STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155820	A. BUILDING 00 B. WING	03/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
APERION CARE LINCOLN	1236 LINCOLN AVE EVANSVILLE, IN 47714

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: February 26, 27, 28, 29, and March 4, 2024 Facility number: 000443 Provider number: 155820 AIM number: 100289580 Census Bed Type: SNF/NF: 32 Total: 32 Census Payor Type: Medicare: 1 Medicaid: 27 Other: 4 Total: 32 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 13, 2024.	F 0000	By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility respectively requests the 2567 plan of correction to be considered our allegation of compliance **effective March 28, 2024** to the State findings of the Annual survey conducted on March 4, 2024	
F 0585 SS=E Bldg. 00	483.10(j)(1)-(4) Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents,			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Teri McNeely	Administrator	03/27/2024

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

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	and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance			

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	process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey			

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	Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. Based on interview and record review, the facility failed to ensure grievances were documented and resolved for 3 anonymous residents interviewed and 9 of 9 residents who attended Resident Council. Findings include: 1. In an anonymous interview, a resident indicated a complaint was made to the Social Services Director (SSD) in January 2024 about a housekeeper who had been disrespectful to the resident. The resident indicated they didn't want the housekeeper to clean their room anymore. At that time, the resident indicated the complaint was never followed up on, and the housekeeper still cleaned their room, but they don't talk to each other. 2. In an anonymous interview, a resident indicated a complaint was made to the Administrator about a staff member who spoke harshly to them about the use of a call light. The resident indicated the Administrator followed up with them about the call light, but not about the behavior of the staff member. 3. In an anonymous interview, a resident indicated the procedure to file a grievance was to write it down on a piece of paper and give it to a staff member. At that time, they indicated they previously handed a complaint to the Director of	F 0585	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* **Residents spoke anonymously so no specific residents were known to be adversely affected by the alleged deficient practice. SSD will meet with all cognitively-intact residents and complete a training on how to fill out the grievance forms and where they are located throughout the building. Activities will remind residents of this information during all subsequent council meetings. Previous DON listed in complaint by anonymous resident is no longer a member of the facility.** *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* **All residents have potential to be affected by this alleged deficient practice. SSD will meet with all cognitively-intact residents and complete a training on how to fill out the**	03/28/2024

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	Nursing (DON) and it was never responded to. They indicated that suggestions usually "go in one ear and out the other". 4. During a resident council meeting on 2/27/24 at 2:03 P.M., all 9 residents in attendance indicated they did not know how to file a grievance or make a complaint outside of the resident council meeting. 5. On 2/27/24 at 10:45 A.M., grievances received in the past 6 months were requested. The Administrator indicated that no grievances had been received since May 2023. On 2/28/24 at 9:40 A.M., the SSD indicated that when a resident had a complaint about anything, she would offer the grievance form for the resident to fill out. If the resident declined to fill out the form, the SSD would send a text message to the appropriate department to take care of the complaint. At that time, she indicated those complaints and resolutions did not get documented anywhere, and if it did not get resolved she would know because the resident would "keep complaining". She indicated that she did not write down grievances or complaints about staff and instead took those directly to the Administrator to handle. At that time, she could not recall any complaints regarding a conflict with a housekeeper. The SSD indicated that the resident council had its own forms that they use for complaints made during the resident council meetings, and the Activities Department handled those. On 2/28/24 at 10:05 A.M., resident council minutes and complaint forms from September to February were reviewed. No complaints regarding staff or housekeeper conflicts were found.		**grievance forms and where they are located throughout the building. Activities will remind residents of this information during all subsequent council meetings.** *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* **In-service will be held by RVP with SSD, Activity Director and Administrator to go over Grievance policy and expectations for meeting criteria. Morning report held with IDT will contain section to include current grievances and resolutions so Administrator is aware and grievance has resolution.** *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* **An audit tool will be developed and implemented to monitor that there are no outstanding grievances. The audit tool will be completed by the Administrator/designee weekly for eight weeks and monthly for 4 months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.**	

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At 2/28/24 at 12:20 P.M., the Administrator indicated that if a resident was "scared", the complaint would be documented and investigated, but if it was "just a personality conflict", there would be a conversation with the resident and staff member that would not get documented. At that time, she indicated no resident-staff conflicts had occurred in the past 3 months that were documented or undocumented.

On 2/28/24 at 3:49 P.M., the Admissions Agreement was reviewed. The Admissions Agreement indicated "The Facility's policy is to support the resident's right to voice concerns and to ensure that after a concern has been received, the Facility will explore the concern, act to resolve the issue and communication [sic] the resolution to the Resident".

On 2/29/24 at 9:56 A.M., the MDS (Minimum Data Set) Coordinator provided a current Filing Grievances/Complaints policy, revised 2004, that indicated "Grievance and/or complaints may be submitted orally or in writing ... The resident, or person filing the grievance and/or complaint in [sic] behalf of the resident, will be informed of the findings of the investigation and the actions that will be taken to correct any identified problems ... A written summary of the report will also be provided to the resident, and a copy will be filed in the business office".

On 2/29/24 at 9:56 A.M., the MDS Coordinator provided a current Grievance/Complaint Log policy, revised December 2004, that indicated "the disposition of all resident grievances and/or complaints will be recorded on our facility's Resident Grievance/Complaint Log ... The Social Service Director will be responsible for recording

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	and maintaining this log". 3.1-7(a)(2) 3.1-7(b)			
F 0636 SS=D Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information			

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	regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on record review and interview, the facility failed to ensure the Admission Minimum Data Set (MDS) Assessment was completed timely within 14 days of admission for 1 of 2 new admission residents reviewed. (Resident 135) Finding includes: On 2/26/24 at 2:39 P.M., Resident 135's clinical record was reviewed. Resident 135 was admitted to the facility on 2/1/24. The Admission Minimum Data Set (MDS) Assessment, dated 2/1/24, indicated it was still in process and not completed.	F 0636	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* **Resident 135 was not adversely affected by the alleged deficient practice. MDS Coordinator has since completed the assessment.** *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective*	03/28/2024

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	During an interview on 3/4/24 at 10:16 A.M., the MDS Coordinator indicated the MDS Assessment was not completed within 14 days of admission. A policy was requested but not provided. The MDS Coordinator stated the facility follows RAI (Resident Assessment Instrument) Manual guidelines that indicate "For the Admission Assessment, the MDS Completion Date must be no later than 13 days after the Entry Date". 3.1-31(d)(1)		*actions will be taken?* **All residents have the potential to be affected by the alleged deficient practice. A baseline audit will be completed by MDS to show assessments are completed and up to date or needing to be completed by date of compliance.** *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* **In-service with MDS Coordinator will be held per Administrator related to the timely completion of assessments per the RAI guidelines.** *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* **Audit tool will be developed and implemented to monitor that correct information related to assessments are in place and completed timely within the 14-day period. This audit tool will be completed by MDS Coordinator/designee weekly for 8 weeks and monthly for four months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.**	

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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 interview and record review, the facility failed to ensure the MDS (Minimum Data Set) Assessment was completed accurately for 1 of 5 residents reviewed for unnecessary medications. (Resident 23) Finding includes: On 2/27/24 at 2:27 P.M., Resident 23's clinical record was reviewed. Diagnosis included, but was not limited to, atrial fibrillation. The most recent quarterly MDS Assessment, dated 12/18/23, indicated Resident 23 was cognitively intact and did not receive an anticoagulant during the 7-day look back period. Current physician orders included, but were not limited to: Eliquis (an anticoagulant) Tablet 5 MG (milligrams) - Give 5 mg by mouth two times a day for blood thinner related to atrial fibrillation, dated 8/17/23. The December 2023 MAR (medication administration record) indicated Resident 23 received Eliquis twice daily in December. On 2/29/24 at 2:20 P.M., the MDS Coordinator indicated that the Eliquis should have been coded as an anticoagulant on the 12/18/23 quarterly MDS Assessment and was overlooked. At that time, the MDS Coordinator indicated that the facility followed the RAI (Resident Assessment Instrument) user's manual.	F 0641	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* **Resident 23 was not adversely affected by the alleged deficient practice. IDT aware of resident's needs and MDS completed an accepted modification to show correct findings related to Resident 23 anti-coagulant during Annual Survey of 3-4-24.** *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* **No other residents were affected by the alleged deficient practice. Audit of current residents on anti-coagulants completed during daily clinical meetings. MDS Coordinator will work with IDT to monitor that all current orders or changes are discussed and updated.** *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* **In-Service will be held with MDS Coordinator per**	03/28/2024

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			Administrator regarding regulations and expectations of inputting information appropriately on MDS. Administrator will work with new company to ensure MDS has access to future trainings and oversight from regional company directors. *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* **Audit tool will be developed and implemented to monitor that correct information related to anti-coagulants and look back periods are in place. This audit tool will be completed by MDS Coordinator/designee weekly for 8 weeks and monthly for four months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.**	
F 0655 SS=D Bldg. 00	483.21(a)(1)-(3) Baseline Care Plan §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care			

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	plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.			
	Based on record review and interview, the facility failed to develop a base line care plan for 1 of 2 residents reviewed for dementia care, respiratory care, and antipsychotic medications. (Resident 85)	F 0655	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?*	03/28/2024

