STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE KOKOMO	3518 S LAFOUNTAIN ST KOKOMO, IN 46902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 23, 24, 25, 26, 27 and 28, 2023 Facility number: 000025 Provider number: 155064 AIM number: 100274850 Census Bed Type: SNF/NF: 46 Total: 46 Census Payor Type: Medicare: 1 Medicaid: 41 Other: 4 Total: 46 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on August 2, 2023.	F 0000	The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may			

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

Paula Carroll | Administrator | 08/24/2023

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

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	be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or			

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	on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on record review and interview, the facility failed to ensure residents with Medicare Part A services ending were issued SNF ABN's (Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage) for 2 of 3 residents reviewed for beneficiary notification. (Resident 8 and 352) Findings include: 1. Resident 8 was started on Medicare Part A services on 11/26/22. The facility initiated the discharge from Medicare Part A service when benefits were not exhausted. A NOMNC (Notice of Medicare Non-Coverage) indicated the last date of Medicare Part A coverage would have started 2/10/23. There was no SNF ABN. 2. Resident 352 was started on Medicare Part A services on 12/5/22. The facility initiated the discharge from Medicare Part A service when benefit days were not exhausted. A NOMNC indicated the last Medicare Coverage date would have started on 1/2/23. There was no SNF ABN. During an interview, on 7/24/23 at 1:30 p.m., the Business Office Manager indicated the Social Worker working at the time was new and she was not sure the Social Worker had completed them. There were no SNF ABN forms. There was no policy for Beneficiary Notices. 3.1-4(f)(3)	F 0582	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 8 and resident 352 II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents at a skilled level of care have the potential to be affected by the alleged deficient practice. The Business Office Manager to complete and audit on all resident with a skilled level of care in the past 30 days for accuracy of the ABN, by date of compliance. 9/8/23. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Administrator re-educated Business Office Manager on ensuring all residents at a skilled level of service receive their ABNs timely by date of compliance. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Administrator/designee will complete an audit to ensure all residents at a skilled level of care have the appropriate ABN issued	09/08/2023

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			timely. Audits will be completed weekly x 12 weeks then monthly x 3 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: September 8, 2023	
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			

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	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; (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;			

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	(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 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 interview and record review, the facility failed to notify the family and Ombudsman for a	F 0623	I. What corrective action(s) will be accomplished for those residents	09/08/2023

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	resident who was hospitalized and then transferred to another facility for 1 of 3 residents reviewed for hospitalization. (Resident 9) Finding includes: During an interview, on 07/23/23 at 2:12 p.m., Resident 9 indicated he was hospitalized recently for psychiatric concerns. The record for Resident 9 was reviewed on 07/25/23 at 9:08 a.m. Diagnoses included, but were not limited to, schizoaffective disorder, bipolar type, and dementia. A progress note, dated 4/20/23, indicated the resident was having suicidal thoughts and the facility decided to send him to the hospital. A progress note, dated 4/20/23, indicated the resident returned from the hospital and was resting in bed. A progress note, dated 4/21/23, indicated a referral was sent and accepted to another facility pending ordered medical equipment was received. A progress note, dated 4/24/23, indicated the resident was transferred to the new facility for treatment. The facility did not notify Resident 9's family or Ombudsman (an individual who investigates and attempts to resolve complaints when dealing with specific state agencies) for the hospitalization or transfer to another facility. During an interview, on 7/26/23 at 4:41 p.m., the DON (Director of Nursing) and Clinical Support Nurse indicated there was no documentation to		found to have been affected by the deficient practice; Resident #9 has returned to the facility. Resident had no adverse reactions related to the cited practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Any resident who transfers or discharges from the facility has the potential to be affected by the cited practice. SSD notified ombudsman of all transfers/discharges in the last 30 days. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Administrator/designee to SSD educate on notifying ombudsman of residents who are transferred or discharged from the facility. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Administrator/designee to review transfers/discharges to ensure the ombudsman has been notified. Audits will be completed weekly x 4 weeks then monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved	

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	support the facility contacted the family or ombudsman. A current policy, titled "Physician-Family Notification- Change in Condition," dated as revised on 11/13/18 and received from the DON on 7/27/23 at 2:18 p.m., indicated "...The facility will inform the resident; consult with the resident's physician or authorized designee such as Nurse practitioner; and if known, notify the resident's legal representative or an interested family member when there is...A decision to transfer or discharge the resident from the facility...." 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iv)		x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: September 8, 2023	
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			

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	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 interview and record review, the facility failed to ensure an initial care plan meeting was held for a cognitively intact resident for 1 of 1 resident reviewed for care plan meetings. (Resident 102) Findings include: During an interview, on 7/23/23 at 3:20 p.m., Resident 102 indicated he had not been to a care plan meeting. The record for Resident 102 was reviewed on 7/24/23 at 3:51 p.m. Diagnoses included, but were not limited to, congestive heart failure, type 2 diabetes mellitus with diabetic neuropathy, major depressive disorder, chronic obstructive pulmonary disease, chronic kidney disease, acquired absence of left leg below the knee, acquired absence of right leg below the knee, anemia, and old myocardial infarction. The progress notes did not include any social services note on the initial care plan or the reason the care plan was not completed. During an interview, on 7/26/23 at 9:42 a.m., the Social Services Director (SSD) indicated she did not have an initial care plan meeting with the resident and still had not had a care plan meeting with the resident. He was upset about being at the facility and did not sign the admission paperwork	F 0657	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #102 had a care plan meeting on 8/3/2023. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All new admissions have the potential to be affected by the cited practice. An audit on the last 30 days of admissions was completed to ensure a care plan meeting had occurred. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Administrator/designee to educate SSD on the policy "Comprehensive Care Plan" to include holding the initial care plan meeting. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee to audit new	09/08/2023

