STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155215	A. BUILDING 00 B. WING	12/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PLAINFIELD HEALTH CARE CENTER	3700 CLARKS CREEK RD PLAINFIELD, IN 46168

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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 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,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mac McCallum	Regional Director of Ops	01/03/2023

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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	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 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 provide notice of Medicare Non-Coverage (NOMNC), in a timely manner for 2 of 3 randomly selected residents who were discharged from a Medicare covered part A stay with benefit days remaining (Residents 196 and 197). Findings include: On 11/11/22 at 9:31 a.m., during the entrance conference, the facility was provided the beneficiary notice worksheet for completion. The facility listed all residents who were discharged from a Medicare covered part A stay with benefit days remaining, in the past six (6) months. Three (3) residents were randomly selected from the list for review of the CMS (Centers for Medicare and Medicaid Services) form 10123, Notice of Non-Coverage. On 12/2/22 at 1:45 p.m., Resident 196's Medicare Non-Coverage (NOMNC) notice was not provided upon request.	F 0582	F582 Medicaid/Medicare coverage/Liability Notice A. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. a. Resident 196—No longer resides within campus and has discharged. b. Resident 197—No longer resides within campus and has discharged. B. 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. a. All residents have the potential to be affected by the alleged deficient practice. b. Education provided to BOM and Memory care coordinator regarding 48 hour notification of	01/03/2023

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	On 12/2/22 at 1:45 p.m., Resident 197's NOMNC notice was reviewed. It indicated a start date of 9/29/22 and a last covered date of 10/17/22. There was no date on the form indicating when it was provided to the resident or Power of Attorney (POA). The second page was signed by the POA. The signature was not dated. On 12/5/22 at 8:00 a.m., during an interview, the Business Office Manager (BOM) indicated notice should have been given 2 days or 48 hours prior to the last covered day of service. The form did not have a date for when it was provided but that was reflected in the date it was signed. They should sign and date to acknowledge the notification. They were unable to find a notice for Resident 196. On 12/5/22 at 8:00 a.m., the BOM provided a copy of the current policy, dated April 2021, titled "Medicare Advance Beneficiary Notice." This policy indicated, "Residents are informed in advance when changes will occur to their bills...If the resident's Medicare Part A benefits are terminating for coverage reasons, the director of admissions or benefits coordinator issues the Notice of Medicare Non-Coverage (CMS form 10123) to the resident at least two calendar days before Medicare covered services end (for coverage reasons)...." 3.1-4(a)		services ending. C. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. ED/designee to audit providers NOMNC letters once weekly x 6 weeks, then weekly x 6 weeks, twice monthly x 3 months and then monthly thereafter. D. How the corrective actions will be monitored to ensure the deficient practice will not recur. a. Review of NOMNC audit tool monthly during QAPI meeting with determination of ongoing monitoring will be completed within the QA process.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, interview, and record	F 0641	F641 Accuracy of assessments	01/03/2023

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	review, the facility failed to ensure the Minimum Data Set (MDS) was accurate for 1 of 24 residents reviewed for MDS accuracy (Resident 70), and failed to ensure Preadmission Screening and Record Review (PASRR) was completed for 1 of 6 residents reviewed for PASRR (Resident 6). Findings include: 1. On 10/6/22 at 10:38 a.m., Resident 70's record was reviewed. On 10/6/22, her weight was 101.4 pounds. On 11/9/22, her weight was 89.9 pounds. A progress note, on 11/9/22 at 3:35 p.m., the Registered Dietician (RD) indicated Resident 70's weight at 89.9 pounds was a significant weight loss of 11.3% in the last month, 15.8% in the last three months, and 17.7% in the last six months. Her body mass index (BMI) was only 14.1, very underweight for her age. A quarterly MDS, dated 10/2/22, indicated Resident 70 was on a physician ordered weight loss regimen. During an interview, on 12/6/22 at 10:39 a.m., the MDS Coordinator (MDSC) indicated the 10/2/22 quarterly assessment was in error. Resident 70 was not on a physician ordered weight loss regimen. She would make the correction and submit it. During an interview, on 12/6/22 at 11:14 a.m., the Regional Consultant indicated Resident 70 was not on a physician order weight loss regimen. During an interview, on 12/6/22 at 11:22 a.m., the Director of Nursing (DON) indicated the Dietary		A. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. a. Resident 70- On 12/06/2022 MDS was modified to correctly reflect resident was not on prescribed weight loss regimen. b. Resident 6 MDS was modified on 12/02/2022 to reflect correct status of PASRR. B. 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. a. All residents have the potential to be affected by the alleged deficient practice. b. Education provided to MDS coordinator, Certified Dietary manager, Memory care coordinator, Business office manager on 12/30/2022. C. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. DON/designee to audit the accuracy of MDS twice weekly x 6 weeks, then weekly x 6 weeks, twice monthly x 3 months and then monthly thereafter. D. How the corrective actions will be monitored to ensure the deficient practice will not recur. **Review of MDS audit tool monthly during QAPI meeting**	

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	Manager put the 10/4/22 information on the MDS regarding Resident 70 being on a physician ordered weight loss regimen. It was an error. She was not on a weight loss regimen. 2. On 12/1/22 at 10:24 a.m., Resident 125's medical record was reviewed. The diagnoses included, but were not limited to Parkinson's Disease, major depressive disorder, psychotic disorder with hallucinations, and psychotic disorder with delusions. Resident 125 had a Level II Preadmission Screening and Resident Review (PASRR) Level II, dated 4/14/21, scanned into the electronic record. This PASRR Level II document indicated, "Since this evaluation has determined that you have a PASRR condition, if you admit to a Medicaid-certified nursing facility, or if you are currently in a Medicaid-certified nursing facility, the facility will need to document your PASRR condition in the Minimum Data Set (MDS) assessment record. The facility should mark yes for question A1500 on the MDS, 'Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?' Also, your specific PASRR condition(s) should be checked in question A1510, 'Level II Preadmission Screening and Resident Review (PASRR) Conditions'." Resident 125's comprehensive Minimum Data Set Assessment (MDS), dated 10/26/22, for a significant change indicated, "No" to the question "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?"		**with determination of ongoing monitoring will be completed within the QA process**	