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	Finding includes: On 2/28/24 at 10:20 A.M., Resident 85's clinical record was reviewed. The resident was admitted to the facility on 2/23/24. Diagnoses included, but were not limited to, dementia in other diseases classified elsewhere, unspecified severity with other behavioral disturbances, and chronic obstructive pulmonary disease with exacerbation. Physician orders included, but were not limited to: Aricept (a cognition-enhancing medication) Oral Tablet 5 MG (Milligrams) (Donepezil Hydrochloride), Give 1 tablet by mouth at bedtime related to dementia in other diseased classified elsewhere, unspecified severity with other behavioral disturbances, dated 2/23/24. Buspirone (an antianxiety medication) HCl Oral Tablet 5 MG (Buspirone HCl). Give 1 tablet by mouth two times a day related to anxiety disorder, dated 2/23/24. Inatropium Bromide Inhalation Solution 0.02% (Inatroprium Bromide) 1 vial inhale orally three times a day for wheezing related to obstructive pulmonary disease with (acute) exacerbatrion dated 2/24/24. O2 (oxygen) at 2LPM (liters per minute) at night as needed every evening and night shift related to chronic obstruction pulmonary disease, dated 2/23/24. The admission MDS (Minimum Data Set) Assessment was still pending completion. The chart lacked a baseline care plan related to dementia care, antipsychotic medications, and		**Resident 85 was not adversely affected by the alleged deficient practice. The baseline care plan for that resident has now been completed and is in compliance.** *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* **All new residents have the potential to be affected by the alleged deficient practice. An audit tool was created to monitor that each new admit will have baseline care plan initiated in timely and accurate fashion as per policy to meet regulation.** *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* **An in-service will be completed with all staff associated with creating baseline care plans in accordance with the regulation and the expectation that they will be completed timely and accurately. Failure to comply with this will result in corrective action.** *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* **An audit tool will be developed**	

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	respiratory care. During an interview on 2/28/24 at 10:51 A.M., the Social Services Director indicated care plans were developed based on conversations and information obtained during the intake assessment and from the hospital or other facility. The care plan should be personalized with the goals and interventions based on behaviors, diagnosis, and cognition of the residents. Medications such as antipsychotics should be care planned when the medication was ordered. On 2/29/24 at 3:15 P.M, a current "Care Plan Development and Review" policy, dated 10/2014, was provided by the Administrator. The policy indicated "... a preliminary care plan is developed upon admission. All disciplines must initiate a care plan addressing pertinent issues related to the care of the resident".		**and implemented to monitor that upon admission all residents will have a baseline care plan that meets regulations on accuracy and timeliness. This audit tool will be completed by DON/designee Monday to Friday for four weeks, weekly for eight weeks and monthly for three months. The outcome of this audit tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.**	
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and			

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	(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	Based on interview and record review, the facility failed to develop and implement care plans for 2 of 3 residents reviewed for urinary tract infections and 3 of 5 residents reviewed for unnecessary medications (Resident 9, Resident 26, Resident 17, Resident 30, and Resident 32). Findings include:	F 0656	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* **Residents 9, 26,17, 30 and 32 were not adversely affected by the alleged deficient practice.** **MDS Coordinator and Social Services Director will update**	03/28/2024

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	1. On 2/27/24 at 1:06 P.M., Resident 9's clinical record was reviewed. Resident 9 was admitted to the facility on 6/30/17. Diagnoses included, but were not limited to, Multiple Sclerosis, epilepsy, and schizoaffective disorder. The most recent Annual MDS (Minimum Data Set) Assessment, dated 12/4/23, indicated Resident 9 was severely cognitively impaired and required extensive assistance from two staff members for toileting. Physician orders included, but were not limited to: Keppra (anticonvulsant) Tablet 1000 MG (milligrams) - Give 1 tablet by mouth two times a day for seizures related to epilepsy, start date 3/5/2020. Cranberry Tablet 450 MG - Give 2 tablets by mouth at bedtime for urinary supplement, start date 9/14/2022. A progress note, dated 12/12/23 at 10:09 A.M., indicated Resident 9 "does have a history of recurrent urinary tract infections." The clinical record lacked a care plan related to monitoring for signs and symptoms related to the diagnosis of epilepsy or the monitoring of medication Resident 9 received for epilepsy. The clinical record lacked documentation that Resident 9's history of frequent urinary tract infections had been recognized and no care plan had been created. 2. On 2/28/24 at 10:57 A.M., Resident 32's clinical record was reviewed. Resident 32 was admitted to the facility on 5/5/23. Diagnoses included, but were not limited to, anxiety, heart failure, and		**all care plans to reflect correct and current diagnoses and medications.** *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* **All residents have the potential to be affected by the alleged deficient practice. All current residents were audited by MDS Coordinator and Social Services Director and their care plans will be updated to reflect current medications and diagnoses by date of compliance.** *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* **In-service with MDS Coordinator and Social Services Director per Administrator to go over policy and expectation for completing care plans with all current diagnoses and medications. In-service will also include the expectation to monitor and update any changes so care plan is current.** *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* **An audit tool will be put in**	

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	anemia. The most recent Quarterly MDS Assessment, dated 2/5/24, indicated Resident 32 was cognitively intact and required supervision from staff during transfers and eating. The 7-day lookback period of the MDS Assessment indicated Resident 32 had taken antianxiety, antidepressant, and anticoagulant medications. Physician orders included, but were not limited to: Sertraline (antidepressant) Tablet 100 MG - Give 1.5 tablet by mouth at bedtime related to anxiety, start date 12/28/2023. Xanax (antianxiety) Oral Tablet 0.5 MG - Give 0.5 mg by mouth two times a day related to anxiety, start date 12/19/2023. Apixaban (anticoagulant) Oral Tablet 2.5 MG - Give 1 tablet by mouth two times a day related to heart failure, start date 5/5/2023. The clinical record lacked care plans related to the antidepressant, antianxiety, or anticoagulant medication taken by Resident 32. 3. On 2/29/24 at 8:59 A.M., Resident 30's clinical record was reviewed. Diagnoses included but were not limited to, unspecified dementia, unspecified severity, with other behavioral disturbance and Parkinson's disease without dyskinesia, with fluctuation. The most recent Quarterly MDS Assessment, dated 12/4/23, indicated that the resident was cognitively impaired and needed extensive assistance with mobility, transfer and eating. The 7-day look back indicated the resident was on an antipsychotic and an antidepressant.		**place to monitor the completion and updating of care plan related to diagnoses and medications and any changes or monitoring needed. This tool will be used Monday to Friday daily for 4 weeks, weekly for 8 weeks and monthly for 3 months. It will be implemented and monitored by the MDS/designee. This outcome of this audit tool will be reviewed at Quality Assurance meeting to determine if any additional action is warranted.**	

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	Current physician orders included, but were not limited to: Risperdal (an antipsychotic) oral tablet 0.5 MG - Give 1 tablet by mouth at bedtime for depression related to major depressive order unspecified, dated 10/9/23. Escitalopram (an antidepressant) Oxalate oral tablet 10 MG - Give 1 tablet by mouth one time a day for depression related to major depressive disorder, recurrent, unspecified dated 10/9/23. The clinical record lacked a current comprehensive care plan related to dementia care and antipsychotic medications. 4. On 2/27/24 at 11:01 A.M., Resident 17's clinical record was reviewed. The resident was admitted to the facility on 8/31/23. Diagnoses included, but were not limited to, insomnia and narcolepsy with cataplexy. The most recent Quarterly MDS Assessment, dated 12/11/23, indicated Resident 17 was cognitively intact and received a hypnotic medication during the 7-day look back period. Current physician orders included, but were not limited to: Ramelteon (a hypnotic medication) Oral Tablet 8 MG - Give 1 tablet by mouth at bedtime related to insomnia, dated 8/31/23. Modafinil (a stimulant medication) Oral Tablet 200 MG - Give 1 tablet by mouth one time a day for narcolepsy, dated 11/29/2023. The clinical record lacked a care plan related to monitoring for signs and symptoms related to the diagnosis of narcolepsy or the monitoring of medication Resident 17 received for narcolepsy.			

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The clinical record lacked a care plan related to monitoring for signs and symptoms related to the diagnosis of insomnia or the monitoring of medication Resident 17 received for insomnia.

5. On 2/28/24 at 11:21 A.M., Resident 26's clinical record was reviewed. Resident 26 was admitted to the facility on 1/27/21. Diagnoses included, but were not limited to, chronic kidney disease and functional urinary incontinence.

The most recent Annual MDS Assessment, dated 1/25/24, indicated the resident had moderate cognitive impairment and required extensive assistance of 1 staff for toileting.

Current physician orders included, but were not limited to:
Macrobid (an antibiotic) Oral Capsule 100 MG - Give 1 capsule by mouth at bedtime for UTI (urinary tract infection) prevention until 03/18/2024, dated 2/23/24.

An IDT (Interdisciplinary Team) note, dated 12/21/23 at 10:52 A.M., indicated the resident was scheduled to see a urologist on January 29th for "problems with recurrent UTIs".

Progress notes indicated that Resident 26 was on antibiotics for UTIs with start dates of 10/18/23, 11/14/23, 1/11/24, and 2/13/24.