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	until 6/28/23. A current policy, titled "Comprehensive Care Plan," dated as revised on 3/8/2017 and received from the Director of Nursing (DON) on 7/26/23 at 11:24 a.m., indicated "...To develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being...The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights...In consultation with the resident and the resident's representative[s]...The resident's goals for admission and desired outcomes...The resident's preference and potential for future discharge...To the extent practicable, the participation of the resident and the resident's representative[s]. An explanation should be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the resident's care plan...The resident and/or representative shall be invited to review the plan of care with the interdisciplinary team either in person, via telephone or video conference[if available] at least quarterly...As a best practice, the interdisciplinary team should attempt to schedule an initial meeting with the resident and/or resident representative within 5 days of admission to review the baseline plan of care and make updates or revisions as indicated based on feedback and input of the resident and/or representative prior to the development of the comprehensive care plan...." 3.1-3(n)(3)		admissions to ensure an initial care plan meeting was held timely. Audits will be completed 5xs a week for 4 weeks, 2xs a week x 4 weeks, then monthly The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: September 8, 2023	

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 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 record review and interview, the facility failed to ensure residents were given anti-anxiety medication as scheduled for 1 of 5 residents reviewed for quality of care. (Resident 49) Finding includes: The record for Resident 49 was reviewed on 7/25/23 at 10:32 a.m. Diagnoses include, but were not limited to, cerebral palsy, protein-calorie malnutrition, epilepsy, hypertension, and intellectual disabilities. A physician's order, dated 7/18/23, indicated Ativan (an anti-anxiety medication) 0.5 mg (milligrams) tablet give 1 tablet twice a day. A Controlled Drug Administration Record indicated the medication was not delivered until 7/23/23 and the first dose was given on 7/23/23 at 8:00 p.m. A care plan, dated 7/18/23, indicated Resident 29 used anti-anxiety medication. Interventions included, but were not limited to, administer anti-anxiety medications as ordered by physician. During an interview, on 7/27/23 at 4:24 p.m., the	F 0684	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #49 has medication on hand and is being administered per physician's order. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Any resident who receives anti-anxiety medication has the potential to be affected by the cited practice. A full house audit was completed on residents receiving anti-anxiety meds to ensure meds are available and administered per physician order. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nurses on the policy "Physicians Orders, Entering and Processing" to	09/08/2023

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	Director of Nursing indicated she was told the Ativan was a hospice issue and not the facility. The medication was ordered on 7/18/23 and the facility did not receive the medication until 7/23/23. The Emergency Drug Kit (EDK) carried Ativan 0.5 mg tablets and no Ativan was removed and given to the resident. The nurse should have taken the medication from the EDK. A current policy, titled "Physician Orders - Entering and Processing," received by the MDS Coordinator on 7/28/23 at 10:42 a.m., indicated "...To provide general guidelines when receiving, entering and confirming physician or prescriber's order. (a prescriber is noted as physician, nurse practitioner, and a physician's assistant) ...Notify the resident's physician (if not the prescribing physician), for verification if applicable. Notify the family/responsible party and the resident of the new orders (if resident is alert) ...If the medication is needed immediately, it will be removed from the Emergency Drug Kit (EDK). All appropriate paperwork will be filled out when a drug is removed from the EDK...." 3.1-37(a)		include procedure to follow if a medication is not available. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee will complete an audit on any new anti-anxiety medication to ensure medication is obtained and administered timely. Audits will be completed 5x a week times 4 weeks, 2x week times 4 weeks then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: September 8, 2023	
F 0692 SS=E 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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	155064	A. BUILDING 00 B. WING	07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE KOKOMO	3518 S LAFOUNTAIN ST KOKOMO, IN 46902

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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 interview and record review, the facility failed to recognize and notify the physician of a significant weight gain for 2 of 5 residents (Resident 40 and 48) and a significant weight loss for 2 of 5 residents reviewed for nutrition (Resident 8 and 9). Findings include: 1. The record for Resident 40 was reviewed on 7/25/23 at 10:03 a.m. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, severe protein-calorie malnutrition, multiple myeloma not having achieved remission, seizures, atrial fibrillation, and chronic obstructive pulmonary disorder. The resident had the following weights: 1. On 12/3/22, the weight was 195.8 pounds. 2. On 3/1/23, the weight was 193.9 pounds. 3. On 6/14/23, the weight was 242.8 pounds. The resident had a 25.22% weight gain in 3 months and a 24.00% weight gain in 6 months.	F 0692	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Physician was notified of weight loss for residents #8 and #9, and of weight gain for residents #40 and #48. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the cited practice. An audit was completed for the past 30 days to ensure the physician was notified of any resident with a weight loss/gain. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nurses on the policy “Weights” to include notifying the physician of any	09/08/2023

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	There was no documentation of the physician being notified of the significant weight gain. A physician's order, dated 7/5/23, indicated the resident was to receive 32 to 48 ounces of fluids a day. The order indicated to give 240 ml's (milliliters) with meals and nursing to provide 160 ml's every shift. The resident would also receive 237 ml's of Nepro (a nutrition shake) twice a day. A care plan, dated as revised on 7/6/23, indicated the resident had an unplanned/unexpected weight gain related to overeating. The interventions included, but were not limited to, dietary to provide 240 ml's fluid at meals, monitor and to record food intake at each meal. An IDT (Interdisciplinary Team) care plan note, dated 7/7/2023, indicated the IDT team met with the resident to discuss his diabetic Low Concentrated Sweets diet with double protein and his fluid restriction. A Documentation Survey Report for 7/2023 indicated the percentage of meals eaten by the resident were 76-100%. During an interview, on 7/27/23 at 1:04 p.m., the Director of Nursing (DON) indicated she implemented a Comprehensive Clinical Review (CCR) meeting starting this week. The facility had not addressed weights since March. When a resident had a weight loss or gain, she would discuss the weights with the Dietary Manager. She noticed many residents had a significant weight loss or gain and it usually triggered at 5 percent. The residents with a weight loss or gain should be reweighed.		resident with a weight loss or gain by date of compliance. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee to audit residents' monthly weights to ensure anyone with a weight loss or gain has physician notification. Audits will be completed during daily clinical meeting weekly x 4 weeks, then monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: September 8, 2023	