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	On 12/2/22 at 11:53 a.m., during an interview, the MDS Coordinator indicated Resident 125's MDS assessment, dated 10/26/22, had been coded wrong. The resident did have a major mental illness and had a PASRR Level II on file. The facility followed the Resident Assessment Instrument (RAI) manual for coding of the MDS assessment. The RAI (Resident Assessment Instrument) manual, dated 7/2010, Pages 3-1 and Z-5 indicated, "...The goal of this chapter is to facilitate the accurate coding of the MDS...To facilitate accurate resident assessment...to the best of your knowledge, most accurately reflects the resident's status...." 3.1-31(i)			
F 0692 SS=G Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;			

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	§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, interview, and record review, the facility failed to ensure residents received assistance, supplements, and appetite stimulants to maintain for weight for 2 of 4 residents reviewed for nutritional status (Residents 70 and 58) resulting in harm due to significant weight loss for both residents; and the facility failed to maintain hydration resulting in abnormal lab values for 1 of 4 residents reviewed for assessments (Resident 58). Findings include: 1. On 12/2/22 at 11:46 a.m., Resident 70's medical record was reviewed. The medical record indicated on 8/9/22 she weighed 107.2 pounds and on 8/15/22 she weighed 106.8 pounds. A physician's progress note, on 8/11/22 at 3:03 p.m., indicated Resident 70's weight and blood pressure remain stable at 107 pounds. Her musculoskeletal system was debilitated with decreased muscle tone. Neurologically, she follows simple commands. The medical record indicated the following weights: a. On 8/24/22, she weighed 108.5 pounds. b. On 8/30/22, she weighed 107.1 pounds. c. On 9/7/22, she weighed 103.8 pounds. d. On 9/13/22, she weighed 103.6 pounds. e. On 9/20/22, she weighed 102.8 pounds. f. On 9/27/22, she weighed 103.0 pounds. g. On 10/6/22, she weighed 101.4 pounds On 10/5/22 at 5:08 p.m., the Nurse Practitioner (NP) 30 charted Resident 70 height was 67 inches, and	F 0692	F692 Nutrition/Hydration Status maintenance A. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. a. Resident 70 and Resident 58 no longer reside in facility. B. 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. a. All residents have the potential to be affected by the alleged deficient practice. b. Education to be provided to nursing staff regarding dietary supplements, appetite stimulants, assist/cue/supervise/encourage of meal consumption on 12/30/2022. C. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. DON/designee to educate staff on nutrition/hydration status twice weekly x 6 weeks, then weekly x 6 weeks, twice monthly x 3 months and then monthly thereafter. D. How the corrective actions will be monitored to ensure the deficient practice will not recur. a. Review of Nutrition/Hydration audit tool monthly during QAPI	01/03/2023

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	her weight was 102.8 pounds. She was being seen today for ongoing management of her psychiatric disorders. No psychotic symptoms. Her Brief Interview for Mental Status (BIMS) indicated she had severe cognitive impairment. The NP would continue to monitor her for medication effectiveness, drug reactions, and significant weight fluctuations. On 10/14/22 at 1:18 p.m., the Registered Dietitian (RD) progress note indicated Resident 70's current body weight was 101.4 pounds. Her body weight a year ago was 133 pounds. Her Body Mass Index (BMI) was 15.9, severely underweight. She triggers for significant weight loss. Her weight reflects insidious (gradual with harmful effects) weight loss for 180 days. Start House shake BID for insidious weight loss. The goal was for weight maintenance within 5%, resolve skin integrity, and stabilize meal intakes. A nutrition care plan, dated 10/14/22, indicated Resident 70 was at nutritional risk related to particular nutritional uses (PNU), Alzheimer's disease, dementia, pain, insomnia, hypothyroidism, hypertension, gastric reflux disease, depression, fatigue, dysphagia (difficulty swallowing), history of covid. pressure injuries, and a Vitamin D deficiency. She received a regular/puree diet. She was experiencing an insidious weight loss. Her BMI indicated she was underweight. The goal was to ensure the resident would consume an adequate diet to meet her estimated caloric needs. The interventions included provided the diet as ordered, honor her foods preferences, offer a substitute if she refused her meal or ate less than 50%, and provided supplements as ordered. On 10/26/22 at 8:39 p.m., the NP 30 charted		meeting with determination of ongoing monitoring will be completed within the QA process.	

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	Resident 70 height was 67 inches, and her weight was 102.8 pounds. She was being seen today for ongoing management of psychiatric disorders. Her level of function for eating was an extensive one person assist. She was total dependent for activities. Her BIMS indicated she had severe cognitive impairment. The NP would continue to monitor her for medication effectiveness, drug reactions, and significant weight fluctuations. On 11/7/22 at 6:31 p.m., the NP 30 charted Resident 70 height was 67 inches, and her weight was 102.8 pounds. She was being seen today for ongoing management of her psychiatric disorders. No psychotic symptoms. Her BIMS indicated she had severe cognitive impairment. The NP would continue to monitor her for medication effectiveness, drug reactions, and significant weight fluctuations. On 11/9/22 at 3:35 p.m., the RD progress note indicated charted Resident 70's current body weight was 89.9 pounds. She showed a significant weight loss of 11.3% in the last 3 months. Her BMI was down to 14.1, very much underweight for her age. She recommended weekly weights for 4 weeks, and to start liquid protein, 30 ml BID. The medical record indicated the following weights: a. On 11/9/22, she weighed 89.9 pounds. b. On 11/16/22, she weighed 85.4 pounds. c. On 11/22/22, she weighed 91.0 pounds. On 11/29/22 at 8:48 a.m., the Nurse Practitioner (NP) 30 charted Resident 70 height was 67 inches, and her weight was 91 pounds. Her chart was reviewed for medication changes, labs, and behaviors with no significant findings. She was taking Zoloft 100 mg for anxiety. She was referred			