A current bladder incontinence care plan, initiated 1/27/21, included an intervention to monitor for signs and symptoms of UTI, dated 1/27/21. This care plan and interventions have not been revised since 1/27/21.

A current chronic kidney disease care plan,

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	initiated 1/27/21, included an intervention to monitor for signs and symptoms of UTI, dated 1/27/21. This care plan and interventions have not been revised since 1/27/21. The clinical record lacked a care plan related to UTIs or recurring UTIs. On 2/28/24 at 9:20 A.M., the MDS Coordinator indicated that any diagnosis for which the resident received medication got added to the care plan whether the resident was admitted with it or the physician ordered it after admission. In addition, anything that the IDT or family identified would be added to the care plan. On 2/29/24 at 2:20 P.M., the Infection Preventionist (IP) indicated that there should be a care plan related to UTIs if the resident had one and there was another more specific care plan that was used for recurrent UTIs. On 2/29/24 at 3:47 P.M., the MDS Coordinator provided a current Care Plan Development and Review policy, dated 10/2014, that indicated "Care plans shall be revised with changes in the resident's condition. Changes in the resident's care as a result of condition change should be promptly addressed on the care plan (i.e. physician orders, diet changes, therapy changes, behavior changes, ADL changes, skin conditions, etc)". 3.1-35(a) 3.1-35(d)(2)(B)			
F 0690 SS=G Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that			

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	resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on observation, interview, and record review, the facility failed to ensure effective treatment and services were provided to residents with Urinary Tract Infections (UTIs) in 2 of 3 residents reviewed for UTIs. Urinalysis (UA) and Culture and Sensitivity (C&S) tests were not	F 0690	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* **Residents 9 and 21 were adversely affected by the alleged deficient practice.**	03/28/2024

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	completed or followed up on, antibiotics were not prescribed in a timely manner, and catheter care was not performed correctly. This deficient practice resulted in Resident 21 being hospitalized for the treatment of pyelonephritis (a kidney infection). (Resident 21 and Resident 9) Findings include: 1.On 2/29/24 at 11:19 A.M., Resident 21's clinical record was reviewed and indicated the resident was re-admitted to the facility from a hospital on 10/25/23 with a newly initiated indwelling urinary catheter and diagnoses including, but not limited to, chronic kidney disease, obstructive and reflux uropathy, and acute kidney failure. The most current Quarterly MDS (Minimum Data Set) Assessment, dated 1/17/24, indicated Resident 21 was cognitively intact, had an indwelling catheter, was always incontinent of bowel and bladder, and received an antibiotic during the 7-day look back period. The physician orders from 10/11/23 to 10/25/23 related to the indwelling urinary catheter, included: May irrigate/flush with 60cc (cubic centimeters) of normal saline PRN (as needed) plugged or leaking every 24 hours as needed, dated 10/25/23. Use catheter anchor and check every shift. Replace if necessary, dated 10/25/23. The most current indwelling catheter care plan, dated 10/26/23, indicated Resident 21 was re-admitted from the hospital with an indwelling catheter related to an acute kidney injury and enlarged prostate.		**They have both had ATB initiated and all physician orders are being followed as directed. Follow up with urologist or other physician will be completed if necessary and both are being monitored for s/s of additional concerns that warrant further care. Neither resident is currently showing any UTI concerns that have not been addressed in a timely manner and physician orders are current.** *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* **All residents have the potential to be affected by the alleged deficient practice. Training and education will be held with all nursing over policy and expectation for UTI care and follow up.** *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* **DON will address current orders and concerns in daily clinical meeting related to incontinence, catheters or UTI issues.** *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program*	

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	An IDT (Interdisciplinary Team) note, dated 10/26/23 at 11:57 A.M., indicated Resident 21 was re-admitted into the facility on 10/25/23 after a hospitalization for an acute kidney injury with a foley catheter due to an enlarged prostate and obstructive uropathy. A nurse's progress note, dated 11/29/23 at 2:11 P.M., indicated the resident's catheter was removed that morning during an appointment from the urologist and an order was given to re-anchor the catheter if he did not urinate in 6 hours (by 5:30 P.M.). A nurse's progress note, dated 11/30/23 at 2:08 P.M., indicated the indwelling catheter was to remain in place following a failed trial at the urologist's office to discontinue the catheter, and the catheter was to be changed once a month. At that time, the resident was scheduled for a cystoscopy (a procedure to view the inside of the bladder). The progress note did not include documentation to indicate the urology physician's order to change the indwelling urinary catheter monthly was included in the resident's orders or was forwarded to the PCP for approval between 12/1/23 and 12/09/23. . The urology physician orders included, but were not limited to: "Change indwelling catheter 16fr [French] 10ml [milliliters] Q [every] month and PRN [as needed] every day shift every 30 day[s] for catheter change", dated 12/10/23. A nurse's progress note, dated 12/14/23 at 11:36 A.M., indicated a nurse from the urologist called to give report on Resident 21. The resident had a cystoscopy performed outside of the facility where a new catheter was placed and a urine		*will be put into place?* **An audit tool will be developed and implemented to monitor that all potential UTI changes are reported timely and accurately and with physician directed orders. This tool will be used daily Monday to Friday for four weeks, weekly for eight weeks and monthly for 3 months. . It will be implemented and monitored by the DON/designee. This outcome of this audit tool will be reviewed at Quality Assurance meeting to determine if any additional action is warranted.**	

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	sample was taken for culture. A nurse's progress note, dated 12/15/23 at 7:30 P.M., indicated (name of Nurse Practitioner) received the results of the cystoscopy and culture which the NP forwarded to the urologist. The note indicated the culture report showed growth of Morganella morganii (a bacteria commonly found in the intestinal tract). The nursing progress notes, dated 12/16/23 through 12/18/23, did not include documentation to indicate the facility staff attempted to contact the NP or the urologist to follow-up on the urine culture and sensitivity results received on 12/15/23. A nurse's progress note, dated 12/19/23 at 9:31 A.M., indicated (name of urologist office) was contacted requesting follow-up orders for the culture that showed growth of Morganella morganii. The skilled nursing evaluations, dated 12/19/23 through 12/31/23, indicated no urine or indwelling urinary catheter abnormalities were identified. The skilled nursing evaluation, dated 12/26/23, indicated the indwelling urinary catheter was last changed on 12/1/23. The December 2023 Medication Administration Record (MAR), Treatment Administration Record (TAR), and nursing progress notes did not include documentation to show the indwelling urinary catheter was changed between 12/14/23 and 12/31/23 or the facility followed up with the urologist after 12/19/23 to ensure the urine culture findings were effectively addressed.			

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	A skilled nursing evaluation, dated 1/4/24, indicated facility staff changed the indwelling urinary catheter on 1/1/24. The evaluation did not include documentation to specifically determine the characteristics of the procedure. A skilled nursing evaluation, dated 1/6/24, indicated facility staff changed the indwelling urinary catheter ten months in the future, on 12/14/24. A skilled nursing evaluation, dated 1/7/24, indicated the facility changed the indwelling urinary catheter seven days in the future, on 1/14/24. The January 2024 Medication Administration Record (MAR), Treatment Administration Record (TAR), and nursing progress notes did not include documentation to show the indwelling urinary catheter was changed between 1/1/24 and 1/10/24 or to show the resident was effectively monitored for signs/symptoms of adverse outcome of indwelling urinary catheter placement. The nursing progress notes and skilled nursing evaluations, dated from 1/1/24 through 1/10/24, indicated Resident 21 did not experience any adverse signs or symptoms related to the use of an indwelling urinary catheter. A nurse's progress note, dated 1/11/24 at 11:34 A.M., indicated that Resident 21 had been having "milky drainage" that was "changing to a bright green tint". Orders were given by the NP (Nurse Practitioner) to change out the catheter and obtain a urine specimen to check for a UTI. The last UA (urinalysis) showed growth of Morganella morganii, but the urologist had never returned the facility's phone call to follow up.			

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Documentation of attempted contacts to the urologist or Medical Director between 12/19/23 and 1/11/24 was requested from the Infection Preventionist (IP). During an interview on 3/4/24 at 10:10 A.M., the IP indicated no documentation could be provided to show attempts were made by facility staff to contact the NP or the urologist for follow-up of the culture and sensitivity results after 12/19/23.

The January 2024 MAR indicated the indwelling urinary catheter was changed on 1/11/24.

A nurse's progress note, dated 1/11/24 at 8:00 P.M., indicated the catheter was changed and approximately 120 ml of amber colored, cloudy urine with sediment and odor was observed on return. At that time, a urine specimen was obtained.

A nurse's progress note, dated 1/12/24 at 10:32 A.M., indicated new orders were received to start ciprofloxacin (an antibiotic) twice a day for 5 days for UTI.

A nurse's progress note, dated 2/4/24 at 5:21 A.M., indicated Resident 21 had "greenish discharge" around the catheter.

A nurse's progress note, dated 2/5/24 at 9:50 P.M., indicated the catheter was changed and a urine specimen was collected and was sent off for testing at (name of hospital).

A nurse's progress note, dated 2/7/24 at 4:43 P.M., indicated the urine culture showed colonization and no new orders were received.

