STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155208	A. BUILDING 00 B. WING	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Complaints IN00425296, IN00424607, IN00424285, IN00423795, IN00423420, and IN00422985. This visit included a State Residential Licensure Survey. Complaint IN00425296- State/Federal deficiency related to the allegation is cited at F686. Complaint IN00424607- No deficiencies cited. Complaint IN00424285- No deficiencies cited. Complaint IN00423795- No deficiencies cited. Complaint IN00423420- No deficiencies cited. Complaint IN00422985- No deficiencies cited. Survey dates: January 2, 3, 4, 5, 8, 9, and 10, 2024. Facility number: 000115 Provider number: 155208 AIM number: 100291080 Census Bed Type: SNF/NF: 66 Residential: 8 Total: 74 Census Payor Type: Medicare: 7 Medicaid: 58 Other: 1 Total: 66	F 0000	Preparation and or the execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Stefanie Jenkins	Administrator	02/02/2024

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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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 18, 2024.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure a resident that self-administered medications was appropriately assessed for self-administration for 1 of 6 residents reviewed for medications. (Resident 44) Findings include: Resident 44 was observed in her bed, in her room, on 01/02/24 at 12:34 P.M. There were three unidentified medications lying on the floor near the resident's over the bed table. The resident indicated the pills spilled from the medication cup and fell on the floor when she was taking them that morning. QMA (Qualified Medication Aide) 10 entered the resident's room on 01/02/24 at 12:41 P.M. She observed the medications on the floor and identified two of the pills as gabapentin (a medication used for nerve pain). She was unsure of what the third pill was. During an interview on 01/02/24 at 12:42 P.M., QMA 10 indicated when she administered medications, she would watch to ensure residents took all their pills, she wouldn't leave the room until she was sure. LPN (Licensed Practical Nurse) 7 administered the resident's medications that	F 0554	This facility follows the policy for self-administered medications. **Resident #44:** The medication was immediately removed from bedside and the nurse associated with this incident was immediately educated on the Self Medication Administration process. All residents have the potential to be affected by this alleged deficient practice. No resident is identified as self-medication administration. On 1-24-2024 the Director of Nursing re-educated all licensed staff and QMAs on the Self Administration of Medication policy to ensure residents that are interested in administering own medication a licensed nurse completes the self-administration of medication assessment, physician order received and appropriate care plan completed. Additionally, the training will include that unless is care planned to be self administer medication no residents	02/16/2024

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	morning. During an interview on 01/02/24 at 12:46 P.M., LPN 7 indicated she prepared the resident's medications, assessed the resident's vital signs, and left the medications in the cup for the resident to take on her own. She came back a little while later to make sure the resident took her medications. She didn't know about the medications on the floor. During an interview on 01/04/24 at 10:35 A.M., the Administrator indicated there were no residents in the facility that self-administered medications. The resident's clinical record was reviewed on 01/08/24 at 10:58 A.M. An Admission MDS (Minimum Data Set) assessment, dated 11/07/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, stroke, hemiplegia of the left upper and lower extremity, and diabetes. The resident's clinical record lacked a medication self-administration assessment and a physician's order to self-administer medications. The current facility policy, titled "MEDICATIONS, SELF-ADMINISTRATION", with a most recent revision date of 09/17, was provided by the Regional Director of Operations on 01/09/24 at 3:24 P.M. The policy indicated, "...Should the resident indicate a desire to self-administer medication(s), the interdisciplinary team shall evaluate the resident for the cognitive, physical, and visual ability to accomplish this task...If the evaluation reveals the resident is capable of participation in self-administration, a physician order reflecting the same shall be obtained to specify which medications may be self-administered by the resident..."		medications will be left at the bedside. The DON/designee will be responsible to conduct random rounds during medication pass times to ensure medication is not left at the bedside. Rounds will be conducted 3 times a week at random times for 4 weeks, bi-weekly times 4 weeks, weekly for 3 months and bi- monthly for 2 months. Any issues identified will be addressed immediately and re-education given as warranted. The results of these rounds will be documented on Medication at Bedside Rounds Tool. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	

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	3.1-11(a)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on observation, interview, and record review, the facility failed to thoroughly investigate and have the appropriate monitoring in place for an alleged resident to resident abuse for 1 of 25 residents reviewed. (Resident 29) Findings include: During an interview on 01/09/24 at 9:28 A.M., the Administrator indicated the previous afternoon, on 01/08/24, Resident 29 was being propelled back to her room on Wing 2 from a Resident Council meeting. She advised an activity aide that Resident 53, who was in front of her and lived on Wing 2, had raped her the night before, on 01/07/24. Resident 29 was taken to her room and	F 0610	It is the practice of this facility to thoroughly investigate all alleged allegations of abuse, neglect, exploitation or mistreatment and prevent further potential abuse, neglect, exploitation or mistreatment while the investigation is in progress. **Resident 29:** This resident was on 15-minute checks due to prior allegation of rape; which investigation was on going. Resident was immediately placed on 1:1 after additional allegations of rape. Additionally, this resident was immediately interviewed by	02/16/2024

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	placed on 1:1 (one staff to one resident) observation. She interviewed Resident 29 where she had said the men in the walls were out to hurt her, Resident 53 and 55, had raped her the night before when she was sleeping. There had been ongoing concerns with Resident 29 and they had contacted the psych NP (Nurse Practitioner). Resident 29 was sent to a neuropsych unit. She had interviewed other residents and staff and had no concerns. She did not place Residents 53 or 55 on any increased supervision. During an interview on 01/09/24 at 10:07 A.M., the Administrator indicated Resident 53's room was across from the nurses station and Resident 55 wasn't able to do anything independently and had bed alarms. There was not always a nurse at the nurses station. She could only assure the residents were in their room based off staff interviews. The residents were not placed on any additional documented supervision. During an observation and interview on 01/09/24 at 10:17 A.M., Resident 53 and 55 were in their rooms on Wing 2. Resident 53 indicated he had never had any physical contact with a female resident and he had never seen any other residents have physical contact with each other. Resident 55 was unable to be interviewed. During an interview on 01/09/24 at 10:23 A.M., RN 13 indicated Resident 53 was not on any increased monitoring and had not been. He didn't come out of his room much. His room was in the line of sight of the nurses station, but there was not always someone at the nurses station to keep his room in view. She assisted the resident back to bed after the resident council meeting and spent about 30 minutes in his room. Resident 55 wasn't on any increased monitoring. He had a mattress		the administrator and resident stated; “The men in the wall raped her.” This resident was care planed for delusional episodes. **Resident 53:** Resident was in line of sight of nurse while administrator re-interviewed female residents on the unit and all stated no resident or others were ever inappropriate with them. **Resident 55:** Resident unable to transfer or ambulate himself and no need to place increased supervision. On 1-9-2024 The Regional Director of Operations re-educated the Administrator regarding the facility abuse and neglect policy. The in-service included the prevention of further potential abuse through additional supervision. The administrator will re-educate all staff regarding the prevention of further abuse once an investigation has started. The Administrator will continue to review all allegations with the Regional Director and Corporate Nurse to ensure proper protection of residents are implemented during an investigation. Copies of these reports will be forwarded to the QAPI committee to ensure compliance for 6 months.	

