procedure for Advanced Directives was reviewed by the IDT team. A random review of Advanced Directives will be completed to ensure compliance. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 residents to ensure that Advanced Directives are present on the chart and signed by the physician. The Social Services Director, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 9, 2022.	

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F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer			

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	would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for			

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	ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. Based on record review and interview, the facility failed to provide the Transfer/Discharge Form for 2 of 6 residents reviewed for discharge and hospitalization. (Residents J and G) Findings include: 1. A clinical record review for Resident J was completed on 8/3/2022 at 10:11 A.M. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease, malignant neoplasm, pneumonia, and generalized anxiety. A Nurses Note, on 7/10/2022 at 4:28 P.M., indicated, "...Resident was shivering and complaining of being cold, SOB [shortness of breath], and increased confusion. Upon check, her vitals were as follows: 102.6 T [Temperature] - 105/60 BP- [Blood Pressure]114 HR [Heart Rate]20 R [Respirations] and 85% [Oxygen Saturation] on 5L [5 liters]. Ran a rapid covid test which was negative. Notified DON [Director of Nursing], NP [Nurse Practitioner], heart to heart hospice, and both emergency contacts. Res [Resident] was sent to [Hospital name] for evaluation...." On 7/10/2022 at 7:21 P.M., a Nurses Note indicated, "...Writer spoke with [nurse's name] at [Hospital Name], resident has been admitted for septic shock...." During an interview on 8/4/2022 at 1:51 P.M., the	F 0622	**F 622** It is the practice of this facility that Transfer/Discharge forms will be provided to residents who are discharged or hospitalized and the Ombudsman notified. The corrective action taken for those residents found to be affected by the deficient practice include: Residents G and J are past transfers. Since it would not be possible to correct the deficiency on the residents that were transferred, please refer to system changes and monitoring below. Other residents that have the potential to be affected have been identified and corrective actions taken: All residents that are discharged or transferred to the hospital have the potential to be affected. Please see system changes below to prevent reoccurrence. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service was held with Social Services on the transfer/discharge form for residents that are discharged or hospitalized and	09/09/2022

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	Social Service Director indicated, nursing services completes the transfer/discharge forms and was unsure where the forms go from that point. On 8/4/2022 At 3:08 P.M., the Director of Nursing indicated the transfer/discharge forms are uploaded by Medical Record Coordinator. She indicated the transfer/discharge forms should be completed on every transfer/discharge out of the facility. During an interview on 8/5/22 at 10:27 A.M., the Medical Record Coordinator indicated all the transfer/discharge forms are up to date in the electronic medical record. A transfer/discharge form could not be located the EMR (electronic medical record) for Resident J.2. A clinical record review was completed, on 8/4/2022 at 1:37 P.M., and indicated Resident G's diagnoses included, but were not limited to: chronic respiratory failure with hypercapnia, bipolar disorder, chronic obstructive pulmonary disorder, type II diabetes, and major depressive disorder. Resident G went out to the hospital on 2/1/2022 with a return date of 2/3/2022 and on 2/23/2022 with a return date of 3/4/2022. During an interview, on 8/05/2022 at 2:33 P.M., the Director of Social Work indicated there was no list sent for the month of February to the Ombudsman on notification of discharges. He was not aware that he was supposed to do that and indicated it should have been done. On 8/5/2022 at 2:55 P.M., the Administrator provided a policy titled, "Transfer and Discharge Notice Policy", dated 6/23/2017, and indicated the policy was the one currently used by the facility. The policy indicated "...m. Notification of resident		notification to the Ombudsman. The policy and procedure regarding transfer/discharge paperwork and notification was reviewed by the IDT team. A random review of Transfer/Discharge forms and Ombudsman notification will be completed to ensure compliance. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 residents to ensure transfer/discharge paperwork was completed and the Ombudsman was notified. The Social Service Director, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 9, 2022.	

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	discharges will be provided to the state ombudsman on a regular basis." 3.1-12(6)(iv)			
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;			

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	(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the			

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	mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on observation, interview, and record review, the facility failed to ensure that hospital transfer form and transfer discharge was filled out when a Resident went to the emergency room for 1 out of 3 charts reviewed for hospitalization. (Resident G) Finding Includes: A clinical record review was completed, on 8/4/2022 at 1:37 P.M., and indicated the Resident 155's diagnoses included, but were not limited to: chronic respiratory failure with hypercapnia, bipolar disorder, chronic obstructive pulmonary	F 0623	**F 623** It is the practice of this facility that all residents that are transferred to the hospital are sent with a hospital transfer form and transfer discharge paperwork. The corrective action taken for those residents found to be affected by the deficient practice include: Resident G is a past hospital transfer. Since it would not be possible to correct the deficiency on the resident that was transferred, please refer to system changes and monitoring	09/09/2022

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	disorder, type II diabetes, and major depressive disorder. Resident G went out to the hospital on 2/1/2022, 2/23/2022 and 3/8/2022. During an interview, on 8/5/2022 at 1:06 P.M., the Director of Nursing indicated that she could not find any hospital transfer forms and the transfer discharge form when she was sent to the emergency room on 2/1/2022, 2/23/2022 and 3/7/2022, they should have been done. On 8/5/2022 at 10:40 A.M., the Administrator provided a policy titled, "Transfer or Discharge, Emergency", dated December 2016, and indicated the policy was the one currently used by the facility. The policy indicated "...4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: a. Notify the resident's Attending Physician; b. Notify the receiving facility that the transfer is being made; c. Prepare the resident for transfer; d. Prepare a transfer form to send with the resident; ; e. Notify the representative (sponsor) or other family member...." 3.1-12(6)(A)(i)(ii)(iii)		below. Other residents that have the potential to be affected have been identified and corrective actions taken: All residents that are discharged or transferred to the hospital have the potential to be affected. Please see system changes below to prevent reoccurrence. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service was held with nursing on required forms to be sent with the resident when transferring to the hospital. The policy and procedure regarding transfer/discharge paperwork to the hospital was reviewed by the IDT team. A random review of hospital tranfer paperwork will be completed to ensure compliance. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 residents to ensure a hospital transfer form and transfer discharge paperwork was sent with residents on hospital transfers. The DON, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled	

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			meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 9, 2022.	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).			

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	§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. Based on record review and interview, the facility failed to ensure that a baseline care plan was developed for the resident and the resident/resident representative was informed of the baseline care plan for 3 of 22 residents reviewed for care plans. (Residents B, J, and 156) Finding includes: 1. On 7/29/2022 at 3:16 P.M., Resident B's husband indicated a care plan meeting had occurred since the admission of his wife on 6/24/2022, and was not aware of the care plans in place. A review of the clinical record on 8/2/2022 at 2:44 P.M., indicated no documentation of a baseline care plan meeting. A record review for Resident B was complete on 8/3/2022 at 10:11 A.M. Diagnoses included, but were not limited to: hyperlipidemia, osteoarthritis, gastroesophageal reflux disorder, dementia with behavioral disturbance, and aphasia. During an interview on 8/3/2022 at 2:48 P.M., the Social Service Director (SSD) indicated, he does	F 0655	**F 655** It is the practice of this facility that baseline care plans are developed on all newly admitted residents and the resident/representative is informed. The corrective action taken for those residents found to be affected by the deficient practice include: Residents B, J and 156 have been in the facility past 48 hours and comprehensive care plans had been developed. Other residents that have the potential to be affected have been identified and corrective actions taken: All residents that are newly admitted have the potential to be affected. There have been no new admissions since 9/2/22. Please see system changes below to prevent reoccurrence. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include:	09/09/2022

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	not inform the resident or resident's representative of a written summary of the base line care plan. On 8/5/2022 at 2:45 P.M., the SSD indicated, a care conference with Resident B's spouse will occur on 8/8/2022.2. A clinical record review was completed on 8/1/2022 at 10:15 A.M., and indicated Resident 156's diagnoses included, but were not limited to: bi-polar disorder, type 2 diabetes, mood disorder, anemia, anxiety disorder, dementia without behavioral and diabetic foot ulcer. The record indicated he was admitted on 7/14/2022. An Admission Minimum Data Set (MDS) assessment, dated 7/20/2022, revealed a brief interview for mental status score of 15, which indicated Resident 156 cognitive status was intact. During an interview, on 8/2/2022 at 11:42 A.M., the Director of Social Work indicated, an initial care plan is done within 48 hours usually with the resident themselves. The care plan is reviewed, and copy is left with the resident. On 8/2/2022 at 3:09 P.M., the Director of Social Work indicated Resident 156 had no documentation that a 48- hour care plan meeting was conducted in the medical record and the meeting should have been done. On 8/2/2022 at 2:55 P.M., the Director of Nursing provided a policy titled, "Care Plans - Baseline, dated 12/2016, and indicated the policy was the one currently used by the facility. The policy indicated "...A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission. 4. The facility must provide the resident and the representative, if applicable with		An in-service was held with MDS and Social Service on the development of baseline care plans within 48 hours of admission and reviewed with the resident/representative. The policy and procedure on baseline care plans was reviewed by the IDT team. A random review of baseline care plans and resident/representative review will be completed to ensure compliance. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 residents to ensure that baseline care plans were developed within 48 hours of admission and reviewed with the resident/representative. The Social Services Director, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 9, 2022.	

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	a written summary of the baseline care plan by completion of the comprehensive care plan...."			
F 0656 SS=E Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document			

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	whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. Based on observation, record review and interviews, the facility failed to ensure a comprehensive care plan was developed and/or implemented for 5 of 19 sampled residents (Residents F, E, J, 255 and 52) Findings include: 1. During an initial observation of Resident F, completed on 7/29/2022 at 10:30 AM., it was unable to be determined if the resident had his own teeth, was edentulous or wore dentures. Resident F was unable to verbalize or answer any questions regarding his teeth. During an observation of care, completed on 8/3/2022 at 10:30 A.M., CNA 16 was observed to have changed and dressed Resident F by herself, while he was lying in his bed. The resident was still lying in his bed when CNAs 16 and 17 assisted him into his wheelchair. He was not offered any oral care. During an observation of care, completed on 8/4/2022 from 10:50 A.M. - 11:20 A.M., CNAs 17 and 18 were observed providing morning care for Resident F. The resident was changed, his face and peri area washed with water and he was redressed. The resident was transferred by the aides using a two person under arm technique, after repositioning him twice to attempt to get him sat up on the edge of the bed correctly. The	F 0656	**F656** Development/Implementation of Comprehensive Care Plans It is the practice of this facility that every resident receive a comprehensive review of all aspects of care and receive care planning that corresponds with their needs individually. The corrective action taken for those residents found to be affected by the deficient practice include: Care plans were reviewed for residents F, E, J, 255 and 52. Comprehensive care plans are all in place. Other residents that have the potential to be affected have been identified and corrective actions taken: All residents have the potential to be affected. Care plans have been reviewed on all residents to ensure a comprehensive care plan is in place. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: In-services were completed for MDS, Social Services and nursing management on the development of comprehensive care plans for all	09/09/2022

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	resident's knees remained in a contracted, seated position and the resident did not bear weight during the transfer. The aides did not utilize a gait belt and instead, held onto the waistband of his pants, pulling them up into position as they proceeded to transfer him into his wheelchair. The resident was noted to cry out and was observed rubbing his legs after the transfer. After transferring the resident to his wheelchair, CNA 18 did comb the resident's hair. He was not offered any assistance with oral care. During an interview with CNAs 17 and 18, on 8/4/2022 at 11:22 A.M., neither CNA was aware of whether the resident had his own teeth or wore dentures. When asked about oral care, CNA 17 indicated she did not think Resident F would allow her to provide oral care. CNA 17 made no attempt to look for the appropriate oral care items or attempt to provide the care to Resident F. When asked if Resident F was ever transferred with a mechanical lift, CNA 17 indicated she had never observed the resident to be transferred with the mechanical lift. CNA 18 indicated it was only her fourth day working at the facility and she was not certain of Resident F's transfer needs. When queried as to any document provided to indicate the care needs of the residents, neither CNA 17 or 18 had any type of assignment document. The top dresser drawer for Resident F was observed open, on 8/4/2022 between 10:50 A.M. - 11:20 A.M. and noted to be filled with an assortment of personal hygiene products. A search of the drawer indicated a clear plastic bag, containing two tubes of toothpaste and a tooth brush at the bottom of the drawer, and a pink plastic container. The outside of the bag was noted to be covered with a clear slimy substance.		residents. An in-service was also held with the C.N.A's regarding the use of the Kardex in PCC for guidance in providing ADL care. The policy for care plans was reviewed by the IDT team. Nursing to review all new orders in morning meeting and care plan those that are applicable. A random audit review will be completed to ensure residents have comprehensive care plans to maintain compliance. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 residents to ensure that comprehensive care plans are in place. The MDS coordinator, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systematic changes will be completed: September 9, 2022	