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	2. The record for Resident 48 was reviewed on 7/25/23 at 10:12 a.m. Diagnoses included, but were not limited to, quadriplegia, traumatic brain injury, aphasia, convulsions, depression, and neurostimulator. The resident had the following weights: 1. On 4/10/23, the weight was 128.2 pounds. 2. On 6/6/23, the weight was 170.0 pounds. The resident had an 34.87% weight gain in 3 months. There was no documentation of the physician being notified of the significant weight gain. A care plan, dated as revised on 1/18/23, indicated the resident required a PEG tube feeding related to malnutrition, dysphagia, and traumatic brain injury. The interventions included, but were not limited to, for the Registered Dietician (RD) to evaluate quarterly and when necessary, to monitor caloric intake, estimate needs and make recommendations for changes to tube feeding as needed. A care plan, dated as revised on 2/14/23, indicated the resident had a nutritional problem or potential nutritional problem related to malnutrition, presence of peg tube. The interventions included, but were not limited to, monitor, record, and report to the physician significant weight loss: 3 pounds in 1 week, more than 5% in 1 month, more than 7.5% in 3 months and more than 10% in 6 months, RD to evaluate and make diet change recommendations when needed. A physician's order, dated 2/13/23, indicated the resident's diet was pureed texture and pudding consistency liquids.			

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A physician's order, dated 4/12/23, indicated to give Jevity 1.5 at 90 milliliters for 8 hours over night from 10:00 p.m. to 6:00 a.m.

During an interview, on 7/25/23 at 12:17 p.m., the Director of Nursing (DON) indicated she thought the resident had incorrect weights on 6/6/23 and 7/6/23. She believed the resident was weighed in his wheelchair and the wheelchair was not deducted. The resident was not reweighed and with a weight gain the resident should had been reweighted.

During an interview, on 7/26/23 at 10:57 a.m., LPN 3 indicated the resident did have continuous Enteral feeding starting in the evening and running through the night. The resident was also eating food by mouth.

3. The record for Resident 8 was reviewed on 7/27/23 at 11:29 a.m. Diagnoses included, but were not limited to, paranoid schizophrenia, morbid (severe) obesity due to excess calories, chronic obstructive pulmonary disease, and major depressive disorder.

The resident had the following weights:
1. On 5/2/2023, the weight was 322.2 pounds.
2. On 5/9/2023, the weight was 302.4 pounds.
3. On 6/2/2023, the weight was 305.6 pounds.

The resident had a 6.1% weight loss in a one-week period.

There was no documentation the significant weight loss was reported to the physician, no documentation from the Dietitian and the resident was not reweighed.

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	A quarterly Minimum Data Set assessment, dated on 6/3/23, indicated Resident 8 had a loss of 5% or more in the last month and was not on prescribed weight loss regimen. A care plan, dated 6/3/23, indicated the resident had a potential nutritional risk. The interventions included, but were not limited to, a desire for weight loss and nutritional status would remain stable with desired weight loss through next review. 4. The record for Resident 9 was reviewed on 07/25/23 at 9:08 a.m. Diagnoses included, but were not limited to, hyperlipidemia, type 2 diabetes, anemia, hypothyroidism, and thrombocytopenia. A weight log indicated the following weights: 1. On 11/3/22, the weight was 236 pounds. 2. On 12/7/22, the weight was 227 pounds. 3. On 1/3/23, the weight was 222 pounds. 4. On 2/2/23, the weight was 218 pounds. The resident had a 7.6% weight loss in 3 months from 11/3/22 to 2/2/23. A care plan, dated 01/28/2021, indicated to monitor the resident's weight and report significant gains and losses to the MD according to the facility protocol. During an interview, on 07/28/23 at 10:33 a.m., the facility indicated the resident's weight did not trigger for a significant weight loss of 7.5% in 90 days. The facility followed the current CMS (Centers for Medicare and Medicaid) guidelines to identify significant weight losses. A current policy, titled "Weights," dated as revised on 10/17/19 and received from the DON on			

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	7/27/23 at 12:48 p.m., indicated "...Each resident shall be weighed on admission and at least monthly thereafter, or in accordance with Physician orders or plan of care. Residents identified at nutritional risk may be weighed weekly or bi-weekly as per physician order or Interdisciplinary Team recommendation. Re-weight should be obtained if there is a difference of 5# or greater (loss or gain) since previous recorded weight. Re-weight should be taken as soon as possible after an unanticipated weight change is noted and prior to calling the physician. (Usually within 72 hours). Efforts should be made to obtain all weights and re-weights by the 10th of each month. Undesired or unanticipated weight gains/loss of 5% in 30 days, 7.5% in three months, or 10% in six months shall be reported to the physician, Dietician and/or Dietary Manager as appropriate...." 3.1-46 (a)(1)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to ensure a resident's PRN (as needed) pain medication was available for administration and to notify the physician the pain medication was not available for 1 of 1 resident reviewed for pain. (Resident 102) Finding includes:	F 0697	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #102 has medication on hand and is being administered per physician order. II. How other residents having the potential to be affected by the	09/08/2023

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	During an interview, on 7/23/23 at 3:30 p.m., the resident indicated he had been out of pain medications for 5 days. The record for Resident 102 was reviewed on 7/24/23 at 3:51 p.m. Diagnoses included, but were not limited to, congestive heart failure, type 2 diabetes mellitus with diabetic neuropathy, major depressive disorder, chronic obstructive pulmonary disease, chronic kidney disease, acquired absence of left leg below the knee, acquired absence of right leg below the knee, anemia, and old myocardial infarction. A physician's order, dated 7/4/23, indicated oxycodone 10 mg tablets to give one every 6 hours as needed for pain. A Pharmascript Controlled Drug Administration Record, dated 7/2023, for oxycodone (an opioid) IR (immediate release) 10 mg (milligram) to give one tablet every 6 hours as needed for pain, showed the last tablet was administered on 7/22/23 at 10:00 p.m. A nursing progress note, dated 7/24/23 at 5:30 a.m., indicated the resident had pain and swelling in the genitals. The resident currently had testicle pain and phantom leg pain. A physician's progress note, dated 7/24/23 at 1:57 p.m., indicated if the resident's pain was not controlled with 10 mg oxycodone, then would make the oxycodone every 4 hours PRN. A physician's order, dated 7/24/23, indicated to give oxycodone 10 mg by mouth every 4 hours as needed for pain. A Pharmascript Controlled Drug Administration		same deficient practice will be identified and what corrective action(s) will be taken; Any resident receiving PRN pain medications has the potential to be affected by the cited practice. A full house audit was completed on residents receiving PRN pain medications to ensure meds are available and administered per physician order. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nurses on the policy “Pain Management Program” to include the proper procedure to follow if a resident’s pain medication is not available. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee will complete an audit on any new PRN pain medication to ensure medication is obtained and administered timely. Audits will be completed 5x a week times 4 weeks, 2x week times 4 weeks, then weekly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make	