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	on the floor that sounded when he got out of bed. The clinical record for Resident 29 was reviewed on 01/05/24 at 10:14 A.M. A Significant Change MDS (Minimum Data Set) assessment, dated 09/29/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, Huntingtons Disease, thyroid disorder, dementia, depression, anxiety, and psychotic disorder. The resident required extensive assistance of two staff members for bed mobility, transfers, dressing, toileting, and personal hygiene. The clinical record for Resident 53 was reviewed on 01/09/24 at 10:06 A.M. A Quarterly MDS assessment, dated 12/23/23, indicated the resident required partial to moderate assistance with activities of daily living. The clinical record for Resident 55 was reviewed on 01/09/24 at 10:06 A.M. A Quarterly MDS assessment indicated the resident was dependent on staff for personal hygiene and eating. He required moderate staff assistance for lying to sitting position and standing. He required maximum staff assistance with dressing. During an observation on 01/04/24 at 2:56 P.M., Resident 53 was propelling himself in his wheelchair to the nurse's station. The clinical record for Resident 53 and 55 lacked any increased monitoring after Resident 29 reported the alleged abuse. The current facility policy titled, "Abuse and Neglect", with a revised date of 08/01/23, was provided by the Administrator on 01/02/24 at 12:20 P.M. The policy indicated, "...Each resident			

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	has the right to be free from abuse, neglect, and misappropriation of resident property. All allegations will be reported according to State and Federal Law and investigated...The facility will implement action to prevent further potential abuse while the investigation is in progress...			
F 0622 SS=E Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate.			

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	(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the			

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	following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.			
	Based on record review and interview, the facility failed to provide appropriate transfer/discharge paperwork and assessments for 4 of 4 residents reviewed for transfer/discharge. (Residents 52, E, 69, and B) Findings include: 1. The clinical record for Resident 52 was reviewed on 01/04/24 at 10:08 A.M. A Quarterly MDS (Minimum Data Set) assessment, dated 11/02/2023, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, Huntington's disease, anxiety, depression, and psychotic disorder. The census report for the resident indicated the resident discharged from the facility on 12/21/23. A Progress Note, dated 12/21/23 at 6:39 P.M., indicated the resident was discharged to another facility. The clinical record lacked a discharge assessment.	F 0622	It is the practice of this facility to when transfer or discharges of a resident occurs the facility ensures the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. Resident 52: This resident was discharged to a psych hospital for extended services and no harm occurred to this resident related to this alleged deficient practice. Resident E: This resident was discharged to the psych hospital and no harm occurred. This resident no longer resides at the facility. Resident 69: This resident was discharged to the hospital and no harm occurred. Resident B: This resident was discharged to the assisted living facility and no harm occurred to	02/16/2024

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	2. The clinical record for Resident E was reviewed on 01/05/24 at 10:53 A.M. An Annual MDS assessment, dated 10/21/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, Huntington's disease, hypertension, and depression. The census report for the resident indicated the resident discharged from the facility on 11/15/23. A Progress Note, dated 11/15/23 at 5:15 A.M., indicated the resident was discharged to a local hospital. The clinical record lacked a discharge assessment. 3. The clinical record for Resident 69 was reviewed on 01/05/24 at 11:04 A.M. An Admission MDS assessment, dated 11/10/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, heart disease, hypertension, anxiety, and pneumonia. The census report for the resident indicated the resident discharged from the facility on 11/16/23. The clinical record lacked a discharge assessment. The clinical record lacked a progress note indicating where the resident was going when she left the facility. During an interview on 01/09/24 at 11:14 A.M., the medical records staff indicated the clinical record lacked a copy of the transfer/discharge packet for residents 52, E, and 69. A transfer/discharge packet should have been completed for each resident. 4. The clinical record for Resident B was reviewed		the resident. This resident no longer resides at the facility. All residents being transferred or discharged have the potential to be affected by this alleged deficient practice. A 100% was conducted of the discharges and transfers over the last 30 days and those identified were assessed to ensure no negative outcome occurred. On 1-24-2024 the Administrator re-educated all licensed staff and the Interdisciplinary Team (IDT) on the Transfer and Discharge of Resident policy. The training includes; recapitulation of the resident's stay; a final summary of the resident's status , post discharge plan of care to assist the resident to adjust to the new/previous living environment, identifies the post-discharge plan identifies the resident's specific needs after discharge and education for resident and / or caregiver, the completion of the state specific Discharge/Transfer/Appeal form and to make a final entry in the clinical record. The Medical Records Coordinator or designee will audit 5 days a week all transfers and discharge paperwork for 4 weeks, then 2 times a week for 4 weeks, weekly for 4 weeks and monthly for 3 months. Any noncompliance will be reported to the Director of Nursing for immediate correction,	

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	on 01/04/24 at 9:58 A.M. An Admission MDS assessment, dated 07/26/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, hypertension and non-Alzheimer's dementia. The census report for the resident indicated the resident discharged from the facility on 09/29/23. A Progress Note, dated 09/29/23 at 6:39 P.M., indicated the resident was discharged to another facility. The clinical record lacked a discharge assessment. During an interview on 01/08/24 at 3:23 P.M., the MDS Coordinator indicated the resident had admitted to the facility. While she was there the family had a lot of dynamics. The day the resident discharged the POA (Power of Attorney) had called and said he was discharging the resident. When a resident discharges from the facility to another facility they would need to call and give report, document in a progress note, and complete a discharge packet. The nurse completing the packet would need to make a copy of the packet, so the facility kept one and the resident took one with them. The resident should have had a discharge packet completed but it could not be found. The current facility policy titled "Discharge of Resident" was provided by the MDS Coordinator on 01/09/24 at 1:30 P.M. The policy indicated, "...To provide a safe discharge from the facility and ensure continuity of care...When a discharge is anticipated, a resident must have a Discharge Summary that includes: A recapitulation of the resident's stay...A final summary of the resident's status to include components of the		including re-education. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	

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	comprehensive assessment, at the time of the discharge, that is available for release to authorized persons and agencies with the consent of the resident or legal representative...A post-discharge plan of care that is developed with the participation of the resident and family/legal representative, which will assist the resident to adjust to his/her new/previous living environment. The post-discharge plan must be presented both orally and in writing and in a language that the resident and family understand...A post-discharge plan identifies specific resident needs after discharge such as personal care, necessary dressings/treatments, and necessary therapy, and describes resident/caregiver education needs with provision of instruction where applicable, to prepare the resident for discharge...Complete state specific Discharge/Transfer/Appeal form and provide a copy to resident/legal representative...Make a final entry in the clinical record, including time of discharge, by whom accompanied, type of transportation and all other pertinent information..." 3.1-36(a)(1) 3.1-36(a)(2) 3.1-36(a)(3) 3.1-36(b)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.			