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	Resident F was admitted to the facility with diagnoses, including but not limited to: Dementia with behavioral disturbance, delusional disorders, generalized anxiety disorder, difficulty in walking, muscle weakness, need for assistance with personal care, unsteadiness on feet, social phobia and metabolic encephalopathy. The most recent Minimum Data Set (MDS) assessment for Resident 20, completed on 5/22/2022 as an annual assessment indicated the resident was severely cognitively impaired, had not exhibited behaviors during the assessment time frame, required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, bathing and personal hygiene needs, was not ambulatory, required supervision for wheelchair mobility and required extensive assistance of one staff for eating needs. The resident was also assessed to always be incontinent of his bowels and bladder. There was no documentation in the section pertaining to oral care to indicate any oral/dental issues. The current care plans for Resident 20 indicated he was to be assisted to the toilet as needed, required the use of a mechanical lift for transfers, required assistance of two staff for toileting and transfer needs, and 1 -2 staff for dressing and bed mobility needs and 1 staff assistance for eating needs. There was no care plan specific to the resident's oral health needs. The care plan related to ADL needs did not include personal hygiene needs or mention oral health needs. However, a dental assessment, completed on 4/27/2022 indicated the following: "Applied topical fluoride varnish to limited future breakdown, teeth are to be brushed 2-3 x daily with a soft bristle brush, ...little			

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	cooperation. Heavy wear and plaque...." During an interview with the MDS coordinator , conducted on 8/5/2022 at 9:20 A.M., he indicated he was unaware of the recommendation by the dental group. He indicated he could care plan specifically and put a task in the computer so the aides can chart against it (oral care). He did state Resident F did have a history of being combative with care but the resident was usually cooperative with a specific third shift staff member. He also confirmed the resident should have been transferred with the mechanical lift. During an interview with LPN 12, on 8/5/2022 at 10:10 A.M., she indicated the facility did not utilize assignment sheets. She indicated the aides get a verbal report from the aide they were relieving. She also indicated there was a census by room number list form at the nurse's station but it only had a name and room number so aide would then need to write notes on the form.2. During the initial tour on 7/30/22, Resident E was observed to have light brown and bright pink lower legs, a wound on the left shin, and some edema to the feet. Resident E indicated she does not want her legs wrapped due to the feeling of claustrophobia. She indicated she has a skin infection to her left lower extremity. A record review for Resident E was complete on 8/3/2022 at 2:23 P.M. Diagnoses included, but were not limited to: sepsis, chronic obstructive pulmonary disease (COPD), Alzheimer's disease, and heart failure. A Quarterly Minimum Data Set (MDS) Assessment on 6/13/22 indicated Resident E was cognitively intact. She required extensive assistance with two or more staff members for bed			

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	mobility, transfer, and toileting. No skin issues were identified on the MDS. A Nurses Note, on 6/24/2022 at 9:23 P.M., indicated, " ...CNA [Certified Nursing Assistant] notified DON [Director of Nursing] that [Resident's name] leg was bleeding. Upon assessment [Resident's name] was noted to have a skin tear to LLE [Left Lower Extremity] measuring 1.2 x 0.2 x 0.1 [measurement in centimeters]. Area was cleaned with NS [normal saline] and gauze. MD [Medical Doctor] notified and N.O.'s [new orders] received to dress with bandage. Dressing was applied. [Resident's name] said she transferred from her electric scooter and bumped her leg on the end of the bed ...." On 6/29/2022 at 2:07 P.M., a Nurses Note indicated, " ...[Nurse Practitioner's name] notified of [Resident's name] LLE red, slight edema, warm to touch, tender to touch. [Nurse Practitioner's name] in building and also assessed [Resident's name] and gave a N.O. for antibiotic due to cellulitis ...." A Nurse Practitioner Note on 6/29/2022 at 2:59 P.M., indicated, " ... Chief Complaint/Reason for this Visit: LLE wound, increased redness, warmth. The patient is seen today to follow up left lower extremity wound with increased redness warmth and pain. Patient has a left lower extremity wound which is scabbed extending surrounding redness warmth and pain to palpation ...Assessment and Plan: 1. LLE wound with surrounding cellulitis: start doxycycline ...Diagnoses: Cellulitis of left lower limb ...." A Skilled Nursing Note on 7/25/2022 at 2:51 P.M., indicated, " ...Skin/Dressing Changes/Repositioning: Resident is independent			

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	with repositioning. No skin issues noted at this time ...." A Nurses Note on 7/27/2022 1:42 P.M., indicated, a new order for doxycycline 100 milligrams twice daily for 7 days and a wound culture of the left lower extremity. On 7/29/2022 at 5:42 P.M., a Nurses Note indicated, " ...[Nurse Practitioner's name} notified of wound culture 4+ abundant growth staphylococcus aureus and 3+ moderate growth proteus mirabilis ...." Physician Orders included: 6/24/2022-6/25/2022 LLE: Cleanse area with NS or wound wash, pat dry, apply border gauze. Change daily and as needed every night shift. 6/29/2022-7/9/2022 Doxycycline Hyalite Tablet 100 MG Give 1 tablet by mouth two times a day for LLE cellulitis for 10 Days. 6/25/2022-7/13/2022 Assess skin tear to left lower extremity for signs and symptoms of infection, keep open to air every shift. 7/13/2022-current Left Lower Extremity: Apply Skin Prep every shift until healed. 7/27/2022 Wound culture stat to left lower extremity. 7/27/2022-8/1/2022 Doxycycline Hyalite Tablet 100 MG Give 1 tablet by mouth two times a day for cellulitis for 7 Days. 8/1/2022-8/11/2022 Linezolid Tablet 600 MG Give 1 tablet by mouth every 12 hours for MRSA (Methicillin-resistant Staphylococcus aureus) infection for 10 Days. 8/3/2022 Betadine Swab Sticks Swab 10 % (Povidone-Iodine) Apply to left lower extremity topically every shift for Wound Care . During an interview on 8/4/22 at 11:21 A.M., the			

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	MDS Coordinator indicated, he was responsible for acute care plans. He indicated a clinical meeting occurs daily Monday thru Friday with most Interdisciplinary Team Members gathering. He indicated a care plan should have been completed for Resident E's cellulitis. On 8/5/22 at 9:53 A.M., the Director of Nursing (DON) indicated a care plan should have been completed for cellulitis and the MRSA infection. 3. On 8/3/2022 at 9:09 A.M., a clinical record review was completed for Resident J. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease (COPD), chronic kidney disease, malignant neoplasm, and pneumonia. An Admission Minimum Data Set (MDS) Assessment, on 7/22/2022 indicated, the Resident J received an antianxiety, antidepressant, anticoagulant, and diuretic for seven days of the seven- day look back period. Resident J had oxygen therapy. A review of medication included, but was not limited to: famotidine 20 mg (milligrams) twice daily, apixaban 5 mg twice daily, levothyroxine 50mcg (micrograms) daily, ipratropium-albuterol solution 0.5-2.5 mg/3ml (milligram per milliliter) 1 vial orally every 4 hours as needed for shortness of breath or wheezing, doxycycline hyalite 100 mg twice daily, and potassium chloride packet daily. Care Plans included diagnoses and medication use for depression, anxiety, agitation, and pain. No other care plans were completed for active diagnoses or medication use. Additional orders included, but were not limited			

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	to: oxygen at 5 liters via nasal cannula for shortness of breath, incentive spirometer at the bedside encourage use every shift, and supplemental oxygen via nasal cannula every shift for acute respiratory failure titrate oxygen to maintain oxygen saturations greater than or equal to 92 percent. A Care Plan on 7/5/2022, indicated, "Oxygen via nasal cannula at 5 liters per minute" The goal was "The resident will experience improvement or non-worsening of airway thru next review with a target date of 8/2/2022. The care plan did not indicate the use of incentive spirometry and the goal for use of the incentive spirometer. During an interview on 8/04/22 at 3:12 P.M., the MDS Coordinator indicated Resident J should have care plans for major diagnoses and medication use, and should be care planned for respiratory issues and interventions. 4. A clinical record review was completed on 8/3/2022 at 10:33 A.M., for Resident 255. Diagnoses included, but were not limited to: cerebral infarction (stroke), vascular dementia, history of venous thrombosis and pulmonary embolism. A Physician's Order on 7/22/2022, indicated Resident 255 received Xarelto 20 milligrams daily for cerebral infarction. There was no order for monitoring for bruising or bleeding while being on an anticoagulant. During an interview on 8/3/2022 at 1:10 P.M., RN 7 indicated, Resident 255 should be monitored for abnormal bruising or bleeding and notify physician as resident is currently on Xarelto.			

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	During an observation on 8/3/2022 at 1:15 P.M., Resident 255 was observed lying in bed. She had dark purple bruises to her right inner arm and the top of her left hand. Resident 255 indicated she does not know how she got the bruise to the top of her hand, but the bruise on her right arm was from receiving a subcutaneous tuberculosis test. During an interview on 8/5/2022 at 3:31 P.M., the Regional Director of Clinical Services indicated, she places the drug monitoring orders in the electronic medical record for side effects of anticoagulants. 5. A clinical record review was completed, on 8/5/2022 at 9:30 A.M., and indicated the Resident 52's diagnoses included, but were not limited to: anxiety disorder, depressive disorder, muscle weakness, chronic pain, obstructive sleep disorder and anemia. During an interview, on 8/5/2022 at 9:30 A.M., the Rehab Coordinator indicated he was last picked up for OT (Occupational Therapy) on 4/5/2022, discharged on 5/20/2022 and was placed on a restorative program for right hand splint with education provided to the staff, the program was then handed to the MDS Coordinator who is the restorative nurse. During an interview, on 8/5/2022 at 9:51 A.M., the MDS Coordinator indicated there is no care plan for restorative for the right hand splint and it should have been care planned. On 8/4/2022 at 10:00 A.M., the Director of Nursing provided a policy titled, "Care Plans, Comprehensive Person-Centered", revised 1/20/2022, and indicated the policy was the one currently used by the facility. The policy indicated "...A comprehensive, person-centered care plan that includes measurable objectives and			

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	timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident...." 3.1--35(a)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on observation, interview and record review, the facility failed to ensure to revise/update resident care plan for fall	F 0657	**F657** Care Plan Timing and Revision It is the practice of this facility to	09/09/2022

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	intervention, compression stocking intervention due to edema, and no care conference held for 2. of 24 residents whose care plans were reviewed. (Resident 18 and 41) Findings include: 1. A clinical record review was completed, on 8/1/2022 at 11:28 A.M., and indicated the Resident 18's diagnoses included but were not limited to: heart failure, type 2 diabetes, cerebral infarction, intellectual disabilities, and obstructive sleep apnea. A Physician Order, dated 1/16/2022, indicated compression stockings to bilateral lower legs-on in A.M. off in PM two times a day for circulation. During an interview, on 8/3/2022 at 10:07 A.M., the Director of Nursing (DON) indicated that the compression stockings were not care planned and should have been. 2. A clinical record review was completed, on 8/2/2022 at 10:05 A.M., and indicated the Resident 41's diagnoses included, but were not limited to: multiple sclerosis, major depressive disorder, bipolar disorder, obsessive-compulsive disorder, anxiety disorder, and post-traumatic distress disorder. The record indicated she was admitted on 3/17/2022. During an interview, on 8/01/2022 at 3:16 P.M., Director of Social Work indicated that he does not see a care conference in the progress notes, so if it is not documented it was not done, and she should have had one. A current policy, titled " Care Plans Comprehensive,-Person Centered" with a hand		ensure care plans are revised/updated with resident changes and care conferences held with care plan reviews. The corrective action taken for those residents found to be affected by the deficient practice include: The care plans for residents number 18 and 41 were revised to include fall interventions and compression stockings. Care conferences have been scheduled to review the care plans of those affected. Other residents that have the potential to be affected have been identified and corrective actions taken: All residents with needed care plan revisions have the potential to be affected. The care plans of all residents have been reviewed and revised include updates in the residents current condition. Care conferences have been scheduled for those residents with upcoming comprehensive and quarterly reviews. The measures and systematic changes that have been put in place to ensure that this deficient practice does not reoccur include: In-services were held with the Social Service Director and MDS coordinator on revising care plans and scheduling care conferences. The care plan policy has been reviewed by the IDT team. An random audit will be completed to ensure revisions have been made	

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	written reviewed date of 1/20/22, was provided by the DON on 8/4/2022 at 8:17 A.M. The policy indicated "...The Comprehensive Care Plan will 8. Incorporate Residents identified problem areas...14. IDT must review and update care plan when b. desired outcome not med...d. at least quarterly in conjunction with the required MDS assessment...." 3.1-35(c)(1)(2)		to the care plan and care conferences have been scheduled to maintain compliance. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 residents to ensure that MDS assessments have been reviewed and revised and care conferences are scheduled. The Social Service Director, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systematic changes will be completed: September 9, 2022	
F 0660 SS=D Bldg. 00	483.21(c)(1)(i)-(ix) Discharge Planning Process §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each			

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	resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.			