The February 2024 MAR indicated the catheter

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	was changed on 2/11 and 2/12. The nursing progress notes did not include documentation to show the procedure was performed or the resident's response to the procedure. A nurse's progress note, dated 2/17/24 at 1:44 P.M., indicated the resident said he could feel urine leaking from around his catheter. An order was received for Pyridium (an analgesic pain reliever) three times a day for two days. The nursing progress notes and the skilled nursing assessments, dated from 2/17/24 through 2/18/24 at 2:00 A.M., did not include documentation to show the facility effectively assessed or monitored the resident for signs and symptoms of adverse outcomes related to indwelling urinary catheter use. A nurse's progress note, dated 2/18/24 at 2:14 A.M., indicated the resident's penis and scrotum were swollen and "bright red, raw to the touch and painful" with thick viscous yellow drainage come from the urethral opening. At that time, the resident complained of bladder spasms and indicated "he never had them before arriving and his catether [sic] is pulled on daily causing irriation [sic]". At that time, an ABD (abdominal) pad was placed under the urethral opening to collect drainage. Blood pressure was 146/74 and resident was "afebrile". PRN Tylenol was administered and was assessed to be "slightly effective". The note did not include sufficient documentation to show Pyridium was administered for pain in accordance with the plan of care or to show staff implemented other interventions for pain relief. A nurse's progress note, dated 2/18/24 at 4:48 A.M., indicated the resident was given a dose of			

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	Pyridium once it arrived from the pharmacy. The provider was notified of the previous assessment and no new orders were given. The NP would see the resident on 2/19/24. A nurse's progress note, dated 2/18/24 at 9:53 A.M., indicated there was a moderate amount of urine and drainage on the ABD pad. The nurse's progress and skilled evaluation notes from 2/18/24 at 9:54 A.M. to 2/20/24 at 4:22 P.M. did not include sufficient documentation to determine facility staff updated the NP or urologist regarding the resident's significant change in condition or that the resident was seen by the NP or urologist on 2/19/24. A nurse's progress note, dated 2/20/24 at 4:33 P.M., indicated that the resident was "noted to be confused, having difficulty forming complete sentences and trouble answering any questions". The urine in the catheter was dark amber with a large amount of thick sediment. A call was placed to NHT (Nursing Home Triage) (a communication line for the Physician) and orders were received for a CBC (complete blood count), renal panel, and UA (urinalysis) and C&S (culture and sensitivity). A nurse's progress note, dated 2/20/24 at 5:46 P.M., indicated the catheter was changed and a urine specimen was collected. The urine specimen was documented to have "blood tinged dark amber" urine during initial insertion of catheter and light-yellow urine at the end of the stream. A nurse's progress note, dated 2/21/24 at 1:23 P.M., indicated the resident was "forgetful, had trouble finding his words, very shaky". An order was received to send the resident to the ER (emergency room).			

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A nurse's progress note, dated 2/21/24 at 10:22 P.M., indicated the resident had been admitted to the hospital for Acute Kidney Injury, Parotid mass (a tumor located in the parotid glands), and UTI.

The Emergency Room (ER) physician note, dated 2/21/24, indicated a urine culture obtained from the facility on 2/6/24 was remarkable for Pseudomonas and Enterococcus secondary to colonization, and the resident had not received antibiotics at that time. The resident was admitted to the hospital for treatment.

A hospitalist physician note, dated 2/22/24, indicated a CT (computed tomography) scan of the abdomen and pelvis was performed 2/22/24 and the catheter balloon was inflated within either the prostatic or membranous urethra.

A urologist hospital progress note, dated 2/24/24, indicated "gross hematuria and AKI [acute kidney injury] in the setting of complicated UTI with bacteremia with malposition of chronic Foley [indwelling urinary catheter] and chronic anticoagulation. Unclear when his Foley was last exchanged".

The hospital discharge instructions, dated 2/27/24, indicated Resident 21 was being discharged to the facility with a diagnosis of Pseudomonas bacteremia due to pyelonephritis and an order for IV (intravenous) Zosyn (an antibiotic).

A nurse's progress note, dated 2/27/24 at 4:24 P.M., indicated Resident 21 had been readmitted from the hospital to the facility.

The re-admission physician orders, dated 2/29/24,

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	included, but were not limited to: Zosyn Intravenous Solution 4-0.5 GM (grams) /100ML (milliliter) (Piperacillin Sodium-Tazobactam Sodium in Dextrose) - Use 4.5 gram intravenously every 8 hours for PBP (pseudomonas bacteremia pyelonephritis) until 03/08/2024. Infuse over 4 hours, dated 2/29/24. During an interview on 2/29/24 at 2:20 P.M., the Infection Preventionist (IP) indicated all communication including attempted contacts between staff and other providers should be documented in the progress notes. During an interview on 2/29/24 at 3:30 P.M., the Administrator indicated that the facility attempted to contact the urologist on 12/19/23 concerning the resident and there was no follow up after that until 1/11/24 when the NP looked back at the note. She indicated that the urologist did not get back with the facility. During an interview on 3/4/24 at 8:27 A.M., Certified Nurse Aide (CNA) 9 and CNA 11 were observed performing catheter care for Resident 21. CNA 11 was observed to not retract the foreskin of the penis during care. At that time, the catheter bag was observed to be completely full and urine was observed backed up into the tubing. During an interview on 3/4/24 at 8:45 A.M., CNA 9 indicated that the procedure to clean a male with a catheter was to clean with soap and water from the top of the penis down and then rinse. If the male was uncircumcised the foreskin should be retracted. At that time, CNA 9 indicated she did not retract Resident 21's foreskin because she was in a hurry and nervous. During an interview on 3/4/24 at 9:19 A.M., the			

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	Director of Nursing (DON) indicated when a catheter was changed it should be documented in both the MAR and progress notes. At that time, she indicated that all communication including attempted contacts between staff and other providers should be documented in the progress notes. During an observation on 3/4/24 at 9:30 A.M., the urinary catheter collection bag was observed to be completely full and urine was observed backed up into the tubing. During an interview on 3/4/24 at 10:10 A.M., the MDS Coordinator indicated the dates of catheter changes on the skilled evaluations should have read 12/14/23 and the dates listed were typos. She was unsure why other dates were listed. At that time, she indicated she wasn't sure if the catheter was changed on 2/11/24 or 2/12/24 or both, and that all foley catheter changes should be documented in the nursing progress notes and in the MAR. On 3/4/24 at 11:23 A.M., the Administrator provided a current Acute Condition Changes - Clinical Protocol policy, revised December 2015, that indicated "The Physician will help identify individuals with a significant risk for having acute changes of condition during their stay; for example, an individual with an indwelling urinary catheter who has had recurrent symptomatic urinary tract infections ... The nursing staff will contact the Physician based on the urgency of the situation ... The staff will notify the Medical Director for additional guidance and consultation if they do not receive a timely or appropriate response". On 3/4/24 at 11:23 A.M., the Administrator			

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	provided a current Perineal Care policy, revised October 2010, that indicated "retract foreskin of the uncircumcised male ... The following information should be recorded in the resident's medical record: the date and time that perineal care was given ... any problems noted at the catheter-urethral junction during perineal care ... how the resident tolerated the procedure". 2. On 02/27/24 at 01:06 P.M., Resident 9's Clinical Record was reviewed. Diagnoses included, but were not limited to, Multiple Sclerosis, epilepsy, and schizoaffective disorder. The most recent Annual MDS Assessment, dated 12/4/23, indicated Resident 9 was severely cognitively impaired, was always incontinent of urine and bowels, and required extensive assistance from two staff members for toileting. The nursing progress notes, dated from 6/2/23 at 2:15 P.M. through 7/9/23 at 4:30 A.M., indicated the Resident had abnormal vaginal discharge, the NHT (Nursing Home Triage) (a communication line for the Physician) was notified, and a new order to obtain a urine specimen with culture and sensitivity if indicated was received on 6/3/23 at 2:27 A.M. The notes indicated the facility made one unsuccessful attempt to obtain the urine specimen, but did not include documentation to show the facility staff updated the physician that treatment and services could not be provided in accordance with the plan of care. A Social Service progress note, on 6/7/23 at 11:10 A.M., indicated Resident 9 was interviewed by a social worker but displayed signs of agitation and was unable to answer questions asked. Resident 9's record indicated the following urinary			

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	tract infection occurrences since June 2023: Event 1 A nurse's progress note, dated 7/9/23 at 4:30 A.M., indicated Resident 9 had abnormal vaginal discharge. The progress note indicated NHT was notified and "[NHT nurse] said resident has history of these symptoms, and in the past, they indicated a urinary tract infection." A nurse's progress note, dated 7/9/23 at 3:01 P.M., indicated NHT returned orders to the facility to collect urine and send to lab for a urinalysis, culture and sensitivity test, and vaginal culture. A nurse's progress note, dated 7/10/23 at 2:30 P.M., indicated urine was collected by in and out catheterization (a temporary catheter placed for the period of time to collect a urine specimen) using sterile technique and lab was notified to pick up sample. Documentation to show what time the specimen was picked up by the laboratory staff was not indicated. A nurse's progress note, on 7/12/23 at 10:26 A.M., indicated NHT called the facility and gave orders to start Macrobid (antibiotic) twice a day for 5 days for a urinary tract infection. A lab report, dated 7/12/23, indicated the urine previously collected, on 7/10/23, was contaminated and a culture could not be completed. A nurse's progress note, dated 7/13/23 at 1:02 P.M., indicated staff reported to NHT Resident 9 was still experiencing vaginal discharge and continued to display symptoms reported prior. A nurse's progress note, dated 7/13/23 at 5:12			