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	(B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to update a resident's plan of care related to preferences for 1 of 17 residents reviewed for care plans. (Resident 36) Findings include: During an interview on 01/03/24 at 10:27 A.M., Resident 36 indicated he was a bit of a germaphobe, especially when it came to the bathroom that he shared with the other residents in the facility. The housekeeping staff routinely cleaned the bathroom, but he liked to clean it as well. He had bleach wipes and a floor mop with a cleaning solution that he purchased with his own money that he kept in his room. Some time ago, management came through and told him he couldn't have those items in his room, and they took them.	F 0657	This facility's interdisciplinary coordinates a comprehensive care plan for each resident. Resident 36: ON 1/31/2024 the care plan was updated to reflect residents ability to request appropriate cleaning supplies from the nursing staff and to be returned, not stored in room, when done. The Administrator will conduct interviews of all interviewable residents to determine those who wish to use own cleaning supplies and update care plan if warranted. On 1-24-2024 the Administrator Interdisciplinary team (IDT) was re-educated on the care plan process; specifically related to	02/16/2024

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	The resident's clinical record was reviewed on 01/04/24 at 3:27 P.M. A Quarterly MDS (Minimum Data Set) assessment, dated 10/19/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, diabetes, anxiety, depression, and cirrhosis of the liver. During an interview on 01/08/24 at 2:18 P.M., the Social Services Director indicated she was familiar with the resident. He had cleaning products that he couldn't keep in his room, things to clean the bathroom. There was someone that was using the resident's shared bathroom that would leave it messy. She talked to the nursing department about keeping his cleaning products at the nurses' station. That would be something that should be part of the resident's care plan. During an interview on 01/08/24 at 2:29 P.M., LPN (Licensed Practical Nurse) 9 indicated she knew the resident had an issue with the bathroom. He had cleaning products that they took from him and locked up in the medication room. She was told if the resident asked for the cleaning products, they could give him some, but he was not allowed to keep them in his room. She knew this because management told her, she was not sure if this was updated on the resident's care plan. The resident's complete and current care plan was provided by the MDS Coordinator on 01/08/24 at 3:23 P.M. The care plan lacked any mention of the resident's desire to clean his bathroom or the procedure for the resident to obtain his cleaning supplies. During an interview on 01/09/24 at 11:06 A.M., the DON (Director of Nursing) indicated the resident's		resident preferences; such as, using own cleaning supplies. The Social Service Director (SSD) will randomly audit 3 care plans as they are up for review to ensure the care plans reflect the personal preferences of the resident. SSD will utilize the Personal Preference Care Plan Audit tool to record the results. If a discrepancy is noted, it will be corrected immediately by updating the plan of care. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	

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	care plan should reflect his desire to use his own cleaning supplies if he asked for them. The current facility policy, titled "CARE PLAN DEVELOPMENT AND REVIEW", dated 10/2014, was provided by the Administrator on 01/08/24 at 11:09 A.M. The policy indicated, "...ensure an interdisciplinary approach to plan for and meet the resident's needs...address needs, strengths, and preferences..." 3.1-37(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to properly assess a resident after a fall for 1 of 6 residents reviewed for Quality of Care. (Resident 25) Findings include: The clinical record for Resident 25 was reviewed on 01/04/24 at 3:01 P.M. An Annual MDS (Minimum Data Set) assessment, dated 12/07/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, non-Alzheimer's dementia, anxiety, and depression.	F 0684	It is the practice of this facility to conduct accurate assessments after a fall or other changes in condition. Resident 25: This resident continues to reside at the community and there was no negative outcome noted to the resident. The staff member related to this specific incident was re-educated on the Accident and Incident Reporting Policy. All residents who fall have the potential to be affected by this alleged practice and on 1-24-2024	02/16/2024

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	A Progress Note, dated 10/16/23 at 2:45 A.M., indicated a CNA (Certified Nurse Aide) called to inform the nurse that she had just picked Resident 25 up off the floor and put her back to bed. When the nurse arrived in Wing 1 and to the resident's room the resident was in bed resting quietly. The resident's vital signs were obtained, and she complained of back pain when getting up which was not a new complaint, and her back was not hurting at that time. The resident denied hitting her head and neurological checks were initiated. The DON (Director of Nursing), MD, and family were notified. During an interview on 01/08/24 at 10:22 A.M., RN 3 indicated when a resident had a fall, he would assess the resident where they were at for injuries and find out what happened. He would then assist them up if there were no injuries that required them to be sent out to the hospital. During an interview on 01/09/24 at 2:20 P.M., CNA 11 indicated if a resident had a fall, she would turn on the resident's call light. If no one answered the call light, she would ensure the resident was safe and go to a phone to call for help. She would never assist the resident up without notifying the nurse first. The current facility policy titled, "Accident and Incident Reporting", dated 10/2014, was provided by the Regional Director of Operations on 01/10/24 at 2:17 P.M. The policy indicated, "...To document all accidents and incidents occurring to residents, employees and visitors...Resident: Complete assessment..." 3.1-37(a)		all nursing staff will be educated on the Accident and Incident Reporting Policy.; specifically related to not transferring a resident after all until the nurse assesses the resident for the safe transfer. The Director of Nursing or designee will audit all fall documentation 5 days a week for 8 weeks, 3 times a week for 8 weeks and monthly for 8 weeks to ensure assessments are completed by the nurse prior to the CNA assisting with transferring the resident and to ensure the Accident and Incident Reporting Policy is followed. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	

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F 0686 SS=E Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to completed weekly assessments and complete weekly measurements related to pressure ulcers for 4 of 4 residents reviewed for pressure ulcers. (Residents B, C, D, and E) Findings included: 1. The clinical record for Resident B was reviewed on 01/04/24 at 9:58 A.M. An Admission MDS (Minimum Data Set) assessment, dated 07/26/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, hypertension and non-Alzheimer's dementia. A Head-to-Toe Skin Check, dated 08/11/23, indicated the resident had an open area to the thoracic (mid back) area that measured 0.1 cm (centimeters) x (by) 0.3 cm.	F 0686	This facility ensures the professional standards of practice to prevent pressure ulcers and ensure residents receive the necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing. Resident B: No longer resides at the. Resident C: As of 12-1-23 all weekly pressure ulcer measurements, assessments and treatments are updated and current. Resident D: As of 12-1-23 all weekly pressure ulcer measurements, assessments and treatments are updated and current. Resident E: As of 12-1-23 all weekly pressure ulcer	02/16/2024

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	A Progress Note, dated 08/12/23 at 4:48 P.M., indicated the resident's POA (Power of Attorney) was notified of an area opening back up on the boney prominence in the thoracic area of the back with new orders. The clinical record lacked any other pressure ulcer measurements, assessments, and no other wound assessments were provided from the initial identification through the resident's discharged date of 09/27/23. During an interview on 01/08/24 at 3:23 P.M., the MDS Coordinator indicated the resident should have had completed weekly wound assessments and she was unable to find any. 2. During on observation on 01/08/24 at 2:56 P.M., Resident C was sitting in her wheelchair in her room. RN 3 let the resident know that he was going to change the dressing on her foot. RN 6 washed his hands and donned gloves. The resident's sock was removed and the dressing on the ball of the right foot was dated 01/03/24. RN 3 indicated the dressing should have been changed sooner than 6 days. The dressing was removed. There was a small amount of drainage. The wound to the ball of the residents right foot was dry and flaky, with some discoloration. The wound was dime sized with no odor. The wound was cleansed and the appropriate dressing was applied and dated. The clinical record for Resident C was reviewed on 01/04/24 at 3:41 P.M. A Quarterly MDS assessment, dated 12/28/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, hypertension, Alzheimer's disease, and depression. The resident had an unhealed Stage 3 (Full-thickness skin loss in		measurements, assessments and treatments are updated and current. The DON/Designee completed audits on all residents with documented treatments to ensure all weekly assessments/documentation is current and accurate. Audit reflected all assessments and documentation are completed weekly since December 2023. Additionally, each treatment was audited to ensure the physician order is followed and the treatment is completed timely per the physician order. Any discrepancies were addressed and corrected immediately. On 1-24-2024 the DON re-educated all licensed staff on the Assessment/Documentation/Monitoring policy related to wound care. This training will include upon identification of a skin condition the nurse will begin the completion of the appropriate initial assessment/ongoing monitoring form, the form will be placed in the Skin Binder and then the weekly assessment and documentation will be initiated. This will remain in place until the ulcer has healed for at least two weeks. Additionally, all treatments will be completed by the licensed as directed by the physician and will be documented on the TAR.	