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	(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. Based on observation, interview and record review, the facility failed to ensure discharge planning was developed for 1 of 2 residents reviewed for discharge. (Resident 156) Finding includes: A clinical record review was completed, on 8/1/2022 at 10:15 A.M. and indicated the Resident 156's diagnoses included, but were not limited to: bi-polar disorder, type 2 diabetes, mood disorder, anemia, anxiety disorder, dementia without behavioral and diabetic foot ulcer.	F 0660	**F 660** Discharge Planning Process It is the practice of this facility that all residents with established goals of discharging back to the community or to another facility will have proper discharge planning that includes care planning for that goal. The corrective action taken for those residents found to be affected by the deficient practice include: A discharge care plan has been implemented for resident 156	09/09/2022

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	An Admission Minimum Data Set (MDS) assessment, dated 7/20/2022, section Q 0300A indicated he expects to be discharged to another facility/institution, Q 0400 indicated yes active discharge planning already occurring for the resident to return to the community. During an interview, on 8/3/2022 at 12:47 P.M., the Director of Social Work indicated there was no discharge care plan, or meeting, they should have had a care plan initiated on discharge plans upon the completion of the Admission MDS. On 8/3/2022 at 1:00 P.M., a policy was requested on discharge planning and one had not been provided by survey exit. 3.1-12(a)(18)(19)		and the discharge plan reviewed with the resident. Other residents that have the potential to be affected have been identified and corrective actions taken: All residents who have established goals for discharge have the potential to be affected. Care plan reviews on these residents have been completed to ensure discharge care plans have been developed. The measures and systematic changes that have been put to place to ensure that the deficient practice does not recur: An in-service has been held with the Social Service Director on the development of discharge planning and reviews for residents with a plan to discharge. The policy for discharge planning has been reviewed by the IDT team. A random audit will be completed on those residents with a plan to discharge to ensure a discharge care plan is in place to maintain compliance. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 residents to ensure that discharge care plans are in place and reviewed for those residents with the goal to discharge. The Social Service Director, or designee, will complete this tool weekly x3, monthly x3, and then	

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			quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systematic changes will be completed: September 9, 2022.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interviews, the facility failed to ensure 1 of 3 residents reviewed who required assistance for activities of daily living received grooming/shaving and oral care assistance. (Resident F) Finding includes: Resident F was observed on the following days with scruffy ungroomed facial hair: 7/28/2022 at 12:30 P.M., in the dining room eating lunch, face unshaven. 7/29/2022 at 10:30 A.M., in his wheelchair in the hallway, face unshaven and hair disheveled. 8/01/2022 at 8:39 A.M., in the dining room, face unshaven. 8/2/2022 at 8:15 A.M. in the dining room feeding himself hot cereal with his fingers, face unshaven. 8/3/2022 at 10:35 A.M., in his room lying on his bed, CNA 16 had just dressed him and she and CNA 17 were observed to transfer the resident	F 0677	**F 677** It is the practice of this facility that necessary services will be provided for residents that require assistance to maintain good grooming and personal hygiene. The corrective action taken for those residents found to be affected by the deficient practice include: Resident F is being groomed, shaved, and provided oral care daily Other residents that have the potential to be affected have been identified and corrective actions taken: All residents who need assistance with activities of daily living have the potential of being affected. Residents that require assistance have been identified and grooming, shaving and oral care assistance is being offered	09/09/2022

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	into his wheelchair. Neither aide offered oral care or shaving/grooming assistance to Resident F. 8/04/2022 at 10:50 A.M. - 11:20 A.M., Resident was provided care and assisted out of his bed and transferred into his wheelchair by CNA 17 and 18. Neither CNA offered oral care or facial shaving. 8/04/22 at 2:20 P.M., - seated in the dining room, awake, unshaven, noted with his natural teeth to be discolored brown. He also had food crumbs in the corner [Resident] observed still seated in the dining room in his wheelchair, awake, unshaven, resident did greet me and said "Hi, how are you.?" He was observed to have his own teeth, they were discolored brown, he was unshaven and seated at table pushing food crumbs around. During an interview with CNA 16, conducted on 8/3/2022 at 1:06 P.M., she indicated Resident F was dependent on care and was unable to do any of his own care, except some wheelchair locomotion. Resident F was seated in his wheelchair nearby and when his unshaven face was pointed out, CNA 16 indicated he was supposed to be shaved. She also indicated that sometimes he would not allow staff to shave him. She indicated at times, the resident became combative with care. During an interview with CNA 17, conducted on 8/4/2022 at 11:20 A.M., she indicated she was uncertain of the status of Resident F's teeth. She indicated she did not routinely shave the resident nor did she attempt to brush his teeth because she did not think Resident F would allow the care. Resident F was admitted to the facility with diagnoses, including but not limited to: Dementia with behavioral disturbance, delusional disorders, generalized anxiety disorder, chronic pain, difficulty in walking, muscle weakness, need for		daily. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: Nurses and CNAs have been in-serviced on providing ADL care to those residents that need assistance, specifically grooming, shaving and oral care assistance. The policy and procedure regarding provision of care has been reviewed by the IDT team. A random review of resident personal hygiene will be completed to ensure compliance. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 residents to ensure personal hygiene was completed to include grooming, shaving and oral care. The DON, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 9, 2022.	

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	assistance with personal care, unsteadiness on feet, social phobia and metabolic encephalopathy. The most recent Minimum Data Set (MDS) assessment for Resident F, completed on 5/22/2022 as an Annual Assessment, indicated the resident was severely cognitively impaired, had not exhibited behaviors during the assessment time frame, required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, bathing and personal hygiene needs, was not ambulatory, required supervision for wheelchair mobility and required extensive assistance of one staff for eating needs. The resident was also assessed to always be incontinent of his bowels and bladder. The current care plans for Resident F indicated he was to be assisted to the toilet as needed, required the use of a mechanical lift for transfers, required staff assistance as needed at meals, required assistance of two staff for toileting and transfer needs, 1 -2 staff for dressing and bed mobility needs and 1 staff assistance for eating needs There was no specific plan to address the resident's oral care needs or shaving needs. During an interview with the MDS coordinator, on 8/5/2022 at 9:20 A.M., he indicated staff should have at least attempted to provide routine grooming and oral care, such as brushing of the teeth and shaving. He indicated at times the resident was combative with care. This Federal tag relates to Complaint IN00382515. 3.1-28(a)(3)			
F 0684 SS=D	483.25 Quality of Care			

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Bldg. 00	§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to ensure appropriate skin care treatment for 1 of 1 resident, and compression stocks were available for 1 of 1 resident. (Resident E and 18) Findings include: 1. During the initial tour on 7/30/22, Resident E was observed to have light brown and bright pink lower legs, a wound on the left shin, and some edema to the feet. Resident E indicated she does not want her legs wrapped due to the feeling of claustrophobia. She indicated she has a skin infection to her left lower extremity. A record review for Resident E was complete on 8/3/2022 at 2:23 P.M. Diagnoses included, but were not limited to: sepsis, chronic obstructive pulmonary disease (COPD), Alzheimer's disease, and heart failure. A Quarterly Minimum Data Set (MDS) Assessment on 6/13/22 indicated Resident E was cognitively intact. She required extensive assistance with two or more staff members for bed mobility, transfer, and toileting. No skin issues were identified on the MDS. A Nurses Note on 6/24/2022 at 9:23 P.M.,	F 0684	**F684** It is the practice of this facility that we ensure that residents receive treatment and care in accordance with professional standards based on the comprehensive assessment of the resident and the physician orders. The corrective action taken for those residents found to be affected by the deficient practice include: Resident E currently has an order per MD/NP for treatment to her left shin. Resident 18 was measured by the DON for correct fitting compression stockings, and they were immediately placed on his bilateral lower extremities with treatment being followed per physician orders. Other residents that have the potential to be affected have been identified and corrective actions taken: All residents who have orders for compression stockings have been reviewed by the DON to ensure the correct sizes are being worn and physician orders are being followed. All residents who have a skin impairment have been	09/09/2022

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	indicated, " ...CNA [Certified Nursing Assistant] notified DON [Director of Nursing] that [Resident's name] leg was bleeding. Upon assessment [Resident's name] was noted to have a skin tear to LLE [Left Lower Extremity] measuring 1.2 x 0.2 x 0.1 [measurement in centimeters]. Area was cleaned with NS [normal saline] and gauze. MD [Medical Doctor] notified and N.O.'s [new orders] received to dress with bandage. Dressing was applied. [Resident's name] said she transferred from her electric scooter and bumped her leg on the end of the bed ...." On 6/29/2022 at 2:07 P.M., a Nurses Note indicated, " ... [Nurse Practitioner's name] notified of [Resident's name] LLE red, slight edema, warm to touch, tender to touch. [Nurse Practitioner's name] in building and also assessed [Resident's name] and gave a N.O. for antibiotic due to cellulitis ...." A Nurse Practitioner Note on 6/29/2022 at 2:59 P.M., indicated, " ... Chief Complaint/Reason for this Visit: LLE wound, increased redness, warmth. The patient is seen today to follow up left lower extremity wound with increased redness warmth and pain. Patient has a left lower extremity wound which is scabbed extending surrounding redness warmth and pain to palpation ...Assessment and Plan: 1. LLE wound with surrounding cellulitis: start doxycycline ...Diagnoses: Cellulitis of left lower limb ...." A Skilled Nursing Note on 7/25/2022 at 2:51 P.M., indicated, " ...Skin/Dressing Changes/Repositioning: Resident is independent with repositioning. No skin issues noted at this time ...." A Nurses Note on 7/27/2022 1:42 P.M., indicated,		reviewed for an active treatment per MD/NP orders. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been provided to nursing staff regarding measuring compression stocking size for therapeutic use, treatment for skin impairments, and adhering to physician orders. The policy and procedure regarding obtaining and following physician orders has been reviewed by the IDT team. A random review of ensuring skin treatments are in place and physician orders are followed will be completed to ensure compliance. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 residents to ensure that skin treatments are in place, compression stockings fit correctly, and physician orders are being followed. The DON, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes	

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	a new order for doxycycline 100 milligrams twice daily for 7 days and a wound culture of the left lower extremity. On 7/29/2022 at 5:42 P.M., a Nurses Note indicated, " ... [Nurse Practitioner's name] notified of wound culture 4+ abundant growth staphylococcus aureus and 3+ moderate growth proteus mirabilis ...." Physician Orders included: 6/24/2022-6/25/2022 LLE: Cleanse area with NS or wound wash, pat dry, apply border gauze. Change daily and as needed every night shift. 6/29/2022-7/9/2022 Doxycycline Hyalite Tablet 100 MG Give 1 tablet by mouth two times a day for LLE cellulitis for 10 days 6/25/2022-7/13/2022 Assess skin tear to left lower extremity for signs and symptoms of infection, keep open to air every shift. 7/13/2022-current Left Lower Extremity: Apply Skin Prep every shift until healed. 7/27/2022 Wound culture stat to left lower extremity. 7/27/2022-8/1/2022 Doxycycline Hyalite Tablet 100 MG Give 1 tablet by mouth two times a day for cellulitis for 7 days. 8/1/2022-8/11/2022 Linezolid Tablet 600 MG Give 1 tablet by mouth every 12 hours for MRSA (Methicillin-resistant Staphylococcus aureus) infection for 10 days. 8/3/2022 Betadine Swab Sticks swab 10 % (Povidone-Iodine) Apply to left lower extremity topically every shift for Wound Care During an interview on 8/5/2022 at 9:53 A.M., the Director of Nursing (DON) indicated any signs or symptoms of infection should be documented, no new skin issues as documented would not be signs or symptoms of infection.		will be completed: September 9, 2022.	