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	for Alzheimer's disease, dementia, difficulty sleeping, and major depression disorder. Her level of function for eating was an extensive one person assist. She was total dependent for activities. No information was found on her psychiatric history prior to her current stay. Her Brief Interview for Mental Status (BIMS) indicated a score of zero, meaning she had severe cognitive impairment. The NP would continue to monitor her for medication effectiveness, drug reactions, and significant weight fluctuations. On 12/2/22 at 12:10 p.m., the RD progress note indicated Resident 70's current body weight was 89.4 pounds. She was down 1.6 pounds this week. She shows a significant weight loss of 13.9% in the last 3 months. Her BMI was down to 14, very much underweight. On 12/6/22 at 9:34 a.m., Resident 70's care plans were reviewed. A nutrition care plan, indicated Resident 70 required set-up, cues, supervision, and assist with activities of daily living (ADLs): hygiene, dressing, grooming, bed mobility, toileting, transfers, locomotion, and eating. During an interview, on 12/5/22 at 1:07 p.m., the RD indicated she did not know why Resident 70 dropped the weight, possibly variable food intake. She did not know why the house shakes were discontinued. The resident could have had a bad month. Her body mass index (BMI) was really low, it should be 23 or above. On 12/2/22, she requested the physician add an appetite stimulant, possibly Remeron. It had been 3 days and she had not received a response yet. On 12/5/22 at 1:28 p.m., an RD progress note indicated the Resident was on Zoloft for appetite. Recommend the physician consider a different			

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	medication to stimulate appetite. On 12/5/22 at 2:29 p.m., Resident 70's physician orders were reviewed with the RD. The RD indicated she was on Medpass, liquid protein and Juven for wound healing, they added incidental calories. a. In June, she was on fortified foods three times a day (TID), ice cream at lunch and dinner, and House shakes. The House shakes were discontinued on 6/27/22. b. In July, she was on fortified foods and ice cream at lunch and dinner. The fortified foods were discontinued on 7/21/22. The Medpass was discontinued on 7/1/22. c. In August, she had ice cream at lunch and dinner. d. In September, she had ice cream at lunch and dinner. Liquid protein was added on 9/22/22. e. In October, she had ice cream at lunch and dinner. The House shake was ordered again, starting 10/14/22 twice a day (BID) and the liquid protein was discontinued on 10/24/22. f. In November, she had House shake BID, ice cream at lunch and dinner, and one Juven packet starting 11/29/22 for wound healing. g. In December, she had House shake on 12/1/22, then to discontinue them from 12/2/22 to 12/7/22 to be replaced with Magic cup BID for 5 days starting on 12/3/22, and ice cream at lunch and dinner. The new order added on 12/6/22 was to add fortified foods. During an interview, on 12/6/22 at 10:20 a.m., the RD indicated she still had not heard from the physician about adding an appetite stimulant. During a meeting with the administrative staff, she provided them with the recommendation to add an appetite stimulant. She indicated the resident was on Zoloft (treats anxiety) as an appetite stimulant,			

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	but it is not something she usually saw for appetites. Usually, she saw Remeron. The RD indicated the resident had a new order on 12/6/22 for House shakes, but the facility was out of them. After searching Resident 70's medical chart, she indicated the previous RD discontinued the House shakes on 6/24/22 and not restarted until 10/24/22. She did not know why the House shake order had been discontinued. She did not know Resident 70 had stopped receiving fortified foods. After reviewing Resident 70's medical chart, she indicated she stopped receiving fortified foods on 7/21/22. A new order was started on 12/6/22 for fortified foods. On 12/2/22, an order was added for Magic cup from 12/2/22 to 12/8/22. During an interview, on 12/6/22 at 10:47 a.m., the RD indicated she tried to order fortified foods on 9/1/22. However, the order did not end up on the Medication Administration Record (MAR) because the order was under instructions. 2. On 11/30/22 at 2:18 p.m., a record review was completed for Resident 58. Resident 58's MDS (Minimum Data Set), dated 11/3/22, was a significant change assessment. It indicated she required supervision and cueing with her meal consumption, did not have her own teeth, and did not wear dentures. Resident 58's care plan, dated 12/5/19, indicated that Resident 58 required a no added salt, regular diet with low potassium. On 10/31/22, the care plan was updated to reflect that Resident 58 was experiencing weight loss. Resident 58's care plan, dated 12/7/19, indicated that Resident 58 was at risk for dehydration related to a history of urinary tract infection, decreased intakes, dementia, and edema. The goal,			

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	dated 2/28/22, indicated that Resident 58's risk factor would be reduced to avoid dehydration. Interventions included encourage fluids, monitor for signs and symptoms of dehydration like poor skin turgor, dry mucous membranes, increase confusion, lethargy, decreased output, monitor labs as ordered. Resident 58 had a care plan, dated 12/7/19, indicating that she was at nutritional risk related to pneumonia (lung inflammation caused by bacterial or viral infection), COPD, edema, hyperlipidemia, dementia, CKD (chronic renal failure), hypothyroidism, diabetes, insomnia, depression, dehydration, hypocalcemia (low calcium), anxiety, vitamin deficiency, pain, GERD, protein-calorie malnutrition, and hypertension. The goal, dated 1/27/20, indicated Resident 58 would consume a diet adequate to meet estimated needs. Interventions included to serve diet as ordered, honor food preferences, monitor weight, offer menu substitution if meal was refused or less than 50% of meal consumed. Resident 58's care plan, initiated on 2/8/21 and revised on 5/19/22, indicated that Resident 58 used an antidepressant medication (Remeron) for depression and weight loss. Interventions included to observe, document, report as needed adverse reactions to antidepressant therapy, provide house shake with meals for nutritional supplement and Remeron 15milligrams (mg) in the evening for appetite stimulant, and encourage PO (by mouth) fluids. During an observation, on 11/30/22 at 10:45 a.m., Resident 58 was lying in her recliner with her eyes closed. Her breakfast tray was sitting on her bedside table in a Styrofoam container. A fork was in her scrambled eggs. Her food was			