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	which subcutaneous fat may be visible in the ulcer and epibole [rolled wound edges] are often present). A PT (Physical Therapy) Wound Assessment, dated 10/15/23, indicated the resident's right foot had dried exudate observed on the sock. The resident had a closed right plantar (bottom) foot wound. The wound bed and periwound (surrounding area) were macerated (the softening and breaking down of skin resulting from prolonged exposure to moisture). The callous was removed and a dressing was applied. A Weekly Skin Condition Report for the resident right heel, was provided by LPN (Licensed Practical Nurse) 6 on 01/10/24 at 1:34 P.M. A Weekly Pressure Ulcer Record for the right ball of the foot indicated, on 08/11/23, the resident's had a Stage 2 (Partial-thickness skin loss with exposed dermis, presenting as a shallow open ulcer). The wound measured 0.3 cm x 0.5 cm x < (less than) 0.1 cm. There was a scant amount of drainage. A Weekly Pressure Ulcer Record for the right ball of the foot indicated, on 08/18/23, the resident's Stage 2 wound measured 0.3 cm x 0.5 cm x < 0.1 cm. There was a scant amount of drainage The clinical record lacked a weekly skin assessment with documented wound measurements or assessments from 08/18/23 through 10/06/23. A Weekly Pressure Ulcer Record for the right ball of the foot indicated, on 10/06/23, the resident's Stage 2 wound measured 0.3 cm x 0.5 cm x <0.2 cm. There was a small amount of drainage,		The Director of Nursing will audit all wound documentation 5 times a week for 8 weeks, 3 times a week for 8 weeks then weekly for 8 weeks. The Skin Integrity Audit Tool will be utilized to record audit results. Any discrepancies noted will be immediately corrected and re-education completed as warranted. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	

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	A Weekly Pressure Ulcer Record for the right ball of the foot indicated, on 11/03/23, the resident's Stage 2 wound measured 0.8 cm 0.8 cm x <0.2 cm. There was a small amount of drainage, and A Weekly Pressure Ulcer Record for the right ball of the foot indicated, on 11/10/23, the resident's Stage 2 wound measured 0.3 cm 0.5 cm x <0.2 cm. There was a small amount of drainage. A Weekly Pressure Ulcer Record for the right ball of the foot indicated, on 12/06/23, the resident's Stage 3 wound measured 0.4 cm x 0.6 x 0.2 cm. A Weekly Pressure Ulcer Record for the right ball of the foot indicated, on 12/13/23, the resident's wound was scabbed. The clinical record lacked any other pressure ulcer measurements or assessments and no other wound measurements or assessments were provided. The August through December 2023 and January 2024 EMAR/ETARS (Electronic Medication Administration Record/ Electronic Treatment Administration Record) lacked documentation the resident's right foot treatments were completed for the following dates and times: - 08/14/23, dayshift, - 08/23/23, dayshift, - 08/25/23, dayshift, - 08/28/23, dayshift, - 09/04/23, dayshift, - 09/11/23, dayshift, - 09/13/23, dayshift, - 09/29/23, dayshift, - 10/11/23, dayshift,			

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	- 10/13/23, dayshift, - 10/27/23, dayshift, - 11/01/23, dayshift, - 11/10/23, dayshift, - 11/24/23, dayshift, - 12/08/23, dayshift, - 12/22/23, dayshift, and - 01/05/24, dayshift. 3. During an observation on 01/08/24 at 2:37 P.M., Resident D was in her room sitting in her recliner. Her right foot was resting over her left leg. RN 3 washed his hands and donned gloves. He removed the resident's sock. There was no dressing to the resident's right heel. The wound to her right heel measured 1.5 cm x .5 cm. There was a black area to the heel that the RN indicated was a scab. The wound was cleansed and the appropriate dressing was applied. The clinical record for Resident D was reviewed on 01/09/24 at 10:36 A.M. A Quarterly MDS assessment, dated 12/20/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, anemia, heart failure, hypertension, non-Alzheimer's dementia, anxiety, depression, and psychotic disorder. A Weekly Pressure Ulcer Record, dated 07/27/23, indicated the resident had a Stage 1 pressure ulcer to an undocumneted heel that measured 7 cm. The wound bed was red and purple. A Weekly Skin Condition Report for the residents right heel, was provided by LPN (Licensed Practical Nurse) 6 on 01/10/24 at 1:34 P.M. The assessments included the following: - 07/28/23, Stage 2. The wound measured 7.0 cm x 7.0 cm with no drainage,			

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	- 08/04/23, Stage 2. The wound measured 7.0 cm x 7.0 cm with no drainage, - 08/11/23, Stage 2. The wound measured 7.0 cm x 7.0 cm with no drainage, - 08/18/23, Stage 2. The wound measured 7.0 cm x 7.0 cm with no drainage, - 08/25/23, Stage 2. The wound measured 7.0 cm x 6.9 cm with no drainage, - 09/08/23, Stage 2. The wound measured 7.0 cm x 6.5 cm with no drainage, - 09/29/23, Stage 2. The wound measured 6.5 cm x 6.3 cm with a scant amount of drainage, - 10/06/23, Stage 2. The wound measured 5.2 cm x 5.0 cm x <0.2 cm with a scant amount of drainage, - 10/13/23, Stage 2. The wound measured 5.2 cm x 5.0 cm x <0.2 cm with a scant amount of drainage, - 10/20/23, Stage 2. The wound measured 5.2 cm x 5.0 cm x <0.2 cm with a scant amount of drainage, - 10/27/23, Stage 2. The wound measured 5.2 cm x 5.0 cm x <0.2 cm with a scant amount of drainage, - 11/03/23, Stage 2. The wound measured 0.5 cm x 1.3 cm x 0.2 cm with a moderate amount of drainage, - 11/10/23, Stage 2. The wound measured 0.5 cm x 1.3 cm x 0.2 cm with a moderate amount of drainage. A Non-Pressure Skin Report, dated 09/05/23, indicated the resident had cracked skin on her right heel that measured 1.5 cm x 0.25 cm. A Weekly Pressure Ulcer Record, dated 12/06/23, indicated the resident had a Stage 3 pressure ulcer to the right heel that measured 0.1 cm x 0.3 cm. A Weekly Pressure Ulcer Record, dated 12/13/23, indicated the resident had a Stage 3 pressure ulcer to the right heel that measured 0.1 cm x 0.3 cm. A Weekly Pressure Ulcer Record, dated 12/20/23,			