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	2. A clinical record review was completed, on 8/1/2022 at 11:28 A.M., and indicated the Resident 18's diagnoses included, but were not limited to: heart failure, type 2 diabetes, cerebral infarction, intellectual disabilities, and obstructive sleep apnea. During an observation, on 7/29/2022, 1:51 P.M., Resident 18's legs were swollen bilaterally, and he was wearing black ankle socks. During an observation, on 8/01/2022 at 9:51 A.M., Resident 18 was wearing black ankle high socks with indents noted at the top of the sock, legs swollen. On 8/1/2022 at 3:08 P.M., observed sitting by the nurse's station with the black ankle socks on. During an observation, on 8/2/2022 at 9:02 A.M., compression stocking on went to the bottom of the calf muscle, indicating incorrect size worn. During an observation, on 8/3/2022 at 8:24 A.M., resident was sitting by the front entrance and was wearing his black ankle socks. A Physician Order, dated 1/16/2022, indicated compression stockings to bilateral lower legs-on in A.M. off in PM two times a day for circulation During an interview, on 8/4/2022 at 10:07 A.M., the Director of Nursing indicated that if he has an order for compression stockings, he should have had them on. On 8/4/2022 at 10:15 A.M. a physician order policy was requested, and one was not provided. 3.1-37(a)			

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F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. Based on observation, record review and interviews, the facility failed to ensure assistance to schedule an audiology exam was provided timely for 1 of 1 residents observed for hearing needs. (Resident H) Finding includes: During an initial tour of the facility, conducted on 7/28/2022 at 12:30 P.M., Resident H was observed seated in the dining room. Resident H was heard speaking very loudly to her tablemate and other staff in the dining room. Staff were noted to have to repeat themselves and increase the volume of their voice in order for Resident H to hear them. During an interview with Resident H, conducted on 8/1/2022, in her room, she was noted to be very hard of hearing, did not have hearing aides in place, and required written communication in order to be interviewed. The clinical record for Resident H was reviewed on 7/29/2022 at 3:00 P.M. Resident H was	F 0685	**F 685** It is the practice of this facility that we ensure that residents receive treatment and care in accordance with professional standards by assisting in scheduling audiology exams as necessary. The corrective action taken for those residents found to be affected by the deficient practice include: Resident H has been scheduled for an appointment with the audiologist. Other residents that have the potential to be affected have been identified and corrective actions taken: A review of the charts for all residents with hearing needs was done and appointments scheduled with the audiologist as indicated on consent form. The measures and systematic changes that have been put into place to ensure that the deficient	09/09/2022

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	admitted to the facility on 10/18/2021 with diagnoses, including but not limited to CVA (Cerebral Vascular accident) affecting right dominant side, idiopathic peripheral autonomic neuropathy, major depressive disorder, anxiety disorder, adult failure to thrive and hearing loss - unspecified ear. The most recent Quarterly MDS assessment for Resident H, completed on 6/29/2022 indicated the resident severely cognitively impaired and had not displayed any behaviors during the assessment time frames. The current health care plans for Resident H reviewed and revised on 6/29/2022 indicated the resident was to be offered a communication board when attending group activities due to hearing loss, was to be given pen and paper to facilitate communication needs and was to have a hearing evaluation annually. Review of consent for audiology services, signed by Resident H's health care representative indicated it was dated on 10/08/2021. During an interview with the Director of Nursing, on 8/3/2022 at 2:30 P.M., it was revealed although the resident had consented to receive audiology services upon her admission to the facility in October 2021, she was not seen by the audiologist when they last visited the facility in December 2021.. During an interview with the SSD, on 8/5/2022 at 2:45 P.M., he indicated the consent for audiology services was signed on 10/18/2021 when the resident was admitted to the facility. He indicated when the audiologist was last in the building, in December 2021, he did not know why the resident was not on the "list" to be seen. He indicated he had attempted to try to call the contact person for		practice does not recur include: An in-service has been provided to the Social Services Director regarding scheduling residents for audiology exams as indicated by the MDS or resident need. The policy for caring for the hearing impaired resident was reviewed by the IDT team. A random review of residents that require services for hearing loss will be completed to ensure compliance. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 residents to ensure services are received for residents with needs related to hearing loss. The Social Service Director, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 9, 2022.	

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	the audiologist but had not had success reaching out to them. 3.1-39(a)(1)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, interview, and record review, the facility failed to ensure a hand splint was applied for 1 of 1 resident reviewed for limited range of motion. (Resident 52) Finding includes: A clinical record review was completed, on 8/5/2022 at 9:30 A.M., and indicated the Resident 52's diagnoses included, but were not limited to: anxiety disorder, depressive disorder, muscle weakness, chronic pain, obstructive sleep disorder and anemia.	F 0688	**F 688** It is the practice of this facility that we ensure that residents receive treatment and care in accordance with professional standards by ensuring hand splints are worn as ordered for limited range of motion. The corrective action taken for those residents found to be affected by the deficient practice include: Resident 52 has been assisted with daily application of his hand splint.	09/09/2022

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	During Resident 18' s initial interview on 7/29/2022 at 10:32 A.M., he indicated he has a splint for his right hand, and they put it on sometimes, his last two fingers on the right hand are folded under touching the palm. A Physician Order, dated 5/27/2022, apply right resting hand splint after supper and remove before breakfast, with skin checks and cleansing. One time a day related to muscle weakness. A Physician Order, dated 5/28/2022, remove resting hand splint after breakfast daily with skin checks and cleansing. One time a day related to muscle weakness. During an observation and interview, on 8/3/2022 at 2:37 P.M., the resident indicated that the hand splint was not put on last night. The splint was lying next to the wall on a table across the room in a mesh type zip bag. During an observation and interview, on 8/4/2022, at 8:00 A.M., Resident 18 was not in his room. He was in the dining room in wheelchair waiting on breakfast. Asked resident if he wore his splint last night and he stated "No, they were too busy". The splint was observed in the residents room in a mesh type zip bag located along wall on top of table. During an interview, on 8/5/2022 at 8:54 A.M., the resident indicated they did not put on his splints last night. The splint was lying next to the wall on a table across the room in a mesh type zip bag. During an interview, on 8/5/2022 at 8:59 A.M., the Director of Nursing indicated if he has an order, he should be wearing the splint at night. When		Other residents that have the potential to be affected have been identified and corrective actions taken: All residents with ordered hand splints have the potential to be affected. All were reviewed to ensure hand splints were applied as ordered. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: The DON conducted an in-service with nursing on the application of hand splints. The policy and procedure for splint application was reviewed by the IDT team. A random audit of splint application with be conducted to ensure compliance. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 residents to ensure hand splints are applied as ordered. The DON, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 9, 2022.	

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	he opened his hand, the Resident had yellow substance and dirt on his palm. On 8/5/2022 at 9:01 A.M., the Director of Nursing reviewed the orders and indicated that he does have an order for the splint to right hand and should be wearing it. During an interview, on 8/5/2022 at 9:30 A.M., the Rehab Coordinator indicated he was last picked up occupational Therapy (OT) on 4/5/2022, discharged on 5/20/2022 and was placed on a restorative program for right hand splint with education provided to the staff. The Treatment Administration Record (TAR) reviewed from 5/27/2022 till 7/31/2022 was signed off by the staff that it was applied. On 8/5/2022 at 10:01 A.M., the Director of Nursing provided a policy titled, "Warsaw Meadows Care Center Contracture Care", dated 2/2/2022, and indicated the policy was the one currently used by the facility. The policy indicated " ...Daily care will be provided to residents with contracted extremities. Gentle range of motion will be provided to inhibit further muscle atrophy. To keep contracted area clean, comfortable and odor free and prevent skin break down ...." On 8/5/2022 at 9:10 A.M., a policy was requested for physician orders, and one had not been provided by survey exit. 3.1-42(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -			

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	§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure residents were free from major injury from falls for 2 of 3 residents reviewed for accidents related to falls. (Residents B and C) Finding includes: 1. A clinical record review was completed on 8/1/2022 at 2:26 P.M., of Resident B . Diagnoses included, but were not limited to: Alzheimer's disease, osteoarthritis, speech disturbances and generalized anxiety. Resident B admitted to the facility on 6/24/2022. A Care Plan initiated on 6/26/2022 indicated the following, " ...The resident is at risk for falls" ...with a goal of "The resident will be free of falls through the review date." Goals included, 1. Anticipate and meet the resident's needs. Initiated: 6/26/2022, be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Provide a prompt response to all requests for assistance. Initiated: 6/26/2022, ensure that the resident is wearing appropriate footwear such as non-skid socks when ambulating or mobilizing in w/c. Initiated: 06/26/2022, and Physical Therapy to evaluate and treat as ordered or PRN. Initiated: 06/26/2022 ...." A Nurses Note, on 6/26/2022 at 1:37 P.M., indicated, " ...around 12pm today, resident was walking to halls as usual activity. Noticed the	F 0689	**F689** Free of Accident Hazards/Supervision/Devices It is the practice of this facility that we ensure that residents are free from major injury resulting from falls in accordance with professional standards based on developed policies and procedures. The corrective action taken for those residents found to be affected by the deficient practice include: Resident B, referred to as 'Janice' in the 2567, no longer resides in this facility. Resident C also no longer resides in this facility. Since it would not be possible to correct the deficiency on the residents that were transferred, please refer to system changes and monitoring below. Other residents that have the potential to be affected have been identified by and corrective actions taken: All residents are at risk for falls and have been reviewed by the IDT for Fall Risk Evaluation scores of 10 or above and provided interventions which address potential or actual root cause factors. Care plans have been updated. The measures and systematic	09/09/2022

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	resident starting walk faster and running into the doors. Caught up to her and resident started to run and took a fall. Resident fell and hit her head and right side of her body on the floor. Has a bump on the right side of the head and a small gash on the forehead? Small gash on her left hand. Resident is mostly nonverbal, noticed her rubbing her arm and shoulder as if maybe in pain. Resident was wearing proper nonslip wear ...." A Nurse Practitioner Note on 6/26/2022 at 2:53 P.M., indicated, " ...The patient has been very restless and anxious since arrival. She has been constantly ambulating up and down hallways. She has been running from staff and unfortunately, she has experienced multiple falls since arrival ...She complains of pain in her right arm and shoulder. She has abrasions and bruising ...." On 6/26/2022 at 10:40 P.M., a Nurses Note indicated, " ...status post fall, resident return from [Hospital Name] via stretcher @ 2200 hr [at 10:00 PM]. Diagnoses of right clavicle fracture and arachnoid cyst. New order: do not lift anything heavier than 10 lbs [pounds], do not put weight on right arm, copies of new order send to physical therapy office. DON [Director of Nursing] order to cont. [continue] with neuro-checks, 1.1 [one to one] safety precaution initiated ...." On 7/1/2022 at 10:08 A.M., an Interdisciplinary Team Note indicated, " ... [Resident name] was noted aimlessly walking very fast in the hallway then attempted to run and landed on the floor. She landed on her R. [right] Side and did hit her head on the floor. Nurse provided a physical assessment and noted an open area to her forehead and posterior L. [left] hand. [Resident name] is non-verbal but did showed signs of pain by rubbing her right arm and shoulder. MD		changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been provided to nursing staff regarding the process for when a resident falls according to policy. The policy and procedure of this facility's Falls Management System has been reviewed by the IDT team. A random audit will be completed to ensure that the fall process has been followed and appropriate interventions developed based on the root cause of the fall. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 residents to ensure that the policy and procedure of the Falls Management System is being followed and an appropriate intervention to prevent further falls has been developed. The DON, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 9, 2022.	