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	Record, dated 7/25/23, indicated 30 oxycodone IR 10 mg tablets were received on 7/25/23. The resident did not have any oxycodone 10 mg tablets at the facility between 7/22/23 and 7/25/23. The progress notes did not include a notification to the physician to indicate the resident had been out of oxycodone since 7/22/23. During an interview, on 7/27/23 at 9:34 a.m., the DON (Director of Nursing) indicated the prescription for the oxycodone had been sent to the pharmacy although the pharmacy needed a physician's signature, and the facility was not notified. This was the reason the resident was without the oxycodone from 7/22/23 through 7/25/23. There was no documentation on the electronic record to show when the prescription was sent in, when the physician was asked for the signature, or if the physician was notified the resident was out of the oxycodone from 7/22/23 through 7/25/23. A current policy, titled "Pain Management Program," dated as revised on 7/6/18 and received from the DON on 7/27/23 at 12:45 p.m., indicated "...To establish a program which can effectively manage pain in order to remove adverse physiologic and physiological effects of unrelieved pain and to develop an optimal pain management plan to enhance healing and promote physiological and psychological wellness...The purpose of this policy is to accomplish that goal through an effective pain management program...The pain management program includes the following components...Documentation of pain assessment and monitoring...Informed resident participation in care decisions, including managing pain...Pain medication shall be		recommendations to revise the plan of correction as indicated. Date of compliance: September 8, 2023	

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	appropriate for the population served...Pharmacological and non-pharmacological interventions will be included in the care plan and addressed in direct and indirect care assignments...The resident's physician will be notified of the resident's complaints of pain which are not relieved by comfort measures, including pain medications...." 3.1-37(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to ensure residents were monitored for a fluid restriction for 1 of 1 resident reviewed for dialysis. (Resident 40) Finding includes: The record for Resident 40 was reviewed on 7/25/23 at 10:03 a.m. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, severe protein-calorie malnutrition, multiple myeloma not having achieved remission, seizures, atrial fibrillation, and chronic obstructive pulmonary disorder. A care plan, dated as revised on 10/20/22, indicated the resident had dialysis 3 times a week related to renal failure. The interventions included, but were not limited to, give 32 oz to 48 oz of	F 0698	I.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #40's fluid restriction was reviewed and revised as applicable by the physician. Resident #40 had not adverse outcomes related to the cited practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; Any resident on a fluid restriction has the potential to be affected by the cited practice. An audit was completed on any resident on a fluid restriction to ensure their fluid	09/08/2023

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	fluids a day. Dietary to provide 240 ml's(milliliters) with meals and nursing to provide 160 ml's every shift and 237 ml's of Nepro (replaces protein loss during dialysis) and to monitor intake and output. A care plan, dated as revised on 7/6/23, indicated the resident had an unplanned/unexpected weight gain related to overeating. The interventions included, but were not limited to, dietary to provide 240 ml's fluid at meals, monitor and record food intake at each meal. A physician's order, dated 7/5/23, indicated the resident was to receive 32 to 48 ounces of fluids a day. The order indicated to give 240 ml's with meals and nursing to provide 160 ml's every shift. The resident would also receive 237 ml's of Nepro twice a day. The resident was on a 1440 ml's a day fluid restriction. A Documentation Survey Report, for 7/2023, indicated 19 out of 20 days the resident went over his daily fluid restriction. An IDT (Interdisciplinary Team) care plan note, dated 7/7/2023, indicated the IDT team met with the resident and discussed his fluid restriction. During an interview, on 7/25/23 at 11:17 a.m., LPN 3 indicated the resident was on a fluid restriction and was not sure how many ml's he was allowed daily. During an interview, on 7/26/23 at 2:13 p.m., the Clinical Support Nurse indicated residents on fluid restriction should be followed and Resident 40 was not. During an interview, on 7/27/23 at 1:04 p.m., the Director of Nursing (DON) indicated the resident		restriction was accurate. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nurses on the policy “Fluid Restrictions” to include physician notification if resident is not following the allotted amount. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON//designee to audit residents fluid restrictions to ensure they are within the allotted amount, or physician notified if resident is not within parameters. Audits will be completed 5xs a week times 4 weeks, 2x a week times 4 weeks then monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: September 8, 2023	

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	was on a fluid restriction and should be monitored daily. A current policy, titled "Fluid Restrictions," dated as revised in 2017 and received from the Administrator on 7/26/23 at 8:50 a.m., indicated "...A fluid restriction may be ordered with any diet consistency or therapeutic order. Fluid restrictions are most likely to be ordered for an individual who would benefit from limiting fluid to prevent fluid retention such as those with kidney, heart or liver failure...Because of the risk of too little fluids being consumed, the individual should be assessed by the Registered Dietitian initially and then routinely thereafter...Fluid restrictions are typically ordered in total ml's allowed per day which then must be divided among nursing, dining services and activities. The amount allowed at meals is usually indicated on the individual's meal card. Nursing services is recommended to include the amount allocated with medications on the MAR or other flow sheet...." 3.1-37(a)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director			

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	155064	A. BUILDING 00 B. WING	07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE KOKOMO	3518 S LAFOUNTAIN ST KOKOMO, IN 46902