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	untouched. She had coffee and a red juice in disposable cups on her Styrofoam tray. Her cup of coffee and red juice was untouched. She was not receiving supervision and cueing prior to an aide coming into the room. Certified Nursing Assistant (CNA) 8 entered the room and indicated that Resident 58 may be dehydrated. CNA 8 encouraged Resident 58 to drink her fluids without success. Resident 58 kept saying that she did not know what was wrong with her. Resident 58 was alert and oriented to her name and that she was in a nursing home. Resident 58 kept repeating, "help me" over and over and that she did not know what happened. CNA 8 left Resident 58's room to summon the nurse. On 11/30/22 at 11:00 a.m., Licensed Practical Nurse (LPN) 9 entered Resident 58's room. She indicated that she was an agency nurse and was not familiar with Resident 58. LPN 9 indicated that she would have to review Resident 58's medical record to familiarize herself with Resident 58. While waiting for the nurse to return, Resident 58 rested her head on the arm of the recliner. Resident 58 indicated that she felt like she was going to vomit. On 11/30/22 at 11:15 a.m., LPN 9 returned to Resident 58's room. LPN 9 indicated that this was Resident 58's usual behavior in the morning. LPN 9 indicated that Resident 58 was totally different in the afternoon. LPN 9 indicated that Resident 58 was a DNR (Do Not Resuscitate) and her son, who was her responsible person, did not want her sent out to the hospital. LPN 9 indicated that staff were encouraging her to drink fluids. LPN 9 did not obtain any vital signs or evaluate Resident 58. During an observation, on 11/30/22 at 2:00 p.m., Resident 58 was lying on her left side in her bed. Resident 58's tray was sitting on her bedside			

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	table. It was in a Styrofoam container and was untouched. She did not have 2% milk, 1 ounce of peanut butter or a house shake on her tray. No staff were present to provide supervision and cueing during the meal. During an observation, on 12/1/22 at 9:31 a.m., Resident 58 was lying in her bed with the covers over her head. She asked if somebody was going to help her. Her breakfast tray was in a Styrofoam container with most of her food uneaten. She did not have peanut butter, or a house shake on her tray. She had taken sips of her juice. Her coffee was untouched. Resident 58 asked if it was 10:00 in the morning or evening. She wanted to know if she had fallen. She yelled out "ouch" when attempting to reposition herself in bed. She indicated that her legs were hurting. Resident 58 indicated that she fell asleep and got confused. There were no staff present to provide supervision and cueing with her meal. During an observation, on 12/1/22 at 10:35 a.m., Resident 58's tray was still on her bedside table and has not taken any more of her food or fluids on the tray. There were no staff present to provide supervision and cueing with her meal. During an observation, on 12/1/22 at 10:45 a.m., LPN 9 took Resident 58's breakfast tray out of her room. LPN 9 did not provide any encouragement to eat or drink before removing Resident 58's tray from her room. During an observation on 12/1/22 at 2:24 p.m., Resident 58's lunch tray was removed from her room. Resident 58 indicated that she did not have much of an appetite. A house shake or peanut butter were not observed on her tray.			

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	During an observation, on 12/2/22 at 10:19 a.m., Resident 58's room was empty. Resident 58 was moved to another room the previous evening due to testing positive for COVID. Upon knocking on the door, staff yelled out "patient care." Upon entering the room, three nursing staff were observed assessing Resident 58 indicating that Resident 58 had just fallen. Resident 58 was sitting up in her wheelchair. A portable vital signs machine was inside the room. Resident 58's new room was set up in the opposite direction of her previous room. Her door was also closed due to testing positive for COVID. The Regional Consultant indicated that the facility would be providing one on one supervision for Resident 58 due to the change in her room set up and the door being closed. Resident 58's breakfast tray was sitting on her bedside table at the end of her bed. Resident 58 had taken bites of her food. She consumed 2, 120 milliliter cups of fluid. During an observation, on 12/2/22 at 1:39 p.m., observed Resident 58's lunch tray at the end of her bed on the bedside table. She had consumed 1 cup (120 milliliters) of a fluid. She did not have any peanut butter or house shake on her tray. Resident 58's son was in her room with her. During an interview, with Resident 58's son on 12/2/22 at 1:40 p.m., he indicated when Resident 58 admitted to the facility she weighed around 143 pounds. Prior to admission Resident 58 weighed around 200 pounds. He indicated that "they" have been trying to get Resident 58 to eat for the past year. Resident 58's son indicated that he visits during lunch and dinner time for Resident 58 and when he visits, Resident 58 did not have house shakes on her trays. He had recently informed the DON about Resident 58 was not receiving her house shakes anymore. He was unsure of how			

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	long she had not received them, but it had been a while. Resident 58's son indicated that she would refuse to eat, and her kidney was not good. He indicated that he brought her a "boost" (a liquid nutritional supplement) to drink. The facility had not spoken to him about alternate interventions for nutrition and hydration. He did not feel Resident 58 would be able to tolerate a feeding tube. During an interview with the Registered Dietician (RD) on 12/2/22 at 2:14 p.m., she indicated the facility ran out of house shakes and more would come in on Tuesday. She would obtain invoices from dietary to see how much and when the house shakes were ordered. During an interview with the RD on 12/5/22 at 11:11 a.m., the RD indicated that house shakes were not available since the last shipment received on 11/22/22. The RD indicated that the facility had a meeting for residents with weight loss called SWAT (Skin Weight Assessment Team). The team attempted to meet on a weekly basis. Resident 58 should have been weighed weekly. Resident 58 had a significant weight loss. Resident 58 received Remeron (an antidepressant often used at a dose of 7.5mg at bedtime to promote an appetite and given at bedtime due to increased sleepiness) to stimulate her appetite. The RD would consult with nursing to inquire about discontinuing the use of Remeron since it was not effective. The RD changed Resident 58's diet on 12/1/22 to a regular diet with no restrictions. Resident 58's previous diet was NAS (No Added Salt). On 12/2/22, the RD indicated she added ice cream to her meals two times per day. There had not been a meeting to discuss alternate options for the resident to receive nutrition and hydration because it was not time to			