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	[Medical Doctor] was notified and N.O.'s [New Orders] received to obtain in house x-ray. X-ray indicated a fix [fracture] to her R. [right] Clavicle. MD [Medical Doctor] was notified after obtaining results and N.O.'s [New Orders] received to send to ER [Emergency Room] for further evaluation. She returned from the ER with a sling to right arm. Neuro Checks & Q [every] 30 min [minutes] checks were initiated. Therapy was ordered. Care plan reviewed and updated. POA [Power of Attorney] [name] was notified and in agreement with POC [Plan of Care]. IDT [Interdisciplinary Team] also in agreement with POC ...." On 7/10/2022 at 8:45 A.M., A Nurses Note indicated, " ...Resident was sitting in a dining room chair, QMA [Qualified Medication Assistant] went to retrieve resident breakfast meal tray and prepare it, QMA went back into dining room and observed resident attempting to sit in the rocker chair and sat directly in front of the chair. Generalized pain reported, non-specific to this fall ...." On 7/13/2022 a Psychiatric Note indicated, " ...Consider Non-pharmacological interventions to include cognitive/emotion-oriented interventions (reminiscence therapy, simulated presence therapy, validation therapy), sensory stimulation interventions (aromatherapy, light therapy, massage/touch, music therapy), behavior management (distraction, redirection, relaxation) techniques, and other psychosocial interventions such as animal assisted therapy and exercise ...." On 7/13/2022 at 5:30 P.M., An Interdisciplinary Team Fall Note indicated, " ...While a QMA was bringing a meal tray to [resident name] the QMA noted [resident name] attempting to sit in the rocker chair and slid to the floor in front of the			

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	chair. Assessment noted no injury, but she did have generalized pain... Dycem was added to the underside of the rocker chair cushion ...." On 7/14/2022 at 10:26 A.M., a Nurses Note indicated, " ...Resident was walking around in dining room on Heritage Fall, went to sit in a rocker chair and cushion slipped out and resident fell on the floor, QMA was initial staff on the scene, resident found lying on her R side with the top cushion of chair on top of her with the blankets that were in chair as well, resident began to move to her knees and get up, RN arrived and helped QMA stand resident. Resident able to stand up and began to walk unit as per usual. VS entered, DON, NP, and family notified. Chair in dining room removed from dining room. On 7/14/2022 at 3:18 P.M., an Interdisciplinary Team Fall Note indicated, " ...The QMA noted [residents name] lying on the floor near a rocker chair in the dining room. Physical assessment noted no injury ...DON notified, and staff was instructed to remove rocker chair from dining room and provide a more stable chair ...." A Nurses Note on 7/15/2022 at 10:42 A.M., indicated, " ...Resident was found by staff on the floor at the foot of her bed with her blankets wrapped around her feet...resident has a 3cm [centimeter] round abrasion on top of forehead at hairline, no bleeding, bruised around abrasion ...." On 7/18/2022 at 11:59 P.M., An Interdisciplinary Team Fall Note indicated, " ...CNA [Certified Nursing Assistant] informed the Charge Nurse that [resident name] was on the floor at the foot of her bed with her bed blankets wrapped around her feet. Physical assessment was provided and injury from previous fall was noted ...Staff x2 [times two]			

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	removed blankets and assisted [resident's name] from off the floor ...Staff to provide morning care nearer to 8:00 A.M ...." On 7/19/2022 at 10:16 A.M., a Nurses Notes indicated, " ...Resident was noted in another resident's room. Resident was on floor laying on her right side next to bed. Resident's head was resting on her hands...No new noted injuries. No new areas of redness of bruising noted. No signs or symptoms of pain or discomfort. Neuro checks initiated ...." On 7/25/2022 at 2:47 P.M., an Interdisciplinary Team Fall Note indicated, " ...The Charge nurse noted [residents name] lying on the floor next to a bed in another room with her head resting on her hands ...Nurse notified the DON and said it appears as though Janice placed herself onto the floor to sleep. Neuro checks were initiated. [Residents name] to be care planned for placing herself onto the floor ...." On 7/28/2022 at 2:28 P.M., A Nurses Note indicated, " ...Resident went into Room 25, was found on the floor, unwitnessed fall. Resident assessment observed bleeding from R [right] forehead, R cheek area. Notified [Nurse Practitioner] at 2:05 P.M., order to send to ER [Emergency Room] for evaluation and treat ...." A Nurses Note on 7/28/2022 at 4:52 P.M., indicated, resident returned from (hospital name) with ten sutures to right forehead. On 7/29/2022 at 1:37 P.M., a Nurses Note indicated, "Resident walking around unit, as per usual, resident then began to walk very fast, in a jogging type of manner, resident went into room 25, was found on the floor, unwitnessed fall.			

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	Resident assessment observed bleeding from R forehead, R cheek area. Notified [nurse practitioner] at 2:05 P.M., order to send to ER [Emergency Room] for evaluation and treatment ...." On 7/29/22 at 1:43 P.M., The Director of Nursing informed the survey team that Resident B fell at 2:03 P.M. in Room 25 and sustained right head laceration that required 10 sutures. During an observation on 7/29/2022 at 1:53 P.M., Resident B was observed ambulating in hallway unassisted gait slightly unsteady, and staring down at floor, multiple staff walking past her with no interaction. On 8/4/2022 at 8:00 P.M., an Incident Note indicated, " ...This nurse alerted by aide stating resident was laying on the floor in the hallway, upon entering hallway, resident noted laying partially on left side and back and was attempting to get herself up off the floor, non-skid socks noted to bilateral feet, resident was then assessed for pain and injury ...small red area noted to mid upper back and upper left back, abnormality noted right rear shoulder, aide states resident had previous injury to said shoulder and will sometimes "pop out", resident noted with full ROM [Range of Motion] to all extremities when up and ambulating and moving arms up and down by herself without this nurse or staff assist, no discomfort noted, vitals obtained, assisted resident to standing position and taken to her room, toileted, immediate intervention provided was staff 1:1 activities with resident then assisted into bed, neuro vitals restarted ...30 minute checks continue, STAT 2 view X ray ordered for right front and rear shoulder ...will continue to monitor and communicate to oncoming nurse ...."			

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	On 8/4/2022 at 10:45 P.M., a Health Status Note indicated, " ...Per[Company Name, Nurse Practitioner Name] new order to discontinue Clonazepam and to start Ativan 1mg TID [three times a day] scheduled and to give x1 dose now for restlessness, also resident not to be sent out to hospital unless comfort needs not met at facility, all orders in place and updated, said [Nurse Practitioner] was advised of earlier fall and pending X-ray results, advised this nurse to please call [company name] on call and advise of results. After speaking with said [nurse practitioner], x ray results received and [company name] on call [nurse Practitioner's name] advised of fracture and dislocation of right clavicle ... {Nurse Practitioner's name] called this nurse back and was advised of findings, states resident is not to be sent to hospital and to implement comfort medications due to inability to immobile said area because of resident current restlessness and continuous movement ...." On 8/5/2022 at 9:06 A.M., a Nurse Practitioner Note indicated, " ...Member sustained another fall last night, unwitnessed with possible injury to R [right] shoulder vs old R clavicle injury from 6/2022 fall. Imaging obtained. Reviewed old vs new radiology reports. Last night's x-ray shows; subacute ununited, complex fracture of the distal diaphysis of the R clavicle, with approximately 1.5cm caudal displacement of the distal fracture moiety. Prior image showed comminuted and displaced R distal clavicular fracture. Without actual images to compare we are unable to determine if there is further injury. Member is not exhibiting any signs of pain, wandering up and down the hall as her usual, slow and shuffling. On examination posterior visually there is a drop to R shoulder asymmetry. Palpable defect to distal			

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	clavicle and palpable/visible possible displacement of R acromial clavicular joint. Difficult to assess as she is restless and will not stay still, even with verbal prompt/cue. She is sitting and places her weight on RUE to stand, placing hand on arm of chair without grimacing, wincing. Without eye contact when name spoken. Morphine ordered last night for comfort as she is end of life and concern for new fracture ...Will refer to Hospice this morning ...." During an observation on 8/05/2022 at 11:28 A.M., Resident B's husband was observed holding his wife hand, walking with his wife in the hallway, her pace is slow and steady. On 8/5/2022 at 2:18 P.M., The Director of Nursing (DON) indicated interventions were put in place, but the care plan was not updated to communicate the changes. 2.. The closed clinical record for Resident C was reviewed on 7/29/2022 at 11:00 A.M. Resident C was admitted to the facility on 1/5/2022 with diagnoses, including but not limited to: Dementia with Lewy Bodies, major depressive disorder, single episode, psychotic disorder with delusions due to know physiological condition, hallucinations, unspecified, delusional disorders restlessness and agitation and anxiety. The resident was readmitted to the facility on 1/13/2022 with new diagnoses of fractures of the fourth metacarpal and bone of the right hand, fracture of the fifth metacarpal bone, right hand. On 5/7/2022 there was only one documented nursing progress note for Resident C . The note was an automated note regarding a medication administration from the electronic medication administration record for Resident C.			

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The next Nursing Progress Note, dated 5/8/2022 at 7:35 A.M., indicated the following: "... Per report from previous shift, pt had a fall and sustained a skin tear on his right elbow, and purplish discoloration on his right forehead with some swelling on his right knuckle. Neurochecks initiated when pt was received, wnl. Pt resting on his bed, sleeping on his bed at the start of the shift. With 1-on-1 sitter accompanying pt...."

There was no electronic fall assessment completed and no nursing note completed for Resident C at the time of his fall. However, there was a Falls Checklist form and a Fall Investigation form completed for Resident C. The Fall investigation form was signed as completed on 5/11/2022 by the Director of Nursing. The form did not indicate the date of the fall , had no blood pressure checks documented, indicated the resident had last been toileted at 16:10 (4:10 P.M.) prior to the fall and his last meal prior to the fall was documented as "approx 7:30 p.m. previous night." The resident was documented as "sleeping." prior to the fall. The form indicated the environment was barrier free, floor was dry, a walker was not utilized and the resident was wearing appropriate footwear at the time of the fall. In addition, the form indicated employees were utilizing proper technique and "gait belt" was handwritten next to the technique question. The portion of the form to document what may have caused the fall was left blank.