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	of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on interview and record review, the facility failed to ensure a pharmacy recommendation was addressed by the physician to review accuracy of a medication prescribed for 1 of 5 residents reviewed for unnecessary medications. (Resident 102) Finding includes:	F 0756	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #102's pharmacy recommendation was addressed, and the medication was discontinued on 7-9-23. II. How other residents having the potential to be affected by the	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155064	A. BUILDING 00 B. WING	07/28/2023

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	The record for Resident 102 was reviewed on 7/24/23 at 3:51 p.m. Diagnoses included, but were not limited to, congestive heart failure, type 2 diabetes mellitus with diabetic neuropathy, major depressive disorder, chronic obstructive pulmonary disease, chronic kidney disease, acquired absence of left leg below the knee, acquired absence of right leg below the knee, anemia, and old myocardial infarction. A physician's order, dated 6/17/23 through 6/28/23, indicated to administer Jardiance (a medication used to lower blood sugar) 10 mg (milligrams) one time a day for diabetes mellitus type 2. A physician's order, dated 6/28/23 through 7/9/23, indicated to give Jardiance 10 mg (milligrams) one time a day for diabetes mellitus type 2. A physician's order, dated 6/28/23 open ended, indicated to administer Humalog (a type of insulin) Kwik pen subcutaneous 100 units per milliliter to inject per sliding scale. A Pharmacist Recommendation Summary, dated 6/30/23, indicated the resident was prescribed Jardiance 10 mg daily although this order was not listed on the resident's transfer records from the previous long term care facility. Please confirm if the medication was to be continued. Please clarify the order with prescriber and update the electronic medication record accordingly. The Pharmacist Recommendation Summary, dated 6/30/23, did not include an answer from the physician. A hospital discharge summary, dated 7/9/23, indicated the resident's hospital diagnoses		same deficient practice will be identified and what corrective action(s) will be taken; Any resident receiving medication has the potential to be affected by the cited practice. An audit was completed on the last 30 days of pharmacy recommendations to ensure they had a physician response. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; RNC to educate DON on the policy “Medication Regimen Review” to include the importance of timely physician response. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee to audit monthly pharmacy recommendations to ensure any recommendation has been addressed by the physician. Audits will be completed monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: September 8, 2023	

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	155064	A. BUILDING 00 B. WING	07/28/2023

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	included, but were not limited to, acute metabolic encephalopathy, acute delirium, polypharmacy (the simultaneous use of multiple drugs to treat a single condition or the use of multiple drugs for one or more conditions), acute kidney injury on chronic kidney disease and hyperkalemia. The discharge orders included to stop Aldactone (a diuretic), Jardiance and Buspar (an anti-anxiety) medication. During an interview, on 7/26/23 at 4:41 p.m., the DON (Director of Nursing) indicated there was no physician response to the Pharmacist Recommendation Summary dated 6/30/23. She started looking at the requests when she started working in July and realized none of the requests from June had been addressed by the physician. The current Nursing Drug Handbook indicated Jardiance was contraindicated in patients with severe kidney impairment and to use cautiously in patients with moderate kidney impairment and in those taking diuretics. A current policy, titled "Medication Regimen Review," dated 8/2020 and received from the DON on 7/27/23 at 12:44 p.m., indicated "...The consultant pharmacist performs a comprehensive review of each resident's medication regimen and clinical record at least monthly. The medication regimen review [MRR] includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and preventing or minimizing adverse consequences related to medication therapy. The MRR also involves a thorough review of the resident records and may include collaboration with other members of the interdisciplinary team, collaboration with the resident, family members, or other resident			

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	155064	A. BUILDING 00 B. WING	07/28/2023

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	representatives. MRR also involves reporting of findings with recommendations for improvement. All findings and recommendations are reported to the Director of Nursing, the Attending Physician, the Medical Director, and the Administrator or in accordance with facility policy...The consultant pharmacist reviews the medication regimen of each resident at least monthly. A more frequent review may be deemed necessary if, for example, the medication regimen is thought to contribute to an acute change in status or adverse consequence of the resident is not expected to stay 30 days...The findings are phoned, faxed, or e-mailed within 24 hours, or in accordance with facility policy, to the Director of Nursing or designee and are documented and stored with the other consultant pharmacist recommendations in the resident's active record...The prescriber is notified if needed...The consultant pharmacist identifies irregularities through a variety of sources including the resident's clinical record, pharmacy records, and other applicable documents...Recommendations are acted upon and documented by the facility staff and/or the prescriber...The prescriber accepts and acts upon recommendation or rejects provides an explanation for disagreeing..." 3.2-25(i)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

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	155064	A. BUILDING 00 B. WING	07/28/2023

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	§483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure medications were stored properly for 1 of 2 medication rooms reviewed for medication storage. (200 Unit) Finding includes: During an observation, on 07/25/23 at 2:26 p.m., a bottle of melatonin (for insomnia) was found in a storage cabinet in the medication room with no name on it and medications were found lying out on the countertop. During an interview, on 07/25/23 at 2:27 p.m., LPN 10 indicated she was unsure who the bottle of medication belonged to and the medications on the countertop were discontinued. A current policy, titled "Medication Storage," dated as revised on 7/2/19 and received from the DON (Director of Nursing) indicated "...Purpose:	F 0761	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The medication room on 200 unit has been cleaned and medications stored properly. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the cited practice. All medication rooms were audited to ensure proper medication storage. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nurses	09/08/2023

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	To ensure proper storage, labeling and expiration dates of medications, biologicals, syringes and needles...6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels...." 3.1-25(j) 3.1-25(o)		on policy "Medication Storage". IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee to audit medication rooms to ensure medications are properly stored and destroyed when applicable. Audits will be completed 3x a week x 4 weeks, weekly times 4 weeks, then monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: September 8, 2023	
F 0790 SS=D Bldg. 00	483.55(a)(1)-(5) Routine/Emergency Dental Srvcs in SNFs §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs			

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	155064	A. BUILDING 00 B. WING	07/28/2023