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	have this conversation with Resident 58's son until now. The RD indicated that she would get a care plan meeting scheduled with Resident 58's son. During an interview, on 12/5/22 at 1:02 p.m., RD reported that she was going to attempt Glucerna (a nutritional supplement) for Resident 58 to consume to aid in her nutrition. During an observation, on 12/5/22 at 1:07 p.m., Resident 58 was observed sitting up on the side of the bed with her tray in front of her. She had taken only bites of her food. She had consumed the entire contents of a 750-milliliter bottle of Gatorade and was drinking her Glucerna. CNA 33 was providing 1:1 supervision of Resident 58 due to a fall. Observed untouched containers of ice cream and magic cup. The magic cup was provided in lieu of a house shake since the facility did not have house shakes to offer. During an interview with the Dietary Manager (DM) on 12/6/22 at 9:24 a.m., she indicated that the facility received their food from US Foods. She indicated that if house shakes were available to order, she ordered them. They were not always available. The DM indicated that they were available for her most recent order. She indicated that she ordered 3 cases. The Dietary Manager indicated that if they are out of a supplement they were permitted to substitute. House shakes were substituted with "magic cups" (a frozen supplement). On 11/30/22 at 2:18 p.m., a record review was completed for Resident 58. Her diagnoses included, but were not limited to, peripheral vascular disease (a slow and progressive circulation disorder), chronic obstructive pulmonary disease (a condition involving			

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	constriction of the airway and difficulty or discomfort in breathing), COVID 19, urinary tract infection, diabetes type 2 (an impairment in the way the body regulates and uses sugar as a fuel), unspecified dementia, hyperkalemia (low potassium), hypothyroidism (abnormally low activity of the thyroid gland), osteoarthritis, dysphagia (difficulty swallowing), pain, age related physical debility, hypertension (a blood pressure higher than normal) , GERD (gastroesophageal reflux disease), chronic kidney disease (means the kidneys are damaged and cannot filter blood the way they should), Alzheimer's disease (progressive mental deterioration), hyperlipidemia (an abnormally high concentration of fats or lipids in the blood), atrial fibrillation (an irregular and often very rapid heart rhythm), and muscle weakness. Resident 58 had the following weights reflecting a significant weight loss. a. On 7/25/22, she weighed 126 pounds. b. On 8/4/22, she weighed 124.6 pounds c. On 8/9/22, she weighed 123.8 pounds. d. On 8/17/22, she weighed 122.9 pounds. e. On 8/25/22, she weighed 121.3 pounds. f. On 8/30/22, she weighed 120.4 pounds. g. On 9/7/22, she weighed 121.8 pounds. h. On 9/13/22, she weighed 120.8 pounds. i. On 9/20/22, she weighed 121 pounds. j. On 9/27/22, she weighed 121.8 pounds. k. On 10/6/22, she weighed 118.8 pounds l. On 10//25/22, she weighed 112.8 pounds. m. On 11/9/22, she weighed 108.8 pounds. n. On 11/15/22, she weighed 103.4 pounds. o. On 11/29/22, she weighed 104.6 pounds. A review of the medical record indicated that Resident 58 was sent to the hospital on 10/23/22 and received treatment for dehydration. She			

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	received fluids while at the hospital. A RD progress note, dated 10/26/22, indicated to weight Resident 58 weekly for four weeks, nutrition monitoring using weight changes will be done through review of weight records. Nutrition monitoring will be done through review of meal and supplement intake. Nutrition monitoring of electrolyte or renal profiles will be completed through review of standard lab reference tools. A RD progress note, dated 11/9/22, indicated that Resident 58's weight was 108.8 pounds. Resident 58 continued to show weight loss, significant for 1 month, 3 months and 6 months. She lost another 4 pounds from her previous weight. To aid in improving appetite, she recommended consideration of appetite stimulate. A review of Resident 58's food consumption indicated that she consumed 50% or less of her meals over the past month from 11/1/22 through 11/30/22 Resident 58's medical record lacked documentation of how much fluids she should consume per day. A review of her fluid consumption logs over the past 14 days from 11/16/22 through 12/1/22 indicated that Resident 58 consumed less than 1200 milliliters of fluid per day. A RD progress note, dated 12/1/22, indicated Resident 58's weight was up from the previous week. Resident 58 required IV (intravenous) fluids for a couple of days recently. She continued a regular diet with no added salt, fortified foods, and house shakes with meals. Her food intake was often less than 50%. Her intake of house shakes generally varies from 50-100%. Resident			