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	indicated the residents right heel wound was healed. A Weekly Pressure Ulcer Record, dated 01/04/24, indicated the resident had a Stage 2 pressure ulcer to the right heel that measured 0.5 cm x 0.4 cm x 0.2 cm. There was a moderate amount of drainage. The clinical record lacked any other pressure ulcer measurements or assessments and no other wound measurements or assessments were provided. The January 2024 EMAR/ETAR lacked documentation the wound treatment for the right heel was completed on the following dates: - 01/05/24, - 01/06/24, and - 01/07/24. During and interview on 01/10/24 at 10:57 A.M., LPN 6 indicated she had been keeping track of wounds prior to 11/10/23. She would assess the wounds weekly and provide measurements and staging of the wounds. The Physical Therapist was wound care certified and would track some of the wounds. If PT assessed the wounds she would send her the measurements and she would input them. She was not sure what the process was since 11/10/23. During an interview on 01/08/24 at 10:22 A.M. RN 3 indicated all medications and treatments were to be documented as completed in the EMAR/ETAR or in a progress note. There should never be a blank in the EMAR/ETAR. If the medication or treatment was not completed it should be documented in a progress note as to why it was not completed. All the residents' skin was			

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HANOVER NURSING CENTER	410 W LAGRANGE RD HANOVER, IN 47243

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	assessed weekly when they got a shower and documented on paper. The residents' pressure wound assessments were documented in a progress note and included the measurements. 4. The clinical record for Resident E was reviewed on 01/08/24 at 10:46 A.M. An Annual MDS assessment, dated 10/21/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, Huntington's disease, hypertension, depression, and pressure ulcers to the right foot. A Physical Therapy Wound Assessment, dated 10/12/23, indicated the resident's right foot had 3 pressure wounds on the areas of the right Achilles (heel area), dorsal (top) foot, and medial (inside) ankle. All wound beds were covered with pale pink good tissue. A Weekly Skin Condition Report for the resident's right heel, was provided by LPN 6 on 01/10/24 at 1:34 P.M. The assessments included the following: - Dated 09/29/23, the resident's Stage 2 wound measured 3.0 cm x 2.5 cm x 0.2 cm, - Dated 10/20/23, the resident's Stage 2 wound measured 1.8 cm x 2.2 cm x <0.2 cm. There was a small amount of drainage. A second wound measured 2.2 cm x 1.3 cm x <0.2 cm. There was a small amount of drainage. The documentation lacked explanation as to which wound was measured and why there was two measurments listed. - Dated 10/23/23, the resident's Stage 2 wound measured 3.3 cm x 2.8 cm x <0.2 cm. There was a small amount of drainage.			

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	- Dated 10/27/23, the resident's Stage 2 wound measures 1.8 cm x 2.1 cm x <0.2 cm. There was a small amount of drainage, and a second measurement was listed as a Stage 2 wound measured 1.7 cm x 2.0 cm x <0.2 cm. There was a small amount of drainage. There was no explanation as to which wound was measured and why there was two measurements listed. - Dated 11/10/23, the resident's right distal lateral foot, Stage 2, wound measured 1.8 cm x 2.0 cm x 0.3 cm. There was a moderate amount of drainage. - Dated 11/10/23, the resident's right planter heel, Stage 2, wound measured 2.1 cm x 1.0 cm x 0.3 cm, there was a moderate amount of drainage. - Dated 11/10/23, the resident's medial ankle, Stage 2, wound measured 1.5 cm x 1.0 cm x 0.2 cm. There was a moderate amount of drainage. - Dated 11/10/23, the resident's right achilles, Stage 2, wound measured 2.9 cm x 3.0 cm x 0.2 cm. There was a moderate amount of drainage. A Physical Therapy Wound Assessment, dated 11/23/23, indicated the resident received PT wound care from 10/12/23 to 10/22/23. The clinical record indicated the resident was out of the facility from 11/15/23 to 11/23/23. The clinical record lacked weekly wound skin assessments or measurements. The current facility policy titled, "Pressure Ulcers" dated 10/2014, was provided by the Regional Director of Operations on 01/09/24 at 1:42 P.M. The policy indicated, "...To assure that residents with pressure ulcers will receive necessary care and treatment to promote healing, prevent new			

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	ulcers from developing and prevent infection...Ongoing measurements shall be obtained by a designated, qualified person..." The current facility policy titled, "Skin Management Program", with a revised dated of 10/2013, was provided by the Regional Director of Operations on 01/09/24 at 1:42 P.M. The policy indicated, "...ASSESSMENT/DOCUMENTATION/MONITORING:...See Weekly Skin Assessment (to be used for weekly skin assessments for all residents and housed in the [Skin Binder]. Should a skin condition be identified, the licensed nurse will begin the completion of the appropriate initial assessment/ongoing monitoring form which is then placed in the Skin Binder in lieu of the weekly skin assessment)...A resident with a newly identified skin condition will have the appropriate assessment ongoing monitoring form initiated on the basis of the [type] of skin condition...See Initial Assessment/Ongoing Monitoring for Pressure Ulcer (to be housed in the [Skin Binder] and remain in place until the ulcer has remain healed for at least two weeks , at which time it is moved to the [Assessments] section of the medical record)...A weekly facility skin condition summary must be submitted to assigned corporate personnel in an effort to ensure ongoing tracking of facility prevalence/incidence in regard to skin condition..." This citation relates to Complaint IN00425296. 3.1-40(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that			

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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 interview and record review, the facility failed to ensure a resident with a urinary tract infection received antibiotic treatment in a timely manner for 1 of 3 residents reviewed for Urinary Tract Infections. (Resident 6) Findings include:	F 0690	This facility ensures that when a resident with a urinary tract infection they receive appropriate treatment; such as antibiotic treatment in a timely manner. Resident 6: On 10/26 was admitted to the hospital for	02/16/2024

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	The clinical record for Resident 6 was reviewed on 01/09/24 at 10:36 A.M. An Admission MDS (Minimum Data Set) assessment, dated 08/02/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, diabetes, renal insufficiency, and obstructive uropathy. The resident had a urinary tract infection within the last 30 days. During an interview on 01/08/24 at 2:34 P.M., LPN (Licensed Practical Nurse)12 indicated the resident had frequent UTIs (Urinary Tract Infections). They had multiple UTIs in October. The resident went out to the urologist to have their indwelling urinary catheter changed out monthly and as needed. If a resident's urinalysis indicated an infection, a C&S (Culture and Sensitivity) would be obtained to check for the appropriate antibiotic to treat the infection. It usually took 3 days to get the results of a C&S. The lab would fax the results to the facility, but nursing staff could use the computer to look up the results too. Once C&S results were available, they would notify the MD, via text or by fax. The MD would usually give an order for an antibiotic that same day. If the medication was available in the EDK (Emergency Drug Kit), nursing staff could pull it and administer it when they got the MD order. If the antibiotic wasn't available in house, the pharmacy would usually have it on the next delivery. The pharmacy made deliveries twice a day. The resident's October 2023 EMAR (Electronic Medication Administration Record) indicated a physician's order, with a start date of 10/17/23, for staff to obtain a follow up urinalysis with a C&S if indicated three days after the resident's antibiotic, Macrobid was finished. The urinalysis was		urosepsis and readmitted on 10-17-24. On 1/31/2024 was assessed and no current signs of urinary tract infection. All residents who have pending lab results have the potential to be affected by this alleged deficient practice and an audit was conduct of lab results within the last 30 days to ensure timely communication with the provider and determined if antibiotic therapy should be started, continued, modified or discontinued. Any issues identified will be addressed immediately and communicated to physician for appropriate intervention. On 1-24-2024 the DON re-educated all licensed staff on the Antibiotic Stewardship – Orders for Antibiotics policy; to include the time timely communication to the prescriber lab results as soon as possible to ensure antibiotic therapy is started, continued, modified or discontinued as warranted. DON will audit all pending labs and follow through to when results are received, physician notified, orders received and implemented. All labs will be tracked daily during 5 days a week for 8 weeks, 3 times a week for 8 weeks, and weekly for 8 weeks. Any issues noted will be addressed immediately with appropriate intervention; including re-education	