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	P.M., indicated a second urine sample was obtained using in and out catheterization. A nurse's progress note, dated 7/14/23 at 4:05 P.M., indicated a vaginal swab was collected and sent to lab for culture. A lab report, dated 7/15/23, indicated the second urine sample, obtained on 7/13/23, was contaminated and a culture could not be completed. The clinical record did not include a lab report for the vaginal swab culture collected on 7/14/23. A nurse's progress note, dated 7/15/23 at 10:05 A.M., indicated new orders were received from the NHT to discontinue Macrobid and repeat urinalysis and culture if Resident 9 experienced vaginal discharge again. The orders did not include sufficient information to determine the clinical indication for stopping the antibiotic. Event 2 A nurse's progress note, dated 11/2/23 at 2:58 P.M., indicated Resident 9 was experiencing urine odor, increased frequency, and altered mental status. NHT gave orders for a urinalysis, and culture and sensitivity, to be collected with in and out catheterization. The clinical record did not indicate when the urine specimen was collected or sent to lab. A nurse's progress note, dated 11/3/23 at 1:59 P.M., indicated an abnormal urinalysis, awaiting final culture and sensitivity results. A lab report, dated 11/3/23, indicated an abnormal urinalysis, including bacteria, increased white			

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	blood cells, nitrites, and blood, but lacked a culture and sensitivity result. The clinical record lacked documentation, from 11/3/23 at 1:59 P.M. through 11/13/23 at 6:02 P.M., showing follow up for the UTI symptoms or the urinalysis results from the urine specimen collected on 11/3/23. Lab reports, including a urinalysis and culture and sensitivity report from urine collected on 11/10/23 at 12:10 A.M., indicated a urine specimen was obtained by clean catch midstream (urine collected during resident-initiated urination) and showed an abnormal urinalysis and culture results; The urine culture result indicated Resident 9's urine was positive for Proteus Mirabilis and E. Coli infections. A nurse's progress note, dated 11/13/23 at 6:02 P.M., indicated a Physician order to start Bactrim (antibiotic) twice a day for five days for the urinary tract infection. A nurse's progress note, dated 11/14/23 at 9:18 P.M., indicated Resident 9 was to remain in contact isolation due to E. Coli/ESBL, until antibiotic therapy was completed. Event 3 A nurse's progress note, dated 12/12/23 at 10:09 A.M., indicated Resident 9 was experiencing foul smelling urine, was more resistive to care than usual, and had a difficult time expressing pain due to cognition. The progress note indicated the NHT was notified. A lab report, dated 12/14/23, indicated the urine specimen, picked up by lab on 12/14/23 at 10:34 P.M., was contaminated during collection on			

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	12/14/23 at 6:30 P.M. A culture and sensitivity result was not provided. A nurse's progress note, dated 12/15/23 at 10:58 A.M., indicated NHT notified the facility that the Nurse Practitioner reviewed the initial urinalysis results and indicated Resident 9 was positive for a urinary tract infection, but would await final culture and sensitivity results before giving antibiotic orders. The clinical record lacked documentation, from 12/15/23 at 10:58 A.M. through 12/22/23 at 3:05 P.M., showing follow up for the UTI symptoms, communication to the physician, or treatment for the positive urinalysis results from the urine specimen collected on 12/14/23. A nurse's progress note, dated 12/22/23 at 3:05 P.M., indicated no orders were given pertaining to the urinalysis on 12/14/23. Event 4 A nurse's progress note, dated 2/2/24 at 11:15 A.M., indicated Resident 9 was experiencing behaviors such as hitting and yelling at staff. A nurse's progress note, dated 2/7/24 at 12:34 P.M., indicated orders, in relation to increased combativeness, were given by the Nurse Practitioner to increase Xanax (sedative) to 0.5 mg (milligrams) twice a day on 2/7/24, and collect a urinalysis and culture and sensitivity. A nurse's progress note, dated 2/8/24 at 1:53 P.M., indicated orders to increase Zoloft (antidepressant) 150 mg (milligrams) on 2/8/24 and monitor for aggression and agitation, and that lab results collected 2/8/24 were contaminated during collection. A recollection of urine was not			

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	performed. A nurse's progress note, dated 2/13/24 at 10:50 A.M., indicated the Nurse Practitioner discontinued the order for a urinalysis, stating Resident 9 was no longer experiencing signs and symptoms of a UTI at this time. Event 5 A nurse's progress note, dated 2/22/24 at 12:51 P.M., indicated Resident 9 was experiencing dark urine with a strong foul odor and mucous vaginal discharge, and "will continue to monitor." The nursing progress and skilled evaluation notes, dated from 2/22/24 at 12:51 P.M. to 2/29/24 at 2:37 P.M., did not include documentation to show facility staff notified the Physician regarding Resident 9's UTI symptoms or provided effective treatment and services for assessment and monitoring of the Resident's urinary status. A nurse's progress note, dated 2/29/24 at 2:37 P.M., indicated facility notified NHT that Resident 9 exhibited increased confusion and combativeness, in addition to foul odor dark urine. A nurse's progress note, on 2/29/24 at 3:06 P.M., indicated Resident 9 struck staff in the face at lunch. A nurse's progress note, dated 2/29/24 at 5:24 P.M., indicated new orders for a urinalysis and culture and sensitivity if indicated. A nurse's progress note, dated 3/1/24 at 2:43 P.M., indicated urine was collected, on 3/1/24 at 2:43 A.M., by in and out catheterization. On 3/1/24 at 6:53 P.M., a nurse's progress note			

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	stated NHT called the facility with orders for Cipro (antibiotic) twice a day for 5 days. During an interview on 2/29/24 at 11:52 A.M., the IP (Infection Preventionist) indicated NHT should be notified any time a resident shows symptoms of a urinary tract infection. The IP nurse indicated sometimes Resident 9 had behaviors when experiencing urinary tract infections and staff would stop attempts to collect urine for a urinalysis order due to Resident 9 attempting to strike staff, and sometimes the urine wasn't collected right away because staff would keep passing it off to the next shift to collect. The IP nurse called lab regarding the vaginal culture collected on 7/15/23; lab stated the culture was collected in the wrong tube. The IP nurse stated she was unsure why the facility never recollected the culture. On 3/4/24 at 11:24 A.M., a current Infections Clinical Protocol policy, revised 2013, was provided by the Administrator. The policy indicated "For anyone who is suspected of having an infection, nursing staff will identify and document specific details of symptoms and physical findings. Nursing staff will notify the Physician of all pertinent details about the resident's condition. The nursing staff and Physician will identify possible complications of the infections such as sepsis and delirium. The nursing staff and Physician will monitor the progress of a resident with an infection until it is resolved. The nursing staff will evaluate and report to the Physician at least weekly until the individual is stable or improving, and more often if the individual is not improving". 3.1-41(a)(2)			

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	155820	A. BUILDING 00 B. WING	03/04/2024

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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 ensure oxygen equipment was properly labeled and oxygen services were provided according to physician order for 2 of 2 residents reviewed for respiratory care. (Resident 85, Resident 17) Findings include: 1. On 2/26/24 at 10:48 A.M., Resident 85 was observed lying in bed with oxygen that lacked a label or date on the tubing and humidification bottle. There was also no storage bag observed anywhere in the room. On 2/28/24 at 11:15 A.M., Resident 85 was sitting in a wheelchair with oxygen on, the tubing and water bottle were not dated. There was no oxygen tubing storage bag present. On 2/29/24 at 2:06 P.M., Resident 85's oxygen tubing was observed to be in an undated, unlabeled storage bag. On 2/28/24 at 10:20 A.M., Resident 85's clinical record review was reviewed. The resident was admitted to the facility on 2/23/24. Diagnoses	F 0695	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* **Residents 85 and 17 were not adversely affected by the alleged deficient practice. The equipment related to oxygen care was replaced and updated with appropriate dating to meet regulation. Respiratory therapist was made aware of concerns for her visits allowing items to be missed. RT is no longer with the building. Nursing will be educated and held responsible for meeting oxygen needs per policy and regulation. Baseline audit completed for all current residents with oxygen to show orders correct and compliance with regulation in place for care and dating.** *How will other residents with the potential to be affected by the same alleged deficient practice be*	03/28/2024