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	58 was recently started on Remeron to help with appetite. RD recommended to change diet from regular to liberalize diet and to continue with weekly weights. The DON provided a copy of the lab results for the 12/5/22 BMP on 12/6/22 at 2:15 p.m. The results were abnormal. Her glucose was 52 (normal is 65-125), BUN (blood urea nitrogen) was 52 (normal is 7-25), creatinine was 2.4 (normal is 0.6-1.2) and calcium was 7.7 (normal is 8.4-10.2), and her GFR (glomerular filtration rate) was 19 and the report indicated that GFR is reliable for adults 17-69 years old with stable kidney function. The lab report indicated that her score of 19 was indicative of stage 4 chronic kidney disease. On 12/5/22, the Regional Consultant provided a list of all the residents that received house shakes. The facility residents required 119 house shakes weekly. For the month of November, an invoice dated 11/22/22, indicated the facility received 50 vanilla house shakes and 75 chocolate house shakes. Another invoice, dated 11/1/22, indicated the facility received 75 strawberry house shakes. The total number of house shakes received for the month of November was 200 total. The facility required 476 house shakes monthly to meet the needs of residents that had orders to receive house shakes. On 12/5/22 at 9:20 a.m., the Regional Consultant provided a policy, titled, "Hydration-Clinical Protocol," dated September 2017. The policy indicated, " ...Cause identification, 1. The physician will help identify the cause(s) of any existing fluid and electrolyte imbalance or help the staff document why the resident should not be tested. A. A limited review for causes. Treatment/Management, 1. The physician will			

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	manage significant fluid and electrolyte imbalance and associated risks, appropriately, and in a timely manner. A. Timeliness depends on the severity, nature, and causes of the fluid and electrolyte imbalance. B. For minor, uncomplicated fluid and electrolyte imbalance, oral hydration may suffice. For more severe or complicated fluid and electrolyte imbalance, subcutaneous (hypodermoclysis) (administering fluids into subcutaneous tissue) or intravenous hydration may be needed. 2. The staff will provide supportive measures such as supplemental fluids and adjusting environmental temperature, where indicated ...." On 12/5/22 at 9:20 a.m., the Regional Clinical Nurse provided a policy, titled, "Nutrition (Impaired)/Unplanned Weight Loss- Clinical Protocol, dated September 2017. The policy indicated, " ...The nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparison over time. The staff and physician will define the individual's current nutritional status (weight, food/fluid intake and pertinent laboratory values) and identify individuals with anorexia (an eating disorder characterized by restriction of food intake leading to low body weight), weight loss or gain, and significant risk for impaired nutrition. The physician will consider whether any assessment including additional diagnostic testing is indicated to help clarify the severity or consequences of weight loss and/or impaired nutrition. The staff will report to the physician significant weight gain or losses or any abrupt or persistent change from baseline appetite or food intake. For individuals with recent or rapid weight gain or loss, the staff will review for possible fluid and electrolyte imbalance as a cause. The physician and staff will collaborate to address any			

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	ethical issues related to weight and nutrition (use of artificial nutrition and hydration) related to severe or prolonged impairment of nutritional status and weight loss ...." 3.1-46(a)(1) 3.1-46(a)(2) 3.1-46(b)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview and record review the facility failed to obtain a physician order to provide routine care and treatment for changing and maintaining oxygen tubing and bipap (a device that helps with breathing) equipment for 1 of 1 resident reviewed for respiratory care (Resident 194). Findings include: On 11/30/22 at 11:30 a.m., Resident 194 was interviewed as she laid on her bed. She wore an oxygen tubing in her nose that was stretched taunt to reach an oxygen concentrator beside her bed. A bipap machine was observed at the head of her bed. The machine was turned off and the tubing draped over the top of the machine. A mask, unbagged laid on top of the machine. The	F 0695	F695 Respiratory/Tracheostomy Care/Suctioning A. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. a. Resident 194 Physician orders obtained on 12/05/2022 for routine care, treatment, changing and maintaining oxygen tubing B. 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. a. All residents who require oxygen or Bipap/Cpap have the	01/03/2023

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	tubing for the oxygen or the the bipap were not labeled or dated. Resident 194 indicated her oxygen tubing was too short and pulled when she moved. Her bipap mask was too small and cut into her face. Someone from the company was supposed to come re-size it but never did. She preferred the old company she had dealt with in the past. This company this facility used did not take care of her needs. On 12/1/22 at 3:00 p.m., Resident 194 was observed as she rested on her bed. The oxygen tubing and bipap tubing remained undated or labeled. The bipap mask was laying, unbagged, on the top of the machine. On 12/2/22 at 10:35 a.m., Resident 194 was observed as she rested on her bed. The oxygen tubing and bipap tubing remained undated or labeled. The bipap mask was laying, unbagged, on the top of the machine. On 12/5/22 at 10:25 a.m., Resident 194 was observed as she rested on her bed. The oxygen tubing and bipap tubing remained undated or labeled. The bipap mask was laying, unbagged, on the top of the machine. On 12/1/22 at 2:29 p.m., Resident 194's medical record was reviewed. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia. The physician's orders indicated O2 (oxygen) on per n/c (nasal canula) at all times at 4 liters every shift, start date 11/23/22. Bipap on Q HS (every night) with O2 on at 4 liters at bedtime, start date 11/23/22.		potential to be affected by the alleged deficient practice. b. Nursing staff educated on Respiratory care provided on 12/30/2022. C. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. DON/designee to audit respiratory care twice weekly x 6 weeks, then weekly x 6 weeks, twice monthly x 3 months and then monthly thereafter. D. How the corrective actions will be monitored to ensure the deficient practice will not recur. a. Review of Respiratory audit tool monthly during QAPI meeting with determination of ongoing monitoring will be completed within the QA process.	