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	obtained on 10/17/23 as ordered. The urinalysis report indicated the sample was tested on 10/18/23 and the C&S results that indicated the antibiotics the bacteria was susceptible to Macrobid. The results were reported to the facility on 10/21/23. A progress note, dated 10/24/23 at 1:49 P.M., indicated the MD was in the facility and looked over the results from the resident's urinalysis. The resident still had a UTI. The MD gave an order to start an antibiotic. A physician's order, with a start date of 10/25/23, indicated the resident received Macrobid (an antibiotic) 100 mg (milligrams) twice a day for UTI until 10/31/23. A progress note, dated 10/27/23 at 4:32 A.M., indicated the resident was admitted to the hospital for urosepsis following a UTI and scrotal pain. The resident's record lacked documentation that the MD was notified of the urinalysis results prior to 10/24/23, when the facility had received the results three days prior. During an interview on 01/09/24 at 10:59 A.M., the DON (Director of Nursing) indicated it shouldn't have taken as long as it did for the resident to start an antibiotic. The resident should have been started on the antibiotic as soon as possible. The current facility policy, titled "Antibiotic Stewardship - Orders for Antibiotics", with a revision date of December 2016, was provided by the DON on 01/10/24 at 11:18 A.M. The policy indicated, "...When a culture and sensitivity (C&S) is ordered, it will be completed, and...Lab		as warranted. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	

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	results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued..." 3.1-41(a)(2)			
F 0732 SS=D 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. (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			

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	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 and interview, the facility failed to post nurse staffing daily for 3 of 7 days observed. (1/2, 1/8, and 1/9/24) Findings include: During an observation on 01/02/24 at 10:40 A.M., the nurse staffing was posted on a table by the front door and dated for 12/29/23. During an observation on 01/08/24 at 10:48 A.M., the nurse staffing was posted on a table by the front door and dated for 01/05/24. During an observation on 01/08/24 at 4:02 P.M., the nurse staffing was posted on a table by the front door and dated for 01/05/24. During an observation on 01/09/24 at 9:40 A.M., the nurse staffing was posted on a table by the front door and dated for 01/05/24. During an interview on 01/10/24 at 11:41 A.M., the Business Office Manager indicated she receives a copy of the daily nursing schedule each morning and updates the staff posting. She works Monday through Friday. Currently no one updates the staff posting on the weekends or when she is off work. The current facility policy titled, "Posting Direct Care Daily Staffing Numbers", with a revision date	F 0732	It is the practice of this facility to post the nurse staffing data daily. On 1/2/2024 the facility posted the Nurse Staffing Information at the front reception area, to show the facility name, current date, total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. The categories included Registered Nurses, Licensed Practical Nurses, or Licensed Vocational Nurses, Certified Nursing Aides, and Resident Census. The posting was in a clear and readable format in a prominent place accessible to residents and visitors. All residents who reside in the facility have the potential to be affected by the alleged deficient practice. On 1-10-2024 the Administrator inserviced the Director of Nursing and all other Department Managers; Business Office Manager, Human Resource Director, MDS Coordinator, Activity Director, Social Service Director, Dining Service Manager,	02/16/2024

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	of July 2016, was provided by the Consultant on 01/10/24 at 11:52 A.M. The policy indicated, "...Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents..."		and Maintenance Director on the requirements of Nursing Information Posting. The Administrator and designee will audit the staff posting daily for 8 weeks to assure compliance with posting requirements, twice a week for 8 weeks and then weekly for 8 weeks. Any issues will be corrected upon finding. The results will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.			

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	§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on record review and interview, the facility failed to accurately reconcile a resident's medications upon readmission to the facility and to verify a diagnosis was appropriate for the administration of an antibiotic for 2 of 6 residents reviewed for pharmacy services. (Residents 6 and 32) Findings include: 1. The clinical record for Resident 6 was reviewed on 01/09/24 at 10:36 A.M. An Admission MDS (Minimum Data Set) assessment, dated 08/02/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, atrial fibrillation, coronary artery disease, diabetes, renal insufficiency, obstructive uropathy, anxiety, depression, bipolar disorder, and PTSD (Post Traumatic Stress Disorder). A progress note, dated 10/26/23 at 5:25 P.M., indicated the resident was complaining of severe testicular pain and was sent to the local hospital	F 0755	The facility provides routine and emergency drugs and biologicals to its residents, or obtains them under an agreement. Resident 6: On 1-31-2024 reviewed resident's physician orders and all are accurately prescribed All new admissions and readmissions have the potential to be affected by this alleged deficient practice. An audit was completed on all new and readmissions within the last 60 days to ensure medications are reconciled accurately. If any discrepancies noted corrections will be made upon discovery. On 1-24-2024 the DON will educate all nurses will be educated on the Medication Reconciliation policy; additionally for readmissions the discharge	02/16/2024

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	for evaluation. A progress note, dated 10/27/23 at 4:32 A.M., indicated the resident was admitted to the hospital for urosepsis following a UTI (Urinary Tract Infection) and scrotal pain. The resident's physician's orders at the time of discharge from the facility included, but were not limited to the following: - A physician's order, with a start date of 07/26/23 and a discontinued date of 10/27/23 for Apixaban (an anticoagulant), 5 mg (milligrams) twice a day for atrial fibrillation. The EMAR (Electronic Medication Administration Record) indicated the medication was administered twice a day at 7:00 A.M. and 7:00 P.M. as it was ordered until 10/27/23. - A physician's order, with a start date of 07/26/23 and a discontinued date of 10/27/23 for Risperidone (an antipsychotic medication) 1 mg twice a day for bipolar disorder. The EMAR indicated the medication was administered twice a day at 7:00 A.M. and 7:00 P.M. as it was ordered until 10/27/23. A progress note, dated 10/27/23 at 8:30 P.M., indicated the resident returned from the local hospital and was assisted back to their room. New physician's orders were put into the computer and the DON/ADON (Director of Nursing/Assistant Director of Nursing) would be notified of their return. The discharge packet from the resident's hospitalization on 10/26/23 to 10/27/23 was reviewed. There was no indication the Apixaban medication order was decreased from twice daily		summary will be compared to orders prior to discharge and note any discrepancies on the Medication Reconciliation Worksheet and communicate to the physician/prescriber when clarifying orders. Additionally, the training will include verifying the diagnosis is appropriate for antibiotic therapy. The DON/designee will audit all new admissions and re-admissions within 24 hours to ensure all medications are accurate and have the accurate supportive diagnosis related to antibiotic therapy. The results of the audit will be recorded on the Medication Reconciliation Audit Tool. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	

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to once a day. There was no indication the Risperidone medication dosage was increased from 1 mg to 1.5 mg twice daily.