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	included, but were not limited to, chronic obstructive pulmonary disease with acute exacerbation and acute and chronic respiratory failure with hypoxia. The Admission MDS (Minimum Data Set) Assessment was still pending. Physician orders included, but were not limited to: O2 (oxygen) at 2LPM (liters per minute) at night as needed every evening and night shift related to chronic obstruction pulmonary disease, dated 2/23/24. The clinical record lacked a baseline care plan for oxygen use. 2. On 2/26/24 at 10:53 A.M., Resident 17 was observed receiving oxygen at 1.5 L (liters) via nasal cannula. The tubing storage bag was dated 2/15 and the humidification bottle was observed empty and dated 2/15. On 2/27/24 at 10:20 A.M., Resident 17 was observed receiving oxygen at 1.5 L via nasal cannula. The tubing storage bag was dated 2/15 and the humidification bottle was observed empty and dated 2/15. On 2/27/24 at 10:22 A.M., the DON (Director of Nursing) indicated Resident 17 was receiving 1.5 L of oxygen, but should be receiving 2 L of oxygen. On 2/28/24, Resident 17 was observed receiving oxygen at 1.5 L via nasal cannula. The tubing storage bag was dated 2/15 and the humidification bottle was observed empty and dated 2/15. On 2/27/24 at 11:01 A.M., Resident 17's clinical record was reviewed. Diagnoses included, but		*identified and what corrective actions will be taken?* **All residents have the potential to be affected by the alleged deficient practice. Training and education will be completed with nurses and QMAs so they are aware of expectation related to the care, dating and management of all residents' oxygen needs and orders.** *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* **Training and education will be completed with nurses and QMAs so they are aware of expectation related to the care, dating and management of all residents' oxygen order needs. Audits will be completed by DON/designee during Monday to Friday daily clinical meetings to assure all policies related to oxygen use is being met.** *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* **An audit tool will be developed and implemented to monitor that all orders for oxygen and subsequent care for equipment has been completed as directed. This tool will be used**	

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	were not limited to, chronic respiratory failure with hypercapnia, obstructive sleep apnea, chronic obstructive pulmonary disease (COPD), and congestive heart failure. The most recent Quarterly MDS Assessment, dated 12/11/23, indicated Resident 17 was cognitively intact, had no behaviors, and was receiving oxygen. Current physician orders included, but were not limited to: Apply O2 (oxygen) 2 liters via nasal cannula at bedtime for SOB (shortness of breath) when lying flat at bedtime, dated 9/1/23. Apply O2 2-4 liters if O2 saturation < 90% on room air every 24 hours as needed for SOB, dated 8/31/2023. Respiratory Therapist (RT) to change/date O2 tubing/bag weekly. Nursing to do if RT is not available, dated 10/27/2023. A current oxygen therapy care plan, dated 8/31/23, included an intervention to provide oxygen via nasal cannula as specified in orders. A current altered respiratory status care plan, dated 8/31/23, included an intervention to provide oxygen as ordered. A current sleep apnea care plan, dated 8/31/23, included an intervention to provide oxygen as ordered. A current COPD care plan, dated 8/31/23, included an intervention to give oxygen therapy as ordered by the physician.		**daily Monday to Friday for four weeks, weekly for eight weeks and monthly for 3 months. . It will be implemented and monitored by the DON/designee. This outcome of this audit tool will be reviewed at Quality Assurance meeting to determine if any additional action is warranted.**	

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	On 2/29/24 at 2:46 P.M., Registered Nurse (RN) 3 indicated that respiratory therapy came every Thursday and changed tubing. The date, time and initials should be on the bag. On 2/29/24 at 3:50 P.M., the Administrator provided a current Oxygen Therapy policy, dated 10/2014, that indicated "Oxygen therapy is administered by licensed personnel per physician's order ... The physician's order will specify the rate of flow of oxygen ... All oxygen delivery devices shall be replaced weekly and PRN (as needed)". 3.1-47(a)(6)			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.			

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	(ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview, and record review, the facility failed to post accurate actual hours worked for licensed and unlicensed nursing staff directly responsible for resident care per shift daily for 4 of 5 days during the annual survey period. Finding includes: During an observation on 2/26/24 at 12:24 P.M. a posted nursing staffing data sheet was observed on the wall in the lobby near the entrance to the main stairwell. The sheet included, but was not limited to, the following information: Census, total number of staff for each shift and total hours of each shift for CNA (Certified Nurse Aide), LPN (Licensed Practical Nurse), Med Tech (Qualified Medication Aide), and RN (Registered Nurse) with Administration Duties. The sheet did not specify which actual hours were worked by each discipline during the specified shift when the total hours were not equal to the number of staff.	F 0732	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* **No residents were affected by the alleged deficient practice. A corrected form which includes any changes to actual worked hours by staff and noted as a change to any regularly scheduled times will be reflected in the daily posting.** *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* **No residents are expected to be affected by the alleged deficient practice. A corrected form which includes any changes to actual worked hours by staff and noted as a**	03/28/2024

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	During an observation on 2/27/24 at 3:03 P.M. a posted nursing staffing data sheet was observed on the wall in the lobby near the entrance to the main stairwell. The sheet included, but was not limited to, the following information: Census, total number of staff for each shift and total hours of each shift for CNA (Certified Nurse Aide), LPN (Licensed Practical Nurse), Med Tech (Qualified Medication Aide), and RN (Registered Nurse) with Administration Duties. The sheet did not specify which actual hours were worked by each discipline during the specified shift when the total hours were not equal to the number of staff. On 2/29/24 at 9:35 A.M., CNA 5 indicated she got called in when they needed help. She indicated the scheduler called regular staff first and then if no one was available they would call in agency staff. On 2/29/24 at 3:45 P.M., the MDS Coordinator provided a copy of posted nurse staffing sheets for dates 2/26/24, 2/27/24, 2/28/24, and 2/29/24. Each of these dates did not reflect actual hours worked. On 3/4/24 at 10:10 A.M., the MDS (Minimum Data Set) Coordinator indicated that some CNAs worked half shifts. She indicated she was unable to tell by looking at the posted nurse staffing sheet which half of the shift was worked. On 2/29/24 at 3:45 P.M., the MDS Coordinator provided a current Posting Direct Care Daily Staffing Numbers policy, revised July 2016, that indicated "the information recorded on the form shall include ...actual time worked during that shift for each category and type of nursing".		**change to any regularly scheduled times will be reflected in the daily posting.** *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* **ADON and DON will be in-serviced on regulation and expected change to reporting tool. DON/designee will review any scheduling changes with ADON during daily morning meeting Monday through Friday. An audit tool will be developed and implemented to monitor that all appropriate schedule changes are reported timely and accurately.** *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* **An audit tool will be developed and implemented to monitor that all appropriate schedule changes are reported timely and accurately. This tool will be used daily Monday to Friday for four weeks, weekly for eight weeks and monthly for 3 months. . It will be implemented and monitored by the DON/designee. This outcome of this audit tool will be reviewed at Quality Assurance meeting to determine if any additional**	

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			action is warranted.	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending			

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	physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to ensure residents were free from unnecessary medications for 1 of 5 residents reviewed for unnecessary medications. A resident's as needed antianxiety medication was ordered for greater than 14 days. (Resident 17) Finding includes: On 2/27/23 at 11:01 A.M., Resident 17's clinical record was reviewed. Diagnoses included, but were not limited to, major depressive disorder and post-traumatic stress disorder. The most recent Quarterly MDS (Minimum Data Set) Assessment, dated 12/11/23, indicated Resident 17 was cognitively intact and received an antianxiety medication during the 7-day lookback period. Current physician orders included, but were not limited to: Klonopin (an antianxiety medication) Oral Tablet 1 MG (milligrams) - Give 1 tablet by mouth every 24 hours as needed for anxiety, dated 1/26/2024 with no stop date indicated. The January 2024 MAR (medication	F 0758	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* **Resident 17 was not adversely affected by the alleged deficient practice. The physician was contacted related to her PRN psychotropic medication and an order was given so a stop date was in place. This was completed during the Annual Survey of 3-4-24.** *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* **All residents have the potential to be affected by the alleged deficient practice. A baseline audit was completed by DON to show all PRN psychotropic medications had a regulatory stop date in place.** *What measures will be put into place and what systemic changes*	03/28/2024

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	administration record) indicated Resident 17 received PRN (as needed) Klonopin on 1/26. The February 2024 MAR indicated Resident 17 received PRN Klonopin on 2/8, 2/21, and 2/27. The clinical record lacked documentation of a clinical rational or evaluation by a Physician of Resident 17 for the Klonopin given greater than 14 days. On 2/29/24 at 2:20 P.M., the MDS Coordinator indicated that PRN antianxiety medications should be re-evaluated every 14 days. If no end date was indicated, there should be a progress note or pharmacy review with the physician's clinical rationale. On 2/29/24 at 3:47 P.M., the MDS Coordinator provided a current Use and Tapering of Psychopharmacological Medications policy, dated 10/2014, that indicated "An unnecessary medication is any medication when used...without adequate monitoring". 3.1-48(a)(2)		*will be made to ensure that the alleged deficient practice does not recur?* **In-service will be completed with nurses and Social Services Director to educate on the need to be aware of PRN psychotropic meds requiring a stop date of 14 days or notation that there was clinical rationale for extending the stop date.** *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* **An audit tool will be developed and implemented to monitor that all orders for PRN psychotropics have a stop date or clinical rationale notation. This tool will be used daily Monday to Friday for four weeks, weekly for eight weeks and monthly for 3 months. It will be implemented and monitored by the DON/designee. This outcome of this audit tool will be reviewed at Quality Assurance meeting to determine if any additional action is warranted.**	
F 0761 SS=E 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			