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	of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.			
	Based on interview and record review, the facility failed to ensure a resident's preference to obtain dental services was assessed for 1 of 1 resident reviewed for dental services. (Resident 102) Finding includes: During an interview, on 7/23/23 at 3:24 p.m., Resident 102 indicated he had no teeth and wanted dentures. He had not been seen by the dentist and no one had helped him to get	F 0790	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 102 is scheduled to see a dentist on September 14, 2023, at 11:00am. Resident 102 had no adverse outcomes related to the cited practice II. How other residents having the potential to be affected by the	09/08/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	dentures. A care plan, dated 6/20/23, indicated the resident had a nutritional problem or potential for a problem related to being edentulous (lacking teeth), diabetes mellitus type 2, kidney disease, and major depressive disorder. The interventions included, but were not limited to, encourage intake of meals and snacks and to monitor for signs of difficulty swallowing. A care plan, dated 6/20/23, indicated the resident was edentulous and chose not to wear dentures. The interventions included, but were not limited to, dental consult as indicated. The electronic health record did not have a consent or decline of dental services for Resident 102. A review of the dental waiting list for the facility dental provider and the dental list for resident's scheduled for outside providers did not include Resident 102. During an interview, on 7/26/23 at 11:29 a.m., the Social Services Director (SSD) indicated the residents were not asked to sign a dental consent or dental decline upon admission. The residents would just let her know if they wanted dental services. There was no information in the admission packet or documentation to explain how the resident would get dental services. Since employed at the facility, she had only set up residents to see outside dentists not the facility dentist. During an interview, on 7/26/23 at 12:06 p.m., the Admissions Director indicated there was no consent in the Admissions Packet for dental		same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the cited practice. A full house audit will be completed by the SS director to ensure all residents dental needs are being met by date of compliance. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Social Services director to inquire about dental issues during initial care plan meeting and with every quarterly MDS assessment. Appointments will be scheduled when applicable. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Social Services Director to audit weekly to ensure all residents wanting dental services are receiving them. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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	155064	A. BUILDING 00 B. WING	07/28/2023

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	services and he did not know why one was not included. A current policy, titled "Dental Services and Loss or Damage of Dentures," dated as revised on 3/8/2017 and received from the Director of Nursing (DON) on 7/27/23 at 12:44 p.m., indicated "...The facility will, if necessary or requested by the resident, assist with scheduling appointments for dental services, arranging for transportation to and from the dental services location and promptly refer residents with lost or damaged dentures for dental services...." 3.1-24(a)(1) 3.1-24(a)(3)			
F 0847 SS=D Bldg. 00	483.70(n)(2)(i)(ii)(3)-(5) Entering into Binding Arbitration Agreements §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident			

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	and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k).			
	Based on interview and record review, the facility failed to ensure residents understood what an arbitration agreement included and to ensure the agreement was electronically signed only if a resident was in agreement to the arbitration for 2 of 3 residents reviewed for arbitration agreements. (Resident 102 and 17) Findings include:	F 0847	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 102 and 17 to have the arbitration agreement explained to them by date of compliance. II. How other residents having the potential to be affected by the	09/08/2023

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	1. During an interview, on 7/23/23 at 3:18 p.m., Resident 102 indicated the facility tried to get him to sign an arbitration agreement and he would not sign it. The record for Resident 102 was reviewed on 7/24/23 at 3:51 p.m. Diagnoses included, but were not limited to, congestive heart failure, type 2 diabetes mellitus with diabetic neuropathy, major depressive disorder, chronic obstructive pulmonary disease, chronic kidney disease, acquired absence of left leg below the knee, acquired absence of right leg below the knee, anemia, and old myocardial infarction. The resident's admission packet, dated 6/16/23 and signed on 6/28/23, had an electronic signature agreeing to the Arbitration Agreement Rider to the Admission Contract. The Business Office Manager (BOM) had signed the contract on 7/11/23. During an interview, on 7/26/23 at 11:40 a.m., the BOM indicated she had been filling in for the Admission Director while he was on leave and completed the admissions packet for Resident 102. Everything in the admissions packet was on autofill and she was not sure if the resident signed the binding arbitration agreement, or the computer just filled in the electronic signature. She did explain the arbitration agreement to the resident and told him he could "fight against anything for the facility" although it would just have to be done and settled at the facility. The resident had been argumentative, and she did not really want to review the information with him. During an interview, on 7/26/23 at 12:01 p.m., the Admissions Director indicated the resident's		same deficient practice will be identified and what corrective action(s) will be taken; All new admissions have the potential to be affected by the cited practice. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Administrator/designee to educate Admissions Director on the importance explaining the arbitration agreement and obtaining a signature when applicable by date of compliance. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Administrator/designee to interview 2 new admission weekly to ensure the arbitration agreement has been explained to them, and a signature obtained when applicable. Audits will be completed weekly x 12 weeks then monthly x 3 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: September 8, 2023	

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	155064	A. BUILDING 00 B. WING	07/28/2023

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	electronic signature on the Arbitration Agreement Rider would only auto populate if the question was answered as a yes. The admissions packet was completed on a computer tablet and the resident would sign once, then the signature would auto populate for each yes. He could talk to the resident again on 7/27/23 to explain the agreement. The agreement could be rescinded although the facility preferred if they agreed to the arbitration agreement. It was no big deal if the resident did not agree. During an interview, on 7/27/23 at 11:06 a.m., the Admissions Director and the BOM were in the resident's room to review the arbitration agreement. The resident indicated he did not know what the arbitration agreement meant. The Admissions Director explained the arbitration agreement again and the resident indicated he was okay with the agreement and did not need it changed. 2. During an interview, on 7/27/23 at 11:50 a.m., Resident 17 indicated he was not sure what an arbitration agreement was and was not aware he signed one when he completed his admission packet to the facility. He was not "in a good spot" when he arrived at the facility and did not remember much about the admission. The record for Resident 17 was reviewed on 7/27/23 at 10:05 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, type 2 diabetes mellitus with diabetic neuropathy, severe morbid obesity, and anxiety disorder. The admissions packet, dated 8/26/22, had an electronic resident's signature dated 9/2/22 and the Arbitration Rider had an electronic resident's			