The form indicated the resident's physician was notified on 5/8/2022 and the resident's family was notified on 5/9/2022 at 10:15 AM., by the receptionist after several attempts. The form indicated the resident had the following injuries: "facial bruising (observation), r. elbow ST (skin

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	tear), R knuckle" The form indicated the falls care plan was updated and "Neuro checks" was documented as the intervention. In addition, "updated with Routine Activities as well" was documented. A Rehabilitation Department Screen, completed 5/10/2022, indicated the resident had a reported fall on 5/7/2022. The form indicated upon observation and speaking with staff, Resident was at previous level of function and no therapy was indicated. The form indicated the facility was to continue to monitor the resident. During an interview with the Director of Nursing, on 8/2/22 at 3:26 P.M., she indicated the charting for Resident C regarding the fall appeared that the previous shift did not document the fall. When queried about staffing patterns on the evening and night shift for 5/7/2022, the DON provided the staff and indicated there was no nurse working on the dementia unit after 6 P.M.. Review of the provided staffing for the dementia unit after 6:00 P.M., indicated there was an agency QMA (Qualified Medication Aide) and two CNAs (Certified Nursing Assistants). The DON indicated she did not have any nurse in the building for the evening of 5/7/2022 and she was called in and worked from about 6:00 P.M. to about 1:00 P.M. She indicated she was working on the "front units" not the dementia unit. She indicated she was not aware of any fall on the dementia unit while she was working. When asked if she had any statements regarding the fall or had talked to the previous staff working prior to the fall, she indicated she did not get any reports or statements. She indicated she had not spoken with the previous shifts staff members when she completed the Fall Investigation. When asked why she put specific information down on			

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	the fall investigation, she looked at the form, thought it was for a different fall and did not really give any answer. During an interview on 8/2/2022 at 11:00 A.M., with an anonymous person who was working at the facility on the dementia unit the night of 5/7/2022, indicated Resident C had an unwitnessed fall and had a "large gooseegg" on his forehead and was bleeding from injuries on his arm. The staff member indicated the nurse working in the front was notified of the fall with injuries but the nurse did not come to the unit to assess and provide care for the resident. The staff person indicated they had notified the Director of Nursing about their concern. Review of nursing notes for Resident C, dated 5/15/2022 at 4:00 P.M., indicated the following: "... Pt had a witnessed fall in the dining room at 3:40 p.m. Pt was sitting on his chair when all of the sudden he said he wanted to go to the bathroom and stood up impulsively. CNA was sitting right next to him but before pt could be caught, he tripped on the dining room chair and fell landing on his bottoms (sic) first on the floor. Pt did not hit his head as witnessed, and was assessed Pt did not hit his head as witnessed and was assessed with no s/sx of pain or injuries. No changes in ROM noted. Pt was safely transferred to his w/c and accompanied by CNA at all times. Pt was then taken to the bathroom. Pt was wearing non-skid socks, at the time of the fall. Pt is very unsteady and has a tendency for impulsive behavior and getting up unassisted due to dx of Dementia with multiple hx of falls. Pt continued to be placed on 1-on-1 supervision by staff. On Call NP notified of situation with no new orders. Attempted to call RP, rang multiple times but did not answer, left a message via VM and to call			

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	facility for any questions or concerns, DON notified of incident.... " The Falls checklist and investigation, completed on 5/16/2022 indicated the resident was eating at time time of the fall and that the fall was witnessed. The intervention implemented at the time of the fall was toileting. The portion of the form to indicate what may have caused the accident was left blank. The supervisor report, not dated or signed indicated the fall committee recommendation was "1:1 observation during meals." Review of a Falls Checklist, Nursing Progress Notes, Rehabilitation Screen and Fall Investigation form for Resident C indicated on 5/28/2022 the resident had another witnessed fall at 7:36 P.M. The resident was documented as having been seated by the nurse's station watching television when he stood up and fell on his buttocks before staff could get to him. He did not incur any injuries. The checklist indicated the resident's care plan was updated but the portion of the assessment form to indicate "what may have caused the accident" was left blank. A care plan intervention, dated 5/27/2022 indicated " encourage resident to toilet immediately following the evening meal." was added to the care plan. Review of nursing progress notes, dated 5/31/2022 at 8:05 P.M., indicated the following: "...start of shift on arrival writer saw res lying down in his room in recliner. while counting NARCS (narcotics)with outgoing nsg (nursing), two other res. standing @ res room door reported that res. was on the floor on arrival res was crawling on both knees, assessed and assisted into w/c x 2 staff left forehead bump noted. attempt to obtain vs (vital signs) physically			

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	combative non-compliant with ice pack application (DON- Director of Nursing) made aware. order 1:1 safety monitor. fed with hot oats meal, ice cream asleep now in bed. vs done...." Review of the Falls Checklist and Fall investigation indicated the resident was last toileted at 7:00 P.M., even though the staff member documenting the fall indicated it was at the start of her shift at 6:00 P.M., when she was counting narcotic medications. The immediate intervention was to provide 1:1 supervision until the resident was in bed. The portion of the investigation to document "what may have caused the accident" was left blank. There was no specific intervention added to the care plan regarding falls after the 5/31/2022 fall. During an interview with the Administrator on 8/5/2022 at 1:56 P.M., he indicated the facility had identified some issues with their fall follow up system and were in the process of implementing some new processes. He indicated the corrective plan was not yet fully in place. " Review of the facility's policy and procedure, titled "Falls Management System", provided by the Director of Nursing on 7/29/2022 at 2:37 P.M., indicated the following was included: "...Resident Evaluations ...D. Any fall that involves an actual head injury and all un-witnessed falls will include follow-up neurological checks. Neurological checks will be documented. E. When a resident sustains a fall, an evaluation may include investigation to determine probable causal factors, considering environmental factors, resident medical condition, resident behavioral manifestations, and medication or assistive devices that may be implicated in the fall. The investigation and appropriate intervention will be			

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	evaluated at the time of the fall and review by Nursing Management or the IDT Interventions secondary to the investigation will be documented in the Care Plan as indicated.F. When a resident sustains a fall, an evaluation for injury by a licensed nurse is completed and the results documented in the medical record....Care Planning: a. Residents with a Falls Risk Evaluation score of 10 or above will have an individualized care plan developed that includes measurable objectives and time frames. The care plan interventions will be developed to prevent falls and will consider the particular elements of the evaluation that put the resident at risk. The care plan for a resident evaluated as at risk for falls will be developed at the time the risk is identified with ongoing evaluation and revisions documented.b. Residents who sustain a fall will have a care plan developed or the existing care plan updated to include the fall and measurable objectives and time frames. The care plan interventions will address those elements determined by investigation as probable causal factors that contributed to the fall. The updated plan will be reviewed and revised as indicated by the Falls Management Action Team at the meeting...." This Federal tag relates to complaint IN00381080. 3.1-45(a)			
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-			

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	§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review and interview, the facility failed to ensure that significant weight loss did not occur for 1 of 4 residents reviewed for nutrition. (Resident 40) Finding includes: During an observation on 7/28/2022 at 12:06 P.M., Resident 40 left the dining table without eating her food. RN 7 indicated that Resident 40 does not eat anything, but a cup of cereal. A clinical record review for Resident 40 was completed on 8/2/2022 at 2:36 P.M. Diagnoses included, but were not limited to: dementia with behavioral disturbances, bipolar disorder, delusional disorder, and hypothyroidism. A Physician NP (Nurse Practitioner) Note on 6/8/2022 at 1:18 P.M., indicated Resident 40 was seen for increased behaviors, combativeness with care and a fall. Her review of systems indicated she had weakness, weight loss and confusion. Resident 40 was 66 inches tall, weight of 107.8 pounds and a BMI of 17.4 percent. She appeared	F 0692	**F 692** Nutrition/Hydration Status Maintenance It is the practice of this facility that we ensure residents receive treatment and care in accordance with professional standards to avoid significant weight loss unless planned or determined to be clinically unavoidable. The corrective action taken for those residents found to be affected by the deficient practice include: Resident 40 has been re-evaluated for significant weight loss and has been stable since February 2022. Other residents that have the potential to be affected have been identified by and corrective actions taken: All residents are at risk for significant weight loss and have been reviewed during the Nutrition at Risk Meeting to ensure significant weight loss is being	09/09/2022

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	chronically ill with a thin and frail body structure. The assessment indicated weight loss and is TSH (thyroid stimulating hormone) lab id normal and Resident 40 continues losing weight, an appetite stimulant should be added. On 6/8/2022 lab work was obtained. Resident 40 had a TSH level of 0.02 which was abnormal. Follow up lab work on 7/15/2022 indicated the TSH level at 1.00 (normal range) and on 7/21/2022 a TSH of 1.29 (normal range) A Quarterly Minimum Data Set (MDS) Assessment on 6/23/2022 indicated severe cognitive impairment. The resident required supervision for eating with one staff member assistance, The MDS indicated Resident 40 had a weight loss of five percent or more in last month and/or loss of ten percent or more in last six months. Resident 40 was on a mechanically altered and therapeutic diet. A Nutritional Risk Assessment on 6/23/2022 at 8:19 P.M., indicated Resident 40 had a diet of mechanical soft with two bowls of favorite cereal at each meal. Her meal intakes ranged from zero to one hundred percent. She received supplementation of a Magic Cup at lunch and supper and Med pass 120 milliliters twice daily with the average consumption of 73.2 percent. She had a 3.6 percent weight loss in thirty days, a 4.2 percent weight loss in three months, and a 19.5 percent weight loss in six months. Her BMI (Body Mass Index) was 18.5 percent and considered underweight. A review of Resident 40's weights indicated a weight on 1/2/2022 of 137 pounds, on 4/1/2022 of 112.4 pounds, on 6/2/2022 of 107.8 pounds and on 8/1/2022 108 pounds. These weights indicated a		addressed per this facility's policy of Nutrition and Clinical Care. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been provided to the Nutrition at Risk Team regarding the policy of Nutrition and Clinical Care. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 residents to ensure that the policy of Nutrition and Clinical Care is being followed. The DON, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 9, 2022.	

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	six-month weigh loss of 21.17 percent. Physician Order's included: 3/9/2021 Magic Cup two times a day at lunch and dinner. Document % (percent) consumed 5/13/2021 Dietitian to evaluate for nutritional intervention if needed 10/11/2021Regular/General diet, Mechanical Soft texture, Regular Fluid Consistency. Provide x2 (times two) bowls of favorite cereal each meal to maximize patient ability to maintain nutrition 3/10/2022 Med Pass 2.0 120 ml (milliliters) two times a day for Supplement A Care Plan on 3/29/2019, and revised on 6/23/22, indicated, "I am at risk for nutritional deficits r/t [related to] meal intakes vary; requires a mechanically altered diet due to chewing difficulties; HX [history of] weight loss/gain due to decreas appetite with illness; DX [diagnoses] include Alzheimer's, hypothyroidism, hyperlipidemia. 1/11/22 significant weight gain x90 days, 3/8/22 significant weight losses x90, 180 days, 6/23/22 significant weight loss x180 days." The care plan goal initiated on 3/29/2019 and revised on 4/7/2021, indicated, "I will be free from significant weight changes through next review" with a target date of 9/22/2022. During an interview on 8/4/2022 at 3:28 P.M., The Director of Nursing (DON) indicated if a resident is identified as nutritionally at risk, the resident is reviewed weekly until improvement or stability at the dietician's discretion. Nutritionally at-risk residents are reviewed every Tuesday. The Don indicated Resident 40 should be followed in the weekly nutritionally at-risk meeting. She indicated Resident 40 dropped from the weekly review between 6/23-6/30/2022.			