The resident's October, November, and December 2023 EMAR indicated the following:

- The resident received Apixaban, 5 mg once a day for blood thinner. The EMAR indicated the medication was administered once daily at 7:00 A.M., from 10/28/23 through 12/04/23., and

- The resident received Risperidone 1.5 mg twice a day for bipolar disorder. The EMAR indicated the medication was administered twice a day at 7:00 A.M. and 7:00 P.M. until 12/04/23.

During an interview on 01/08/24 at 2:09 P.M., RN 3 indicated when a resident returned from the hospital, nursing staff were to review the hospital discharge packet and verify the physician's orders. They would check for new orders, changes to existing orders, and discontinued orders. They would give the hospital paperwork to the facility medical records person. RN 3 was not sure if the packet was reviewed further.

During an interview on 01/09/24 at 10:59 A.M., the DON indicated nursing staff were to call the MD and verify orders/request clarification of orders if needed. The discharge packet would be placed in a binder and would be double checked by the ADON or DON. The resident's hospital discharge orders should have been double checked. The facility should have resumed the previous medication orders for the Apixaban and the Risperidone. The resident suffered no ill effects from the medication errors.

The current facility policy, titled "MEDICATION

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	RECONCILLIATION", with a revision date of 10/15, was provided by the DON on 01/09/24 at 1:49 P.M. The policy indicated, "...The admitting nurse must reconcile (compare) the medications from the resident's history with those medications ordered for treating current conditions upon admission...Discrepancies...must be noted using the Medication Reconciliation Worksheet and communicated to the physician/prescriber when clarifying admission orders..." 2. The clinical record for Resident 32 was reviewed on 01/03/24 at 2:35 P.M. A Quarterly MDS assessment, dated 11/10/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, pneumonia and wound infection. The resident was taking an antibiotic. The October 2023 EMAR was provided by the Administrator on 01/08/24 at 3:07 P.M., and indicated the resident had received the following antibiotics: - Azithromycin 500 mg one time a day related to Huntington's disease, with a start date of 11/04/23 and a discontinued date of 11/06/23. - Azithromycin 500 mg one time a day related to Huntington's disease, with a start date of 11/07/23 and a discontinued date of 11/10/23. During an interview on 01/08/24 at 2:35 P.M., LPN (Licensed Practical Nurse) 6 indicated when new antibiotics were prescribed, she reviewed the orders, then she and the NP (Nurse Practitioner) determined if the the diagnosis for the order was appropriate. They determined which antibiotic to use based on the residents' individual laboratory results. Huntington's Disease was not an appropriate diagnosis for an antibiotic.			

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	During an interview on 01/09/24 at 9:37 A.M., LPN 9 indicated the staff asked the MD when receiving the order for the diagnosis. If she questioned the diagnosis, she would call the MD to verify. The current Physician Recapitulation Order Review policy, dated 10/2014, was provided by the Administrator on 01/08/24 at 3:14 PM. The policy indicated, "...Physician orders are reviewed monthly to validate that orders are clear, complete and accurate...Carefully note diagnoses..." 3.1-25(e)(3) 3.1-37(a) 3.1-48(a)(1)			
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the			

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	attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on interview and record review, the facility failed to follow pharmacy recommendations for 1 of 5 residents reviewed for medication irregularities. (Resident 6) Findings include: The clinical record for Resident 6 was reviewed on 01/09/24 at 10:36 A.M. An Admission MDS (Minimum Data Set) assessment, dated 08/02/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, atrial fibrillation, coronary artery disease, diabetes, renal insufficiency, obstructive uropathy, anxiety, depression, and bipolar disorder. Findings include:	F 0756	This facility follows policy and procedures for the monthly drug regimen that, include but not limited to, time frames for pharmacy recommendations when irregularities are identified that requires urgent action to protect the resident. Resident 6: The pharmacy recommendation was addressed on 12-4-2024 and the medication transcription error corrected. All residents with recommendations from the pharmacist have the potential to be affected by this alleged deficient practice. An audit was completed on all pharmacy	02/16/2024

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	1. The clinical record for Resident 6 was reviewed on 01/09/24 at 10:36 A.M. An Admission MDS (Minimum Data Set) assessment, dated 08/02/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, atrial fibrillation, coronary artery disease, peripheral vascular disease, diabetes, renal insufficiency, and obstructive uropathy. The resident was hospitalized on 10/26/23 and returned to the facility on 10/27/23. A Consultant Pharmacy Recommendation to Nursing, dated 11/03/23, recommended nursing staff look at a couple of possible medication errors. The recommendation indicated, in reviewing the hospital discharge orders from 10/27/23, it looked like the resident should have come back with Apixaban (an anticoagulant medication) 5 mg (milligrams) twice a day and Risperdal (an antipsychotic medication) 1 mg twice a day. However, for whatever reason, Apixaban 5 mg once daily and Risperdal 1.5 mg twice daily was on the EMAR (Electronic Medication Administration Record) at that time. "...Please evaluate and go back to the previous orders..." The resident's October, November, and December 2023 EMAR indicated the following: A physician's order, with a start date of A physician's order, with a start date of 10/28/23 and a discontinued date of 12/04/23 for Apixaban, 5 mg once a day for blood thinner. The EMAR indicated the medication was administered once daily at 7:00 A.M., from 10/28/23 through 12/04/23. A physician's order, with a start date of 10/28/23 and a discontinued date of 12/04/23 for		recommendations for October, November and December and any issues identified were communicated immediately to the provider and addressed. On 1-23-24 the Administrator educated the Director of Nurses on Documentation and Communication of Consultant Pharmacist Recommendation policy; specifically related to the timely communication to ensure the issue is addressed prior to the next medication regimen review. Additionally, in the event a issue is identified with the prescriber response, the prescriber and/or physician's designee will be contacted by the consulting pharmacist or the facility, and the prescriber's response will be documented on the consultant pharmacist review record or in the medical record. The Director of Nursing will audit all monthly pharmacy recommendations to ensure timely response from the provider/prescriber. Once the monthly pharmacy recommendations are received the provider/prescriber will be notified during the weekly visit to the facility. The is recommendations will be audited weekly for 8 weeks, bi-monthly for 8 weeks and monthly for 8 weeks. This process will be audited on the Pharmacy Recommendation Audit Tool. The findings will be reported to the	

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	Risperidone (Risperdal) 1.5 mg twice a day for bipolar disorder. The EMAR indicated the medication was administered twice a day at 7:00 A.M. and 7:00 P.M. until 12/04/23. The resident's clinical record lacked any indication the pharmacy recommendation was addressed until 12/04/23 when the medications were changed back to the prior dosage and administration frequency. During an interview on 01/09/24 at 10:59 A.M., the DON (Director of Nursing) indicated pharmacy recommendations should be addressed within a few days, or immediately depending on the recommendation. Sometimes it took a long time for a response from the MD for the recommendation. This recommendation should have been addressed immediately. The current facility policy, titled "Documentation and Communication of Consultant Pharmacist Recommendations", with an effective date of 08/2020, was provided by the Regional Consultant on 01/10/24 at 11:36 A.M. The policy indicated, "...Comments and recommendations concerning medication therapy are communicated in a timely fashion...The timing of these recommendations should enable a response prior to the next medication regimen review...In the event of a problem requiring the immediate attention of the prescriber, the responsible prescriber or physician's designee is contacted by the consultant pharmacist or the facility, and the prescriber's response is documented on the consultant pharmacist review record or elsewhere in the resident's medical record..." 3.1-25(i)		Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 100%.	