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	155064	A. BUILDING 00 B. WING	07/28/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	signature dated 9/2/22. During an interview, on 7/27/23 at 12:45 p.m., the Administrator indicated the facility did not have a policy on arbitration agreements and followed the federal guidelines. 3.1-3(u)(3) 3.1-4(a)			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical			

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	155064	A. BUILDING 00 B. WING	07/28/2023

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	contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on record review and interview, the facility failed to ensure the residents who received influenza vaccines signed consents and education for 3 out of 5 residents reviewed for immunizations. (Residents 39, 23 and 17) Findings include: 1. The immunization record for Resident 39 was reviewed on 7/27/23 at 3:25 p.m. The electronic record indicated the resident had received an influenza vaccine on 10/18/22. There was no	F 0883	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents #39, #23 and # 17 had no adverse outcomes related to the cited practice. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All	09/08/2023

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	consent. 2. The immunization record for Resident 23 was reviewed on 7/27/23 at 3:27 p.m. The electronic record indicated the resident had received an influenza vaccine on 10/12/22. There was no consent. 3. The immunization record for Resident 17 was reviewed on 7/27/23 at 3:35 p.m. The electronic record indicated the resident had received an influenza vaccine on 10/22/22. There was no consent. During an interview, on 7/28/23 at 2:00 p.m., the Director of Nursing indicated she was unable to find the consents for the influenza vaccines. A current policy, titled "Influenza and Pneumococcal Immunizations," dated 4/21/22, indicated "...a new consent form and CDC Influenza Vaccine Information Sheet will be provided to the resident or representative each year...the residents medical includes documentation that indicates, at a minimum, the following...resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization...the resident either received or did not receive the influenza immunization due to medical contraindications or refusal...." 3.1-13(a)(1)		residents have the potential to be affected by the cited practice. A full house audit to be completed to ensure all residents have consents or declinations for influenza vaccines by date of compliance. A list of declinations will be created to ensure they do not receive the vaccine. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; DON/designee to educate nursing staff to ensure a resident has consented to receive an influenza vaccine prior to administering. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; DON/designee to audit new admissions for influenza consents or declinations. Audits will be completed 5x a week for 4 weeks, 2x a week for 4 weeks, then monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: September 8, 2023	

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F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the walls were free from cracks, scratches, gouges, peeling wallpaper and paint chips, ceiling tiles were not leaking water, did not have brown stains or were falling from the ceiling, drywall was not exposed, gouges were not on doors, debris was not on the room floors and to ensure a plant chemical was not left unattended for 8 of 8 rooms and failed to ensure concrete was not broken and uneven for 1 of 1 smoking area and debris was not on the hallway floors for 3 of 3 halls reviewed for environment. (Rooms 100, 101, 103, 105, 201, 203, 204, 207, the 100, 200 and 300 halls, and the smoking area) Findings include: 1. During room observations, starting on 7/23/23 at 10:44 a.m., the following were observed: a. Room 100, the bed sheets appeared dirty, and the bed was not made, the room had scuff marks on the bottom of the walls, and the floor had debris. b. Room 101, the floor had debris and treatment supplies were scattered on the top of the resident's dresser. c. Room 103, the baseboard below the air conditioner was hanging down and exposing drywall and the walls had peeling wallpaper. d. Room 105 had peeling paint on the corner wall, the left side of the window had scratched paint, the door entering the room had approximately a	F 0921	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Room 100-bed linens changed, debris removed from floor. Scuff marks on bottom of the walls to be removed with 30 days. Room 101-debris removed from floor; treatment supplies removed from dresser. Room 103-baseboard below air conditioner, torn wallpaper to be repaired within 30 days. Room 105-peeling/scratched paint , scuff marks to door and black mark to door to be repaired within 30 days. Room 201- baseboard trim, black marks to door and ceiling panels to be repaired within 30 days. Room 203- brown stains on ceiling tiles to be repaired within 30 days. Room 204-gouges in wall, black marks to door, and paint behind bed to be repaired within 30 days. Room 207-black marks to closet door, nightstand in room, closet door, wall by sink to be repaired within 30 days, debris removed from floor. Debris removed from all hallways. The water drip in the 300 hall to be repaired within 30 days. Exit door	09/08/2023

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	10-inch black scuff mark along the bottom of the door and approximately a 5-foot black mark on the bottom of the left wall. e. Room 201 had the baseboard trim sunken in and black marks on door, the ceiling panels had brown stains. f. Room 203 had eleven (11) brown stained areas on the ceiling tiles. g. Room 204, the wall by the bathroom had gouges, the door to the bathroom had black marks and the paint behind the bed was missing. h. Room 207, the closet door had black marks on bottom, an empty medicine cup was on the floor by the television, the nightstand had gouges, paint was missing on the left closet door and the wall by the sink had black marks and gouges. 2. During hallway observations, the following were observed: a. The hallway floors on the 100, 200 and 300 halls had debris. b. The 300 hall had a pink basin in the middle of the hallway and water was dripping into the basin from the ceiling. c. The exit door to the smoking area had the bottom half of the door scuffed with black marks. d. The 200 hall had a ceiling tile fall approximately 20 feet from a surveyor and staff. 3. The smoking area had a large amount of broken concrete in the middle of the sidewalk A Concern/Compliment form, dated 6/10/23, indicated a resident was concerned when going out to smoke he was going to fall out of his wheelchair due to an uneven and broken sidewalk. During a facility tour, on 7/26/23 at 10:35 a.m., the Maintenance Director indicated the facility was having a hard time getting ceiling tiles, and the		to the smoking area scuff marks to be removed within 30 days. Ceiling tile in 200 hall to be replaced within 30 days. Concrete to smoking area scheduled to be repaired within 90 days. Miracle Gro was immediately removed from residents room. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents have the potential to be affected by the cited practice. The Maintenance Director/Housekeeping Supervisor performed a 100% audit of the facility regarding any needs for repair/cleaning III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Administrator to re-educate Maintenance Director and Housekeeping Supervisor on ensuring a comfortable, clean environment for all residents to include cleanliness, and repairs by date of compliance. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; Maintenance Director/designee will audit 5 resident rooms and 5 common areas weekly for necessary repairs. Housekeeping	