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	accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §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 provide proper storage of medications in 1 of 3 medication carts and 1 treatment cart observed. Loose pills and unlabeled medications were found in the medication and treatment carts. (Holy Name Medication Cart and JJ Nurses Station) Findings include: 1. On 2/28/24 at 8:15 A.M., the following was observed in the Holy Name Medication cart: 1 large brown pill 1 large white pill The following, found at the same time, were	F 0761	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* **Although no specific residents were identified, all residents have the potential to be affected by the alleged deficient practice. Nurses and QMAs were educated on the regulation and expectation of all drugs and biologicals being properly labeled and stored. An audit of all the medication carts and rooms was completed with any loose pills**	03/28/2024

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	marked with [resident name] but lacked an open date or label: 1 bottle of stool softener 1 bottle of Donepezil 1 bottle of acetaminophen 500 mg (Milligrams) 1 bottle of calcium 1 bottle of daily fiber 1 bottle of women's multivitamin 1 bottle of powdered laxative 2. On 2/28/24 at 8:27 A.M., the following was observed in the treatment cart in the JJ Nurses Station: 1 bottle of Tuberculin Solution with an open date of 11/22/23 and an expiration date of 2/25, lot number 66059 1 tube of pain relief cream with [resident name] that lacked an open date or label 1 bottle of powdered laxative that lacked a resident name, open date or label 1 bottle of eye vitamin with name of medication written in marker and lacked a resident name or label During an interview on 2/28/24 at 8:20 A.M., LPN (Licensed Practical Nurse) 8 indicated that when loose pills were found they were placed in the sharp's container or in a drug dissolving solution. She also indicated there should be a label with the resident name, room number, and physician name. At that time, LPN 8 indicated tuberculin solution was only good for 1 month after opened. On 3/4/24 at 11:25 A.M., a current "Labeling of Medication Containers" policy, dated 4/2007, was provided by the Administrator. The policy indicated "... medication labels must be legible at all times...labels for individual drug containers shall include all necessary information such as: resident name, prescribing physician name...the		**removed and open bottles labeled correctly.** *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* **All residents have the potential to be affected by the alleged deficient practice. An audit of all the medication carts and rooms was completed and all nurses and QMAs were educated on proper labeling and storage of drugs and biologicals.** *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* **In-Service will be held with all nurses and QMAs related to proper labeling and storage of drugs and biologicals. Each shift will be held responsible for completing a thorough check of their cart and the medication room and will need to sign off that they have accurately met expectations from recent education. A baseline audit of all carts and medication rooms will be completed to show there are no drugs or biologicals out of step with regulation.** *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie*	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	date the medication was dispensed...and expiration date when applicable...Labels for over-the-counter drugs shall include all necessary information such as: the original label, the resident's name, expiration date, and use". On 2/28/24 at 12:56 P.M., a current "Storage of Medications" policy, dated 4/2007, was provided by the Administrator. The policy indicated "... drugs and biologicals shall be stored in the packaging, containers...and medications requiring refrigeration must be store in a refrigerator located in the drug room at the nurses' station... must be labeled accordingly...". 3.1-25(j) 3.1-25(m)		*what quality assurance program will be put into place?* **An audit tool will be developed and implemented to monitor that there are no outstanding drugs or biologicals that do not meet regulations. The audit tool will be completed by the DON/designee weekly for eight weeks and monthly for 4 months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional action is warranted.**	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure food was stored, labeled, and dated properly in accordance with professional standards for food service for 2 of 2 kitchen observations. Finding includes: On 2/26/24 at 9:22 A.M., an initial tour of the kitchen was conducted. The following items were observed: In the reach-in refrigerator: a clear plastic container with a green lid contained a white liquid; not labeled with contents or date A sour cream container with soup inside; not labeled with contents or date 1 opened can of dessert topping; no date 1 red drink pitcher with no date or contents label, and 1 red drink pitcher with a prep date 2/23/24 and use by date 2/25/24 2 blue drink pitchers; not labeled with contents or date In the walk-in freezer: a gallon plastic Ziploc bag labeled spaghetti sauce dated 12/20/23 and use by 6/2/23 1 opened bag of pepperonis with a manufacture expiration date 12/17/23 In the dry storage area: 1 dented can stewed tomatoes 2 dented cans mushroom stems and pieces 1 dented can blueberry pie filling Opened bag of elbow macaroni, no dates 2 opened bags of penne pasta, no dates 1 bag of angel hair pasta, no dates	F 0812	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* **Although no specific residents were identified during the survey, all residents have the potential to be affected by the deficient practice. An audit of all food was completed to determined that there were no items currently in contrast with the regulation related to storage, labeling and dating. Food items that did not meet criteria were disposed of immediately. All dietary staff have been educated and re-trained and disciplined in relation to not adhering to this regulation.** *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* **Although no specific residents were identified during the survey, all residents have the potential to be affected by the deficient practice. An audit of all food was completed to determined that there were no items currently in contrast with the regulation related to storage, labeling and dating. Food items that did not meet**	03/28/2024

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	1 bag of croutons, opened date 1/21/24 and use by date 2/12/24 1 opened bag fried crispy onions, no date 1 opened bag of marshmallows, dated 9/17/23 use by 10/17/23 1 opened bag raspberry gelatin, no dates 1 plastic bag brownie mix wrapped in plastic wrap, no dates In the walk-in refrigerator: a plastic jug of lemon juice, open date 1/10/24 and use by date 2/19/24 1 container of mayonnaise, open date 1/9/24 no use by date 1 package of hot dogs opened to air, open date 2/18/24 use by date 2/24/24 1 package of gouda cheese, no open or use by date 1 package of cheddar cheese, dated 2/24/24, no open or use by date 1 package mozzarella cheese, open date 2/12/24 use by date 2/18/24 plastic Ziploc bag of hard boiled eggs, dated 2/24/24, no use by date pan labeled chicken noodle soup, dated 2/16/24 use by date 2/22/24 2 uncrustable PB&J sandwiches with manufacturer expiration date 8/30/23 (manufacturer instructions state to store in freezer) 3 cartons of blueberry toppings (manufacturer instructions say store at 0 degrees; refrigerator thermometer read 42 at time of observation) 1 container of cottage cheese, dated 2/8/24 use by date 2/14/24 plastic container labeled chicken nuggets, dated 2/18/24 use by 2/20/24 plastic container labeled baked beans, dated 2/18/24 used by 2/20/24 plastic container labeled chili, dated 2/16/24 use		**criteria were disposed of immediately. All dietary staff have been educated and re-trained and disciplined in relation to not adhering to this regulation.** *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* **An in-service has been completed for all dietary staff per the Certified Dietary Manager for that department. This in-service includes what to do upon receiving stock and how to maintain appropriate regulation for storage, labeling and dating once used or if past date for use in accordance with professional standards.** *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* **An audit tool will be developed and implemented to monitor for appropriate storage, labeling and dating of all food item in accordance with professional safety standards. This tool will be completed by the CDM/designee for eight weeks and monthly for four months. The outcome of this tool will be reviewed at the Quality Assurance meeting to determine if any additional**	

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	by 2/18/24 plastic container labeled chicken noodle, dated 2/14/24 use by 2/20/24 plastic container labeled peaches, dated 2/15/24 use by 2/21/24 plastic container labeled meatloaf, dated 2/21/24 no use by date plastic container labeled mushrooms, dated 2/12/24 use by date 2/13/24 plastic container labeled orange chicken, dated 2/23/24 use by 2/25/24 plastic container labeled pork chops, dated 2/22/24 use by 2/24/24 During an observation on 2/29/24 at 09:17 A.M., the following items were observed: In the reach-in refrigerator: a clear plastic container with a green lid contained a white liquid; not labeled with contents or date A sour cream container with soup inside; not labeled with contents or date In the walk-in freezer: a gallon plastic Ziploc bag labeled spaghetti sauce, dated 12/20/23 and use by 6/2/23 1 opened bag of pepperonis with a manufacturer expiration date 12/17/23 1 opened bag of uncooked chicken breast strips, no dates 1 cooked bag of chicken breast strips, no dates In the dry storage: 1 dented can of stewed tomatoes 2 dented cans of mushroom stems and pieces 1 dented can blueberry pie filling Opened bag of elbow macaroni, no dates 2 opened bags of penne pasta, no dates 1 bag of angel hair pasta, no dates 1 opened bag fried crispy onions, no dates		**action is warranted.**	

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	1 opened bag of marshmallows, dated 9/17/23 use by 10/17/23 1 opened bag raspberry gelatin, no dates 1 plastic bag brownie mix wrapped in plastic wrap, no dates In the walk-in refrigerator: a plastic jug of lemon juice, open date 1/10/24 and use by date 2/19/24 1 container of mayonnaise, open date 1/9/24 no use by date a container of honey BBQ, open date 1/28/24 use by date 2/28/24 1 package of hot dogs opened to air, open date 2/18/24 use by date 2/24/24 1 block of meat labeled turkey, open date 2/26, use by 2/28 plastic Ziploc bag of hard boiled eggs, dated 2/24/24 1 carton blueberry topping (manufacturer instructions say store at 0 degrees; refrigerator thermometer read 41 at time of observation) 1 container of cottage cheese, dated 2/8/24 use by date 2/14/24 During an interview on 2/29/24 at 9:24 A.M., the Dietary Manager indicated any can that was dented should not be used and should be sent back to the food supplier. The dietary manager indicated anything opened in the kitchen should have an opened date. Some things may not have a use by date but staff should be able to look at the open date and know when it should be used by according to the labeling and dating policy. On 3/4/24 at 11:24 A.M., the Administrator provided a policy titled Storage of Food under Sanitary Conditions, dated 6/2018, that indicated "all food items stored in the refrigerator must be labeled and dated if not scheduled to be served at			