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	A policy was provided by the Director of Nursing on 8/5/2022 at 3:48 P.M., titled "Nutrition and Clinical Care". The current policy indicated, " ...Residents who require additional calories and protein will receive fortified foods ...1. When the Registered Dietician determines that is NAR, Nutritionally at Risk, and would benefit from fortified foods she recommends them for physician's approval. 3. Fortified foods replace menu items as appropriate, i.e., fortified milk replaced regular milk as a beverage or fortified cereal replaces regular cereal at breakfast ...." During an observation on 8/8/2022 at 11:55 A.M., Resident 40 was sitting at the dining table with one bowl of dry cereal and milk. The additional portions of the meal remained on the food hot cart. At 12:05 P.M., Resident 40 was not in the dining area. The bowl of cereal was empty, and the remaining portions of her meal remained in the food hot cart. 3.1-46(a)(1)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interviews, the facility failed to ensure oxygen equipment was maintained in a sanitary manor and	F 0695	**F 695** It is the practice of this facility that the resident receives proper respiratory/tracheostomy	09/09/2022

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	oxygen use was identified properly for 3 of 4 residents reviewed for oxygen use. (Residents E G, and H) In addition, the facility failed to ensure tracheostomy button care was provided to meet professional standards of care for 1 of 1 resident reviewed for tracheostomy care. (Resident 22) Findings include: 1. During the initial tour of the facility, conducted on 7/28/2022 from 10:30 - 12:30 P.M. and 2:30 - 3:30 P.M., the following was observed: The oxygen tubing and CPAP (continuous positive airway pressure) mask was lying on a visibly dirty overbed table in Resident E's room. The tubing was also undated. In addition, the humidified water container was empty on the oxygen condenser unit. There was no oxygen signs on the door, no date on the oxygen tubing or the humidifier on the concentrator, and the CPAP mask was stored in an undated trash type bag for Resident G. This was again observed on 7/29/22 at 10:40 A.M. On 8/1/2022 at 9:56 A.M., there was still no oxygen sign on the door, the CPAP equipment was stored in an undated trash bag, the humidifier bottle had no open date on it. The oxygen tubing was dated 7/31/2022. On 07/29/2022 at 9:30 A.M., the oxygen tubing was not dated for Resident H and there was no bottle of water for humidification on the condenser. On 8/1/2022 at 10:00 A.M., there was a bottle on the condenser for Resident H but there was no connecting tubing to the oxygen tubing going from the oxygen condenser to the Resident H,		care and suctioning and equipment maintained in a sanitary manner. The corrective action taken for those residents found to be affected by the deficient practice include: Resident G and Resident E were provided with appropriate respiratory equipment as well as correct storage bags and proper dates. Oxygen signs were placed on both resident's outer door frame. Resident 22 has been provided sufficient supplies for nursing staff to care for a stoma or voice prosthesis. Other residents that have the potential to be affected have been identified and corrective actions taken: All residents who receive respiratory care have been identified and have the potential to be affected by this practice. No other residents receive stoma care for a voice prosthesis. All residents with respiratory equipment have signs placed outside their door, proper storage vessels for tubing/masks, oxygen condensers if needed and dated equipment. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: DON provided Nursing staff	

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	who was lying in her bed. Review of the facility policy and procedure, titled, Oxygen Therapy, provided by the Director of Nursing on 8/4/2022 at 10:17 A.M., the following procedures were included: "...1. Place "Oxygen in Use" sign on the door. (Resident's room door)...6. Change tubing, cannula and Mask monthly and date when changed. 7. Humidifier bottles will be checked daily and will be refilled with water by the night shift staff. Humidifier bottles will be cleaned weakly (sic) and charged (sic) as needed....9. Masks and cannulas will be stored in plastic bag in not in use (sic)...."2. During an observation ,on 8/5/2022 at 1:09 P.M., the trach button for Resident 22 was dated 8/4/2022, and the outer dressing was dated 8/2/2022. On 8/5/2022 at 1:25 P.M., the Unit Manager brought a basket to Resident 22's room. The basket included, isopropyl alcohol, adhesive base plate, trach buttons, 8mm tube brush. An opened non-dated bottle of 100 ml (milliliter) normal saline was brought into the room. The Unit Manager indicated she did not feel comfortable completing this task, but indicated it needed completed. On 8/5/2022 at 1:34 P.M., the Unit Manager began the trach button change. She applied non-sterile gloves to complete the task. The outer dressing from 8/2/2022, the trach button from 8/4/2022, and the inner cannula were thrown in the trash. A larger sized white brush (small blue brush in package) was placed in the opened, non-dated Normal Saline and used to cleanse the outer portion of the tracheostomy stoma. The brush did not have a date place on it. An alcohol prep was used to the outside of stoma for cleansing. An internal device was placed for the button to be attached. The button was obtained from a		education regarding proper storage and care of respiratory and trach stoma supplies as well as education on “Caring for a stoma and voice prosthesis after a total laryngectomy.” The policy and procedures were reviewed by the IDT team. Random audits will be completed for sanitary maintenance of equipment, oxygen signs and button care for the stoma. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 residents to ensure that respiratory and trach stoma supplies are being stored properly when not in use and maintained properly while in use, and care is being provided for a stoma and voice prosthesis per facility policy and procedure. The DON, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 9, 2022.	

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	multi-use bag and a glove change did not occur prior to retrieving the button. A dressing for the button placement externally was not placed. During an interview on 8/5/2022 at1:48 P.M., The Unit Manager, when questioned about a base dressing, indicated "It looked like something was there when I changed it, but I can't find it." She indicated sterile technique should be used, and using an opened bottle of normal saline is not sterile technique, and using dirty gloved hand to get a button out of the multi-bag was not sterile technique." A policy was provided by the Director of Nursing on 8/8/2022 at 12:46 P.M., titled, " Caring for a stoma and voice prosthesis after a total laryngectomy." The policy included cleaning instructions but did not specify if sterile technique was to be utilized. This Federal tag relates to IN00382515. 3.1-47(a)(4)(6)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or			

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	§483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on observation, record review and interview, the facility failed to ensure there was adequate monitoring of medications for 1 of 5 residents reviewed for medications. (Resident F) Findings include: On 7/29/2022 at 10:35 A.M., Resident F was observed propelling their wheelchair slightly in the hallway. The resident was noted to have some minor upper extremity twitching. The clinical record for Resident F was reviewed on 7/30/2022 at 2:00 P.M. Resident F had diagnoses, including but not limited to: essential hypertension, anemia and constipation. The current medication orders for Resident F included orders for Propranolol for hypertension, Atorvastatin Calcium for hypertension, Colace for constipation, Vitramin D for Vitamin D deficiency and Ferrous Sulfate for anemia. The current care plans for Resident F did not include a care plan to address the resident's diagnosis of anemia, constipation or hypertension. There was also no plan to address the resident's use of Vitamin D supplement.	F 0757	**F757** Drug regimen is Free From Unnecessary Drugs It is the practice of this facility that residents not receive unnecessary medications and that all medications are care planned. The corrective action taken for the resident found to be affected by the deficient practice includes: Resident F had all orders and care plans reviewed to ensure medications were care planned for. Other residents that have the potential to be affected have been identified and corrective actions taken: All residents have the potential to be affected by the deficient practice. Care plans were reviewed for all residents to ensure medications and medical diagnosis were addressed. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service was completed with the MDS coordinator to address care planning of medications and	09/09/2022

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	During an interview with MDS coordinator, on 8/5/2022 at 10:30 A.M., he indicated the resident's care plan was reviewed around 5/31/2022. He confirmed there was no plan to address the resident's anemia, constipation, vitamin D deficiency and hypertension. A current policy, titled " Care Plans Comprehensive,-Person Centered" with a hand written reviewed date of 1/20/22, was provided by the DON on 8/4/2022 at 8:17 A.M. The policy indicated "...The Comprehensive Care Plan will 8. Incorporate Residents identified problem areas...14. IDT must review and update care plan when b. desired outcome not med...d. at least quarterly in conjunction with the required MDS assessment...." 3.1-48(a)(3)		medical diagnosis of residents. The policy and procedure for care planning was reviewed by the IDT team. A random audit will be conducted to ensure medications and medical diagnosis are addressed on the care plan to maintain compliance. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 residents that orders and diagnosis are addressed on their care plans. The MDS Coordinator, or designee, will complete this tool weekly X3, monthly X3, and then quarterly X3. Any issues identified will be immediately corrected. The Quality Assurance Process Improvement Committee will review the tools at the scheduled meetings monthly with recommendations as needed based on the outcomes of the tools. The date the systematic changes will be completed: September 9, 2022.	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, record review and interview, the facility failed to ensure 1 of 3 staff	F 0760	**F 760** It is the practice of this facility that the resident is free of significant medication errors.	09/09/2022

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	(LPN 12) observed administering medication followed the facility's policy and professional standards in regards to insulin administration for 1 of 6 residents observed receiving medications. (Resident 28) Finding includes: During an observation of a medication pass, conducted on 8/2/2022 at 11:55 A.M., LPN 12 was observed preparing to administer insulin for Resident 28 . Prior to preparing the insulin, LPN 12 had entered Resident 28 's room and had taken his blood glucose level. The resident's blood glucose level was noted to be 380 mg/dL. She then returned to medication cart and after cleaning the blood glucose machine, placed a disposable needle on the end of an insulin pen containing Insulin Lispro. She then dialed the pen to 20 units and added 5 more units. Next, LPN 12 entered Resident 28 's room and after wiping the resident's arm with an alcohol swab, administered the insulin via the pen to Resident 28 She was not observed to prime the pen prior to moving the dial to the appropriate dose and administering the insulin. During an interview with LPN 12, on 8/4/2022 10:39 A.M.,. she confirmed she had not primed the insulin pen and indicated she thought the insulin pen only needed primed on the first use after opening a new pen. Review of the current facility policy and procedure, titled,"Insulin Pens", effective 8/9/2019, indicated the following procedure was included: "...7. Prime the pen by removing air from the needle by turning the dial to two units. For most pen types you will hear a click for each unit of insulin you dial. Hold the pen and point the needle up. Gently tap the pen to move the air		The corrective action taken for those residents found to be affected by the deficient practice include: Resident 28 was assessed and found to not be affected by this deficient practice. MD/NP and family were notified. Other residents that have the potential to be affected have been identified and corrective actions taken: All residents who receive insulin via an insulin pen have the potential to be affected by this process. DON provided Nursing staff education regarding use of insulins pens and proper procedure for priming. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: All nursing staff have been in-serviced by the DON on the proper use of insulins pens per this facility's policy and procedure titled, "Insulin Pens". The policy and procedure was reviewed by the IDT team. Random observations will be completed with the nursing staff to ensure compliance The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool	

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	bubble up to the top of the pen. Press the inject button. You should see a drop of insulin appear at the tip of the needle/pen...." 3.1-48(c)(2)		has been initiated that randomly reviews 5 residents to ensure that Insulin is being administered correctly via an insulin pen. The DON, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 9, 2022.	
F 0805 SS=D Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. Based on observation, interview and record review, the facility failed to ensure a recipe was followed for fortified mashed potatoes for 1 of 4 residents who were reviewed for nutrition. (Resident 39) Finding includes: During an observation on 8/2/2022 at 11:23 A.M., food prepared in the steam table for the lunch meal service was observed. The Cook 4 was asked if there was a separate pan of fortified mashed potatoes. The cook indicated that butter was	F 0805	**F 805** Food In Form to Meet Individual Needs It is the practice of this facility that dietician recommendations for food recipes are followed and consistent with every meal. The corrective action taken for residents identified as being affected by this deficient practice: Resident number 39 is being served fortified mashed potatoes according to the recipe when on the menu.	09/09/2022

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	added to the potatoes for fortification, and all the potatoes had the butter added for flavor. There was not a separate pan of fortified mashed potatoes. A clinical record review of Resident 39 on 8/3/2022 at 8:50 A.M., indicated, a Physician Order on 5/12/2021 for fortified potatoes two times daily and to document the percent consumed. During an interview on 8/4/2022 at 11:56 A.M., Cook 4 indicated the one container of potatoes in the steamtable were made with boiled water, mashed potatoes flakes and butter. Cook 4 indicated these are fortified. On 8/4/2022 at 1:32 P.M., Cook 5 indicated the facility did not have the supplies to make the fortified mashed potatoes. She indicated the dry milk would not be available until Tuesday evening. Dry milk was observed in the dry storage area unopened, and Cook 5 indicated that maybe the staff did not know that the dry milk was available. Cook 5 indicated the evaporated milk still was not available, and would inform the Human Resource Director who completes the food order. On 8/5/2022 at 3:48 P.M., the Director of Nursing (DON) provided a recipe titled, "Super Potatoes". The recipe indicated for ten servings the following ingredients: 5 cups water, 2 and 2/3 cups dry milk powder, 3 cups mashed potato flakes, 1 cup evaporated milk and 4 tablespoons butter. On 8/5/2022 at 3:48 P.M., the DON provided a current policy titled, "Nutrition and Clinical Care". The policy indicated, " ...Residents who require additional calories and protein will receive fortified foods when ordered ...2. Fortified menu items have		Other residents that have the potential to be affected have been identified and corrective actions taken: All residents who receive fortified mashed potatoes have the potential of being affected. The recipe for this food item was reviewed to ensure it was properly prepared prior to serving. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: Dietary staff were inserviced on the proper method of preparing fortified mashed potatoes. The procedure for the recipe was reviewed with the dietician. A random audit will be completed to ensure the recipe is followed as written. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 residents to ensure the fortified food item is served according to recipe. The dietary manager, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	specific recipes ...." 1.3-21(a)(3)		of the tools. The date the systemic changes will be completed: September 9, 2022.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to ensure items in the refrigerator were dated/labeled, failed to ensure used by dates on a milk container were disposed; failed to dispose of unlabeled cooked food; failed to ensure cleanliness/maintenance of paper-lined storage shelves, upright refrigerator, ice machine, overhead lights, stream table guard, plate warmer, and flooring; and failed to properly dry bowls and	F 0812	**F 812** Food Procurement, Store/Prepare/Serve – Sanitary It is the practice of this facility that the kitchen and equipment used to store and prepare food is maintained in a safe and sanitary condition. The corrective action taken for residents identified as being	09/09/2022