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	155215	A. BUILDING 00 B. WING	12/06/2022

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	The November physician's orders indicated oxygen tubing/humidification bottle, nasal canula, etc. for both concentrator and portable O2 container-ensure new storage bag is provided and all items dated/signed Q (every) week and PRN (as needed) every Sunday. Start date 11/6/22, D/C (discontinue) 11/22/22. The November and December treatment records (TAR) had an order to contact (Name of Oxygen Company) about Resident 194's bipap mask not fitting. There was no initial on the TAR, which would have indicated when they had been contacted. The TAR for the first three weeks of November had documentation to change Oxygen tubing every week. The last week of November and the December TAR did not reflect those orders or have documentation of tubing changed. A discontinue date was listed as 11/22/22. The last change date was listed as 11/20/22. On 12/5/22 at 11:24 a.m., during an interview, the Regional Consultant indicated Resident 194's oxygen and bipap tubing should have been changed and dated each week. It appeared the order had been discontinued from her record, possibly in error. The facility did have longer oxygen tubing she could provide for her. They would call the oxygen company to come adjust her mask size. On 12/2/22 at 3:00 p.m., a policy on oxygen and bipap tubing change was requested but not provided during the survey. 3.1-47(a)(6)			

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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 observation, interview, and record review, the facility failed to perform and document pre and post assessments for 1 of 1 residents reviewed for dialysis. Findings include: On 12/1/22 at 10:09 a.m., Resident 13 was observed and interviewed as she rested on her bed. She indicated she was tired and sleepy. She had dialysis three (3) times a week. On 12/1/22 at 10:39 a.m., Resident 13's medical record was reviewed. The diagnoses included, but were not limited to chronic kidney disease, stage 5 (severe kidney disease). A review of the scanned in assessments showed the last pre and post dialysis assessments available in the record were dated 5/23/22. The physician's order set did not have an order for the resident to have dialysis. The treatment record did not indicate the nursing staff was assessing the resident's port/fistula or access site. There was no entry for an assessment to have been documented. A copy of pre and post assessments, for the past month, was requested for review.	F 0698	F698 Dialysis A. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. a. Resident 13- Physician orders obtained on 12/05/2022 pre and post dialysis assessments. B. 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. a. No other residents receive hemodialysis. C. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. Nursing staff educated on pre/post dialysis assessments on 12/20/2022. b. DON/designee to audit dialysis Pre/Post assessments twice weekly x 6 weeks, then weekly x 6 weeks, twice monthly x 3 months and then monthly thereafter D. How the corrective actions	01/03/2023

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	On 12/5/22 at 9:50 a.m., during an interview, Registered Nurse (RN) 16 indicated Resident 13 went to dialysis on night shift, every Monday, Wednesday and Friday. When she returned, on day shift, she checked her dialysis binder for any notes from the dialysis center. They always recorded her weight and vital signs taken during her dialysis procedure. The staff here at the facility needed to check vital signs and her access site for bruit and thrill. Her son transported her to and from dialysis appointments. On 12/5/22 at 2:55 p.m., a second request was made to view pre and post dialysis assessment documentation. The Regional Consultant indicated they did not have pre and post dialysis assessments for Resident 13. On 12/5/22 at 8:00 a.m., the Regional Consultant provided a current policy, dated September 2010, titled "End-Stage Renal Disease." This policy indicated "Residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care...the care of grafts and fistulas...." 3.1-37(a)		will be monitored to ensure the deficient practice will not recur. a. Review of audit tool monthly during QAPI meeting with determination of ongoing monitoring will be completed within the QA process.	
F 0809 SS=F Bldg. 00	483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14			

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	hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. Based on observation, interview, and record review, the facility failed to ensure all residents were provided with an evening snack when the time lapse between the dinner and breakfast period exceeded fourteen (14) hours. This deficient practice had the potential to effect 88 of 88 residents who received meals from the kitchen. Findings include: On 12/5/22 at 10:30 a.m., during a telephone interview, Resident B indicated she had been a resident at the facility, for rehabilitation, for about a month. She did not like some of the meals that were served. Sometimes family brought in meals so she would not be hungry. She was never given a snack between meals or at bedtime. She was not aware of any snacks having been available. No one ever offered her a snack, even if she did not eat her meal. A review of the mealtimes, posted outside the main dining room (DR) indicated Breakfast was served from 8:00 to 8:15 a.m., Lunch was served from 12:00 to 12:15 p.m., and Dinner was served from 5:00 p.m. to 5:15 p.m. There was no posting	F 0809	F809 Frequency of Meals/Snacks at bedtime A. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. a. Resident B- No longer resides and has discharged from the campus. Campus has reviewed all meal signage and added snack choices to inform all residents of “always available” options. All dietary staff have been educated on frequency of meals. B. 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. a. All Residents have the potential to be affected by this practice. C. What measures will be put into place and what systemic changes will be made to ensure	01/03/2023

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	of snacks or a time for bedtime snacks on the time schedule or daily menu posting. Room service to other halls started at 7:45 a.m. in Caring Hands and was staggered throughout the building with the ending mealtime service listed as 6:00 p.m., on the Grove. On 12/5/22 at 11:04 a.m., during an interview, the Registered Dietician (RD) indicated she didn't know if snacks were provided to all residents, some had orders for bedtime snacks. Those were prepared by the kitchen and documented in the medical record by the nursing staff. On 12/5/22 at 11:31 a.m., during a random observation of the Rehabilitation Hall pantry, and interview with the Dietary Manager (DM), a small mini refrigerator had 2 pre-made containers of Jell-O inside, nothing else. Inside a bottom cabinet of the pantry, next to the sink, a box/container had some graham crackers and other individual wrapped crackers. There were also two individual packets of pre-made Jell-O and some granola bars. She indicated snacks were in all the nourishment rooms (on each hall). The kitchen was locked at night, but they brought out a cart and stocked the nourishment rooms at the end of the day. A resident who did not have an order for a bedtime snack would have to ask for a snack, they were not automatically provided to all residents. On 12/5/22 at 11:34 a.m., the RD provided a list of snacks available in the nourishment rooms on each hall. The list indicated granola bars, cheese crackers, peanut butter crackers, apple sauce, fruit cups, Jell-O, pudding and graham crackers. She indicated she was not aware that there was 15 hours between dinner and breakfast, but she had looked at the schedule of mealtimes and identified		that the deficient practice does not reoccur. a. Nursing staff educated on frequency of meals and regulation on time between dinner and breakfast. All food pantries have been reviewed, audited and provided additional items b. ED/designee to audit food pantries twice weekly x 6 weeks, then weekly x 6 weeks, twice monthly x 3 months and then monthly thereafter. ED/Designee to audit/interview at random Residents for snacks being offered twice weekly x6 weeks, then weekly x6 weeks, twice monthly x3 months and then monthly thereafter. D. How the corrective actions will be monitored to ensure the deficient practice will not recur. a. Review of audit tool monthly during QAPI meeting with determination of ongoing monitoring will be completed within the QA process.	