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	doors were being painted. He was not aware of Room 103's baseboard under the air conditioner fallen off the brackets. Hall 300 had a pink basin with a caution sign beside it and there was water in the bottom of the basin. The ceiling tile was dripping because of condensation from the pipe in the ceiling needing repaired. The concrete outside the smoking door was uneven making it hard for staff and residents to walk or push a wheelchair. During an interview, on 7/26/23 at 11:30 a.m., the Administrator indicated the basin was in the hallway collecting condensation from the ceiling pipe.4. During an observation, on 7/24/23 at 11:08 a.m., there was a Colligan drinking water gallon container half full sitting on the windowsill of Room 203. The liquid in the container was a bluish-green color. LPN 2 indicated it was miracle grow used to fertilize the residents' plants. Resident 31 had multiple plants in the facility and used miracle grow for all the plants. The container was not marked indicating it was Miracle-Gro and not a substance for drinking. During an interview, on 7/24/23 at 11:22 a.m., the Administrator indicated the container of bluish-green liquid was for the plants and she thought the container belonged to Resident 31. During an interview, on 7/24/23 at 11:24 a.m., Resident 31 told the Administrator the container was filled with Miracle-Gro, and he also had a Miracle-Gro container on the bottom shelf of his plant stand which had the same color of liquid in it. A Safety Data Sheet, last revised on 12/04/2015, indicated for Miracle-Gro all-purpose plant food to read the label before use. For eye contact, to immediately flush eyes with plenty of water and to		supervisor/designee will audit 5 resident rooms and hallways weekly to ensure cleanliness, and rooms are free of chemicals. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. Date of compliance: September 8, 2023	

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	check for and remove any contact lenses. For inhalation, to move the victim to fresh air and keep at rest in a position comfortable for breathing. For skin contact, to flush skin and remove contaminated clothing and shoes. If material had been swallowed and the exposed person was conscious, to give small quantities of water to drink. Do not induce vomiting unless directed by medical personnel. Contact a poison treatment specialist immediately if large quantities had been ingested or inhaled. Gloves should be always worn when handling the material. A current policy, titled "Resident Rights," dated as reviewed on 1/4/19 and received from the Administrator on 7/23/23 at 11:25 a.m., indicated "...To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of their rights...Notice of resident rights will be provided upon admission to the facility. These rights include the resident's right to: Voice grievances and have the facility respond to those grievances, exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care...." 3.1-19(f)(5)			
F 9999 Bldg. 00	Sec. 1.4. (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in	F 9999	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; LPN 3, LPN 4, CNA 5, LPN 6, CNA 7, CNA 8 and CNA 9 will have physicals and TB	09/08/2023

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	accordance with IC 16-28-13-3. p) Initial orientation of all staff must be conducted and documented and shall include the following: (1) Instructions on the needs of the specialized population or populations served in the facility, for example: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) children; or (E) care of cognitively impaired; residents. (2) A review of residents' rights and other pertinent portions of the facility's policy manual. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures and universal precautions. (4) A detailed review of the appropriate job description, including a demonstration of equipment and procedures required of the specific position to which the employee will be assigned. (5) Review of ethical considerations and confidentiality in resident care and records. (6) For direct care staff, instruction in the particular needs of each resident to whom the employee will be providing care. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure		testing/or annual risk assessments completed by date of compliance. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All employees have the potential to be affected by the cited practice. The HR director is performing a 100% employee file audit for compliance to be completed within 30 days of date of compliance. III. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Administrator/designee to educate DON/nursing staff/HR director on requirements for annual and new hire employees. IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place; All employee files (current and new hire) to be audited weekly for 6 months (10 employee files corrected each week) until 100% compliant. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until an average of 90% compliance or greater is achieved x4 consecutive weeks. The QA Committee will identify any trends or patterns and make	

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	the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination This state rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure new employees received a 1st and/or 2nd step PPD (Purified Protein Derivative) (a skin test to determine if a person had been exposed to TB) upon hire, to have an annual risk assessment completed, and to have a physical exam for 7 of 10 employee records reviewed. (LPN 3, LPN 4, CNA 5, LPN 6, CNA 7, CNA 8 and CNA 9) Findings include: 1. Employee personnel files for LPN 3, with a hire date of 9/27/11, did not contain an annual risk assessment. 2. Employee personnel files for LPN 4, with a hire date of 6/26/23, did not contain a 2nd step TB test.		recommendations to revise the plan of correction as indicated. Date of compliance: September 8, 2023	

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	3. Employee personnel files for CNA 5, with a hire date of 4/14/23, did not contain a 1st or 2nd step TB test. 4. Employee personnel files for LPN 6, with a hire date of 6/12/23, did not contain a 2nd step TB test. 5. Employee personnel files for CNA 7, with a hire date of 10/18/18, did not contain an annual risk assessment. 6. Employee personnel files for CNA 8, with a hire date of 5/20/14, did not contain an annual risk assessment. 7. Employee personnel files for CNA 9, with a hire date of 3/1/23, did not contain a physical exam or a 1st or 2nd step TB test. During an interview, on 7/27/23 at 9:34 a.m., the Director of Nursing (DON) indicated the facility did not have the TB tests, annual risk assessments or the physical exam for the staff and they should have had them completed and in their employee files. A current policy, titled "Tuberculosis Testing," not dated and received from the Receptionist on 7/25/23 at 9:00 a.m., indicated "...All healthcare workers will be screened for tuberculosis (TB) risk and symptoms upon hire and yearly thereafter...Two-Step PPD: The first dose given and read at 48-72 hours. If the first dose is negative, the second "booster dose" given 1 to 3 weeks after the first dose was read...."			