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	the next meal. All food should be placed in seamless containers with tight-fitting lids. Leftover foods should be placed in an approved storage container and should be discarded after three days. Canned goods with a compromised seal are discarded and/or removed from the kitchen for return to the vendor for credit". 3.1-21(i)(2) 3.1-21(i)(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable			

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	law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic			

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	services reports as required under §483.50. Based on interview and record review, the facility failed to ensure medical records were accurate for 1 of 2 residents reviewed for hospitalizations. Dates of indwelling catheter changes were incorrectly documented. (Resident 21) Finding includes: On 2/29/24 at 11:19 A.M., Resident 21's clinical record was reviewed. Resident 21 was admitted to the facility on 10/11/23. Diagnoses included, but were not limited to, chronic kidney disease, obstructive and reflux uropathy, and acute kidney failure. The most current Quarterly MDS (Minimum Data Set) Assessment, dated 1/17/24, indicated Resident 21 was cognitively intact, had an indwelling catheter, and was always incontinent of bowel and bladder. Physician orders included, but were not limited to: Change indwelling catheter 16fr (French) 10ml (milliliters) Q (every) month and PRN (as needed) every day shift every 30 day(s) for catheter change, dated 12/10/23. Change indwelling catheter 16fr 10ml Q month and PRN every day shift starting on the 11th and ending on the 12th every month for catheter change, dated 2/11/2024. A progress note, dated 12/14/23 at 11:36 A.M., indicated the resident had a cystoscopy performed outside of the facility where a new catheter was placed. On 12/26/23, the skilled evaluation indicated the catheter was last changed on 12/1/23.	F 0842	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* **Resident 21 was not adversely affected by the alleged deficient practice. Nursing staff will be trained and educated on proper documentation regulations for accuracy and timeliness of follow up completed.** *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* **All residents have the potential to be affected by the alleged deficient practice. All nursing staff will be trained and educated on following up with all orders to make sure they are followed as directed and noted timely.** *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* **DON will address current orders and concerns in daily clinical meeting related to documentation and follow up to physician orders being completed accurately and timely. DON will make sure either a progress note or information on MAR/TAR is**	03/28/2024

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	On 1/4/24, the skilled evaluation indicated the catheter was last changed on 1/1/24. On 1/6/24, the skilled evaluation indicated the catheter was last changed, 11 months in the future, on 12/14/24. On 1/7/24, the skilled evaluation indicated the catheter was last changed, 7 days in the future, on 1/14/24. There were no progress notes or indication in the MAR (medication administration record) or TAR (treatment administration record) that the catheter had been changed since 12/14/23. The February 2024 MAR indicated the catheter was changed on 2/11 and 2/12. The clinical record lacked a progress note documenting the procedure or indication for the catheter changes. On 3/4/24 at 10:10 A.M., the MDS Coordinator indicated the dates on the skilled evaluations should read 12/14/23 and the dates listed were typos. She was unsure why other dates were listed. At that time, she indicated she wasn't sure if the catheter was changed on 2/11/24 or 2/12/24 or both, and that all foley catheter changes should be documented in the progress notes and in the MAR. On 3/4/24 at 11:23 A.M., the Administrator provided a current Perineal Care policy, revised October 2010, that indicated "The following information should be recorded in the resident's medical record: the date and time that perineal care was given ... any problems noted at the catheter-urethral junction during perineal care ... how the resident tolerated the procedure".		**reflective of current directive from physician.** *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* **An audit tool will be developed and implemented to monitor that all orders are documented timely and accurately. This tool will be used daily Monday to Friday for four weeks, weekly for eight weeks and monthly for 3 months. It will be implemented and monitored by the DON/designee. This outcome of this audit tool will be reviewed at Quality Assurance meeting to determine if any additional action is warranted.**	

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	3.1-50(a)(2)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;			

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	(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, interview, and record review, the facility failed to ensure infection control practices and standards were followed in 2 of 2 residents observed during care and 3 of 3 residents observed during medication	F 0880	*What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice?* **Residents 32, 8, 29, 21 and 26**	03/28/2024

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	administration. Hand hygiene was not performed correctly and vital sign equipment was not cleaned between residents. (Resident 32, Resident 8, Resident 29, Resident 21, and Resident 26) Findings include: 1. On 2/28/24 at 6:45 A.M., during a medication pass for Resident 32, LPN (Licensed Practical Nurse) 7 was observed entering the room without performing hand hygiene. LPN 7 took a temperature of 97 degrees Fahrenheit using a digital temporal thermometer and administered medications. Upon completion, LPN 32 left the room without hand sanitizing or cleaning the equipment after usage. 2. On 2/28/24 at 7:15 A.M., during a medication pass for Resident 8, LPN 8 was observed taking a blood pressure of 152/74 for the resident, and did not clean equipment after usage. 3. On 2/28/24 at 7:51 A.M., during a medication pass for Resident 29, LPN 8 was observed taking a temperature of 97.6 and oxygen saturation of 98 for the resident, and did not clean equipment after usage. During an interview on 2/29/24 at 2:30 P.M., QMA (Qualified Medication Aide) 4 indicated equipment should be cleaned in between residents with cleaning wipes. 4. On 3/4/24 at 8:27 A.M., Certified Nurse Aide (CNA) 9 and CNA 11 were observed performing catheter care for Resident 21. CNA 11 was observed to not retract the foreskin of the penis during care. On 3/4/24 at 8:45 A.M., CNA 9 indicated that the procedure to clean a male with a catheter was to		**were not adversely affected by the alleged deficient practice.** **All nursing staff given in-service on handwashing, equipment cleaning and sanitization and incontinence care.** *How will other residents with the potential to be affected by the same alleged deficient practice be identified and what corrective actions will be taken?* **All residents have the potential to be affected by the alleged deficient practice. All nursing staff will be observed and educated on infection control standards and best practices. Staff will be randomly monitored by DON/designee when performing care to show they are meeting regulation and expectations.** *What measures will be put into place and what systemic changes will be made to ensure that the alleged deficient practice does not recur?* **In-service will be held with all nursing staff to educate on infection control practices. Facility will show training and education sheets given as visual reminder.** *How will the corrective actions be monitored to ensure the alleged deficient practice will not recur (ie what quality assurance program will be put into place?* **Audit tool will be developed**	

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	155820	A. BUILDING 00 B. WING	03/04/2024

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	clean with soap and water from the top of the penis down and then rinse. If the male was uncircumcised the foreskin should be retracted. At that time, CNA 9 indicated she did not retract Resident 21's foreskin because she was in a hurry and nervous. 5. On 2/29/24 at 9:00 A.M., CNA 5 was observed performing incontinence care for Resident 26. CNA 5 assisted Resident 26 to sit on the toilet. CNA 5 washed her hands for 13 seconds and then put gloves on. CNA 5 cleaned Resident 26's front side using soap and water and pat her dry. CNA 5 removed her gloves, washed her hands for 16 seconds and then put new gloves on. CNA 5 cleaned Resident 26's buttock area using soap and water. CNA 5 removed her gloves, washed her hands for 12 seconds, and put new gloves on. CNA 5 pat Resident 26's buttock area dry, applied zinc oxide to the resident's buttock area, changed gloves, applied zinc oxide to the resident's front, changed gloves, applied lotion to the resident's legs, and then removed her gloves. CNA 5 washed her hands for 18 seconds. During this time, the resident had a bowel movement. CNA 5 put on gloves, wiped the resident's buttock area with toilet paper, and removed her gloves. CNA 5 washed her hands for 11 seconds. CNA 5 washed the resident's buttock area with a wet towel and patted her dry. Without changing gloves, CNA 5 applied zinc oxide to resident's buttock area and then removed her gloves. CNA 5 washed her hands for 8 seconds, flushed the toilet using a paper towel without rinsing off the soap, and then kept washing her hands for 6 more seconds. On 2/29/24 at 2:15 P.M., the Infection Preventionist (IP) indicated staff should wash their hands continuously for 30 seconds with soap and water while performing hand hygiene.		**and implemented to monitor through random checks that handwashing, proper equipment cleaning and appropriate catheter care follow the regulations currently in place. This audit tool will be completed by DON/designee weekly for eight weeks and monthly for four months. The outcome of this tool will be reviewed in the Quality Assurance meeting to determine if any additional action is warranted.**	

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	On 2/29/24 at 3:47 P.M., the IP provided a current Handwashing/Hand Hygiene policy, dated 10/2014, that indicated "Rub hands together vigorously, as follows, for at least 20 seconds, covering all surfaces of the hands and fingers". On 3/4/24 at 11:23 A.M., the Administrator provided a current Perineal Care policy, revised October 2010, that indicated "retract foreskin of the uncircumcised male". On 3/4/24 at 11:25 A.M., the Administrator provided a current Cleaning and Disinfection of Resident-Care Items and Equipment policy, dated 7/2014, that indicated "...reusable items are cleaned and disinfected or sterilized between residents...". 3.18(b)(1) 3.1-18(l)			