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	155566	A. BUILDING 00 B. WING	08/08/2022

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	dinner plate lids prior to storage. This deficient practice had the potential to affect 60 of 60 residents who received meals from the kitchen. Finding includes: During an observation of the kitchen on 7/28/2022 at 9:55 A.M., the following was observed in the walk-in refrigerator: a gallon milk container with the use by date of 7/27/2022; orange, apple, and tea without labels; vegetable soup without a label; and two containers of unidentified liquid food due to separation of the contents. The ice machine had visible rust and dirt debris on the outside of the lift cabinet, and a black sticky substance along the rim of the machine. The overhead lights had dead bugs present. The stream table guard and plate warmer were dirty with a build-up of residue and debris. The bowls and dinner plate covers for the bottom and top were stored wet. The plastic containers that hold cooking utensils had crumbs in the container and the serving utensils had dried food on them. The kitchen floor was soiled with food and crumbs on the floor with a dirt/grease residue build up. This was very visible under the prep and steam table areas. On 8/2/2022 at 11:10 A.M., during an observation, dishes were observed on a shelf, stacked, and wet. Dinner plate covers were observed stacked and wet. During an interview on 8/4/2022 at 1:32 P.M., Cook		affected by this deficient practice: The undated/unlabeled/expired food items were disposed of. The equipment and general kitchen areas were cleaned. Dishes were washed, dried and stacked as appropriate. Other residents that have the potential to be affected have been identified and corrective actions taken: All residents that eat meals in the facility have the potential to be affect. An inspection has been completed of kitchen sanitation and storage to ensure compliance. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: Dietary staff were inserviced on labeling and dating of food items, checking expiration dates, cleaning of the kitchen and equipment and dish storage. The cleaning checklist was reviewed by the IDT team. A random audit will be completed on cleanliness of the kitchen and storage of food and dishes. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 areas for cleanliness of the kitchen and equipment and storage of food and dishes. The dietary manager, or designee, will complete this tool weekly x3,	

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	5 indicated dishes and dinner plate lids should not be stored wet and the dishes should be left to dry prior to storage or wiped with a clean cloth to dry. She indicated she removed the contents in the refrigerator that was not labeled or disposed of by the use by date. On 8/4/2022 at 2:57 P.M., Cook 5 provided a daily and weekly cleaning schedule for the kitchen. There were no initials for August indicated the cleaning had been completed. When asked for the prior month's documentation of cleaning, cook 5 indicated, "They really haven't been using it." She indicated the kitchen would have a new manager starting August 15, 2022. On 8/8/2022 at 11:32 A.M., the following policies were requested: Kitchen sanitation and cleaning, labeling of prepared/open foods for refrigeration, storage of prepared foods/general foods, and storage of dishes and cookware. On 8/8/2022 at 12:46 P.M., the Director of Nursing (DON) indicated these policies could not be located. 3.1-20(a)		monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. Date of systematic changes being completed: September 9, 2022.	
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.			

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	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; (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			

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	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 1 of 3 nursing staff (LPN 12) observed administering medications followed infection control protocols for the prevention of COVID-19 and other airborne illnesses for 1 of 1 residents observed receiving an inhalation respiratory treatment. (Resident J) Finding includes: During the medication administration pass observation, conducted on 7/29/2022 at 8:30 A.M., LPN 12 was observed to set up and initiated an aerosol breathing treatment for Resident J. After placing the appropriate mediation into the container connected to the mask, she handed the mask with medication to Resident J and exited the room, shutting the Resident's room door. On 7/29/2022 around 9:00 A.M., LPN 12 was	F 0880	**F880** Infection Control and Prevention It is the practice of this facility that all measures of infection control mandated by the federal, state, and county authorities will be monitored and be in compliance daily. The corrective action taken for residents identified as being affected by this deficient practice: LPN 12 was immediately educated on infection control protocols for the prevention of Covid 19 while performing an aerosol treatment. Other residents that have the potential to be affected have been identified and corrective actions taken: All resident who receive	09/09/2022

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	observed to enter Resident J's room to remove the aerosol treatment mask and reassess the resident's respiratory status. There was a yellow sign on the resident's door indicating an aerosol treatment had been administered and a plastic bin with Personal Protective Equipment (PPE). After LPN 12 was a few steps into the resident's room, she was asked about the PPE and she came back outside the resident's room and proceeded to put on the PPE designated by the sign on the resident's door. Review of the facility policy and procedure, titled, "Aerosol Generating Procedures" provided by the Director of Nursing on 8/4/2022 at 10:17 A.M., included a chart which indicated for a resident in the "General Population" as Resident J resided, a well fitted face mask within 6 feet of the resident, eye protection and additional PPE based on type of patient precautions were indicated for staff use. The sign, however, on the resident's door indicated an N95 respirator mask, eye protections, gown and gloves were indicated upon entry to Resident J's room within 1 hour of the administration of the aerosol treatment. 3.1-18(b)(1)		aerosol treatments have the potential to be affected. Audits were done for each resident to ensure proper signage was on the door and PPE available. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur: A root cause analysis was conducted to identify the failure in protocol. All staff were in-serviced on proper PPE donning and knowledge of the signage on resident doors. Infection control protocols for aerosol treatments was reviewed by the IDT team. A random audit will be completed on PPE use by licensed nursing while performing an aerosol generating procedure. The corrective action taken to monitor the deficient practice to ensure it will not recur: The DON, or designee, will watch aerosol treatments randomly daily for six weeks and until compliance maintained. The outcomes will be monitored on a performance improvement tool that is presented to the Administrator daily. Any deviation from protocols will be addressed immediately. Recommendations will be made as required and any deviation in process will be corrected immediately. The date the systematic changes will be completed: September 9, 2022	

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F 0882 SS=F Bldg. 00	483.80(b)(1)-(4)(c) Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. Based on observation, interview and record review, the facility failed to ensure they had a certified Infection Preventionist on staff, this affects 60 out of 60 residents that reside in the facility. Finding includes: On 7/28/2022 at 9:45 A.M., during the entrance conference the Director of Nursing indicated that	F 0882	**F 882** Infection Preventionist Qualifications/Role It is the practice of this facility to secure a designated individual as the infection preventionist who is responsible for the facility's infection control program. The corrective action taken for those residents found to be affected by the deficient practice	09/09/2022

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	they did not have an Infection Preventionist. The Director of Nursing and the Assistant Director of Nursing are responsible for Infection Control and COVID Infection Control in the building. During an interview, on 8/04/2022 at 3:54 P.M., the Director of Nursing indicated that they should have had a certified Infection Preventionist. On 8/4/2022 at 3:00 P.M., the Administrator provided a policy titled, "Infection Preventionist", dated 7/2016, and indicated the policy was the one currently used by the facility. The policy indicated " ... The Infection Preventionist is responsible for coordinating the implementation and up dating of our established infection prevention and control policies and practices ...."		include: All residents were affected by the deficient practice. A staff licensed nurse is in the process of taking the Infection Preventionist training course. Other residents that have the potential to be affected have been identified and corrective actions taken: All resident have been affected by the deficient practice. A staff licensed nurse is in the process of taking the Infection Preventionist training course. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: Two licensed nurses on staff have been enrolled in the infection preventionist training to obtain certification in the event one nurse is no longer able to hold the position. The corrective action taken to monitor the deficient practice to ensure it will not recur: The DON will monitor the certifications to ensure there is always an Infection Preventionist on staff. The date the systemic changes will be completed: September 9, 2022.	
F 9999 Bldg. 00	A.Based on record review and interviews, the facility failed to ensure there was a criminal	F 9999	**F 9999** It is the practice of this facility to ensure newly hired employees have a criminal history check, TB test if indicated and a	09/09/2022

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	history inquiry completed prior to allowing 1 of 5 newly hired employees reviewed to work. (Employee 15) B. Based on record review and interviews, the facility failed to ensure a physical examination was completed by a physician and/or nurse practioner/physician's assistant for 3 of 5 newly hired employees reviewed. (Employees 1, 4 and 7) Finding includes: 1. During a review of the personal files, conducted on 8/4/2022 at 11:30 A.M., for Employee 15, , who was hired on 6/5/2022, there was no criminal history inquiry located in the file. During an interview with the Human Resources Manager, on 8/5/2022 at 10:20 A.M., she indicated she was newer to her position and had been told by the previous facility administrator that the facility did not check the criminal histories of minor aged employees. Review of the facility's policy and procedure, titled, Abuse Prevention, provided by the Director of Nursing on 7/30/2022 at 3:00 P.M., included the following: "I. Background screening investigations: Our facility will not knowingly hire any individual who has a history of abusing other persons. This facility will conduct employment background screening checks, reference checks and criminal conviction investigation checks on individuals making application for employment with this facility." There were no specific instructions or procedures denoting the process for obtaining the criminal history report for a minor aged employee. 2. During a review of the personnel files,		physical examination completed by an MD, NP or PA prior to starting work. The corrective action taken for those employees found to be affected by the deficient practice include: A criminal history check was completed on employee 15. The completed physical exams for employees 1, 4 and 7 were signed and dated by the physician. A TB skin test was obtained for employee number 4 and placed in her personnel file. How other employees that have the potential to be affected have been identified and corrective actions taken: All new employees have the potential to be affected by the deficient practice. Audits of all employee files have been completed to ensure physician signed physicals, criminal history checks and TB tests if applicable are present. The measures and systematic changes that have been put into place to ensure that the deficient practice does not recur include: An in-service has been conducted with HR to ensure all documents are present in the employee file. The policy and procedure for new hire documentation was reviewed	

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	conducted on 8/4/2022 at 11:30 A.M., the following was noted: Employee 1, with an employment start date of 5/2/2022, had an undated physical examination form completed. The form was signed but the signature was difficult to read and the form was not dated as to when it was signed. During an interview with the Human Resources manager, on 8/5/2022 at 10:30 A.M., they indicated the MDS coordinator, an RN, had signed the form. She confirmed the MDS coordinator was neither a physician or a nurse practioner. Employee 4, with an employment start date of 7/7/2022, had an undated physical examination form completed. The form was signed by the Director of Nursing. During an interview with the Human Resources manger, on 8/5/2022 at 10:50 A.M., she confirmed the Director of Nursing was not a nurse practioner or medical doctor. In addition, Employee 4 had a copy of a tuberculin skin test completed at her former employer on 11/22/2021. There was no documented tuberculin skin test, tuberculin screening assessment or tuberculin spot blood test noted in the file. Employee 7, with an employment start date of 6/20/2022 had an undated physical examination form signed by the Director of Nursing. A policy regarding pre-employment physical examinations and tuberculin screening of new employees was requested but not received by the survey exit date of 8/8/2022.		by the IDT team. A random review of employee files will be completed to ensure compliance. The corrective action taken to monitor the deficient practice to ensure it will not recur: A Performance Improvement Tool has been initiated that randomly reviews 5 new employee files to ensure that physician signed physicals, criminal history checks and TB test if applicable are present. The Human Resources Director, or designee, will complete this tool weekly x3, monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed based on the outcomes of the tools. The date the systemic changes will be completed: September 9, 2022.	