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	it was 15 hours. On 12/5/22 at 11:58 p.m., during an interview, the Activity Director (AD) indicated mealtimes or snacks had never been discussed in resident council. On 12/5/22 at 12:10 p.m., the Regional Consultant provided a current policy, dated July 2017, titled, "Frequency of Meals." This policy indicated "...The facility will serve at least three (3) meals or their equivalent daily at scheduled times. There will not be more than a fourteen (14) hour span between the evening meal and breakfast...A schedule of mealtimes and snacks shall be posted in resident areas...Nourishing snacks will be available for residents who need or desire additional food between meals. Evening snacks will be offered routinely to all residents...Residents will also be offered nourishing snacks if the time span between the evening meal and the next day's breakfast exceeds fourteen (14) hours. Nourishing snacks are items from the basic food groups, offered either separately or with each other...The facility will choose the snacks that are served at bedtime. However, the dietician and food services manager will solicit input from the residents and/or the resident council...." This Federal tag relates to Complaint IN00389098. 1.3-21(d)			
F 0882 SS=F Bldg. 00	483.80(b)(1)-(4) Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's			

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	IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. Based on interview and record review, the facility failed to designate a qualified person that worked at least part-time to fulfill the role of the Infection Preventionist (IP) for 5 of 5 days of the survey. This deficient practice had the potential to effect 88 of 88 residents. Findings include: The facility employed a Qualified Medication Aide (QMA) 34 to conduct Infection Preventionist (IP) roles for the facility with the Director of Nursing (DON) to oversee the program. QMA 34 was designated as the IP for the facility. She conducted all the COVID-19 testing for staff and residents and other duties assigned by the DON. On 12/6/22 at 10:40 a.m., during an interview with the DON, she indicated that QMA 34 was the IP. The DON indicated that she supervised and signed off on IP tasks. The DON indicated that QMA was working as an assistant for her. QMA 34 was delegated to do tasks related to COVID-19 but the ultimate responsibility for IP was her.	F 0882	F882 Infection preventionist qualification/role A. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. a. No residents affected by the alleged deficient practice. B. 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. a. All residents have the potential to be affected by alleged deficient practice. b. DON educated on IP qualifications 12/30/2022. C. What measures will be put into place and what systemic changes will be made to ensure	01/03/2023

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	The DON provided a job description for QMA 34. It did not include tasks that the QMA was assigned related to her IP role. Both the DON and QMA went to class to become IP certified, however, neither meet the criteria of the standards of an IP. A policy titled, "Coronavirus Disease (COVID 19)-Vaccination of Staff," dated January 2022, provided by the Regional Clinical Nurse on 11/30/22 at 2:30 p.m., indicated, " ...The infection preventionist maintains a tracking worksheet of staff member and their vaccination status. The tracking worksheet provides the most current vaccination status of staff who provide any care, treatment, or other services for the facility and/or its residents. The worksheet includes a.) staff name (and/or employee ID), b.) initial start of employment, c.) termination of employment or service (if applicable), d.) job title or role, e. assigned work area, g.) 1.) The specified vaccine received, 2.) Dates of each dose, 3.) Date of the next scheduled dose (for multi-dose vaccine), and 4.) Any booster doses (date and specific type of vaccine), exemption status (type of exemption and documentation) and delays (reason for the delay and date when vaccination can be safely administered). A policy titled, "Coronavirus Disease (COVID 19)-Vaccination of Residents," dated December 2021, provided by the Regional Clinical Nurse on 11/30/22 at 2:30 p.m., indicated, "Facility data on resident vaccine status is reported to the NHSN by the IP, and questions regarding the COVID-19 vaccine or the vaccine program area handled by the IP ...." 3.1-35		that the deficient practice does not recur. a. Qualified IP appointed on 01/03/2022. D. How the corrective actions will be monitored to ensure the deficient practice will not recur. a. IP certification to be reviewed annually by DON/designee.	

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F 9999 Bldg. 00	3.1-14 PERSONNEL (s) Professional staff must be licensed, certified, or registered in accordance with applicable state laws or rules. This state rule was not met as evidenced by: Based on interview and record review, the facility failed to ensure all working healthcare staff were licensed. This deficient practice had the potential to effect 88 of 88 residents. Findings include: On 12/6/22 at 1:45 p.m., a review of the facility's licensed staff was conducted. During this review, it was observed that Certified Nursing Aide (CNA) 29 license was expired on 11/18/22. The facility failed to ensure she had an active and current license. On 12/6/22 at 2:30 p.m., an interview was conducted with the Director of Nursing (DON). She indicated that CNA 29 was a current employee of the facility and that she worked at the facility even after her license expired. The DON provided a list of dates that CNA 29 worked after her license expired. The total numbers of days were 13. She worked 11/19/ to 11/21, 11/23 to 11/25, 11/28 to 11/30, and 12/2 to 12/5/22. CNA 29's license was renewed on 12/5/22. No policy was provided.	F 9999	F9999 Personnel What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. a. All residents have the potential to be affected by this practice. Identified staff members have completed licensure renewal and are in compliance with state and federal licensing requirements. B. 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. a. All residents have the potential to be affected by alleged deficient practice. b. Staff member educated, in addition to HR director and scheduler. C. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur. a. A licensure review was completed to ensure all license holders are within compliance parameters. Following will be completed on hire and annually thereafter D. How the corrective actions will be monitored to ensure the deficient practice will not recur.	01/03/2023

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			a. Monthly, HR/ED will review all license holders during QAPI meeting to ensure accuracy and timeliness of renewal.	