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F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §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 appropriately store medications for 1 of 2 medication rooms (Unit 1 medication room) and 2 of 4 medication carts reviewed. (Wing 1 Medication Cart and Wing 2 Medication Cart) Findings include: 1. The medication room on Wing 1 was observed on 01/05/24 at 11:25 A.M., with QMA (Qualified Medication Aide) 2. The refrigerator contained a	F 0761	The facility does label and store drugs and biologicals in a safe, secure and orderly manner. Additionally, the facility returns discontinued, outdated or deteriorated drugs or biologicals to the pharmacy in a timely manner. 1 Tuberculin serum was open and with no date: On 1/5/24 this was discarded 2 Insulin Pen was open and	02/16/2024

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	vial of Tuberculin serum that was half full and had no open date on the vial or box containing the vial. The QMA indicated staff were to date items when they were opened. During an interview on 01/08/24 at 9:44 A.M., on Wing 1, RN 3 indicated he had been working on the unit since October of 2023, he usually worked day shift, and he had not used the TB serum. He had not completed any new admissions since he had been on the unit but there had been one admission on 11/15/23, Resident 58. The Tuberculin serum package insert was provided by the Regional Director of Operations on 01/09/24 at 3:42 P.M. The insert indicated, "...Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency..." 2. The Wing 1 Medication Cart was observed on 01/05/24 at 11:32 A.M., with QMA 2 and contained the following: - A Humalog insulin pen for Resident 22, 1/4 full with no open date and a delivery date of 10/06/23, - one medium size round brown tablet, - one medium size round white table, - one medium size oval white tablet, - one, 3/4 piece of a medium round green tablet, and - two, 1/4 pieces of white tablets in the bottom of the drawers of medications. The QMA indicated Resident 22 received Humalog insulin usually every day. Staff were to date items when they were opened. 3. The Blue Medication Cart on Wing 2 was observed on 01/05/24 at 11:49 A.M., with LPN		no date: On 1/5/24 this was discarded 3 5 Cards of tetrabenazine; consisting of 4 full cards of 30 tablets and 1 card of 16 tablets were destroyed On 1-10-24 an audit was completed off all medication rooms for all refrigerated medication to ensure appropriated stored and labeled and on 1-10-24 an audit of all medication carts completed and all discrepancies addressed. On 1-24-24 the DON re-educated all licensed staff on Storage of Medications policy; specifically related to open vials and appropriate dates and the process to manage medications of all discharged/transferred residents. The DON/Designee will random conduct audits of the medication rooms and medication carts to ensure the process for storing and dating medications is in compliance. These audits will be weekly for 8 weeks, bi-weekly for 8 weeks and monthly for 8 weeks. If issues are identified they will be addressed and immediately corrected. The findings will be reported to the Monthly QAPI Committee and if any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved	

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	(Licensed Practical Nurse) 4 and contained the following: - 5 cards of medications, for Resident 70, tetrabenazine 12.5 milligrams, four full cards of 30 tablets and one card with 16 tablets. LPN 4 indicated the resident was no longer on the unit and if a resident was discharged, they would destroy the medications, send them back to the pharmacy, or send them home with the resident. During an interview on 01/05/24 at 12:00 P.M., LPN 5 indicated the resident had passed away in October. Medications were usually put in the medication room and LPN 6 would address them. The pharmacy would not take the tetrabenazine back, it had to be destroyed. The current "Storage of Medications" policy, with a revised date of April 2007, was provided by the Regional Director of Operations on 01/09/24 at 3:24 P.M. The policy indicated, "...The facility shall store all drugs and biological in a safe, secure, and orderly manner...The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals..." 3.1-25(k)(6) 3.1-25(o)		and substantial compliance is achieved 95% or greater.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.			

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	(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to store food safely, monitor the dishwasher, and provide a clean kitchen environment for 3 of 3 kitchen observations. This deficient practice had the potential to effect 67 of 67 residents that resided in the facility. Findings include: During an initial tour of the kitchen on 01/04/24 at 10:48 A.M., the following areas of concern were observed: The walk-in refrigerator contained the following: - an undated, five pound bag of shredded cheddar cheese, 1/3 full. The bag was open to air. - an undated, gallon sized bag of sliced Swiss cheese. The bag was open to air, several slices of cheese were dry around the edges, and	F 0812	It is the practice of this facility to ensure all food preparation and serving areas are maintained in accordance with state and local sanitation and safe food handling standards. The following areas were corrected on 1-4-24: 1 The Undated open bag of cheese was discarded. 2 The ground beef was moved to the bottom shelf. 3 The refrigerator in the serving was cleaned. 4 The undated bag of bologna was discarded. 5 The undated package of sliced deli turkey was discarded. 6 The updated package of Swiss cheese was discarded. 7 The dishwasher service technician replaced the temperature gauge, supplied the	02/16/2024

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	- a box that contained a 20 pound plastic bag of ground beef on the third shelf up from the bottom of the rack. The box was dry and the seal on the plastic bag was intact, without leakage. The box was stored directly over a shelf that contained sealed packages of pre-cooked ham and deli turkey. During an interview on 01/04/24 at 10:50 A.M., the Kitchen Manager indicated the ground beef was thawing. The meat should have been placed on the lowest shelf in a shallow pan. It should never be stored above any other food. The Kitchen Manager moved the ground beef to the lowest shelf. The cheese should have been sealed properly and labeled with an opened on and use by date. The refrigerator in the serving room had a shelf inside the refrigerator door with an area approximately 5 inches in diameter of a sticky brown/green substance where the following items were stored: - an undated, gallon sized bag of bologna, - an undated package of sliced deli turkey. The meat in the package was pink with areas of brown around the edges, and - an undated package of Swiss cheese slices. The package was open to air, the cheese slices were dry around the edges. The dishwasher cleaning cycle was observed on 1/04/24 at 10:21 A.M., with the Kitchen Manager. The Kitchen Manager placed some items on a rack and started the dishwasher. The cover of the temperature gauge was very cloudy and difficult to read. The gauge did not seem to move to		appropriate test strips to check chemical sanitization; thus, the dishwasher temperature and level of sanitizer was tested and was appropriate. All residents have the potential to be affected by this affected deficient practice. On 1/4/24 The Administrator re-educated the Dining Service staff scheduled on Testing Sanitizer Concentration in Low Temperature Dish Machines and Cleaning Schedules. On 1-11-24 the Dietary Manager re-educated all dining service staff on Testing Sanitizer Concentration in Low Temperature Dish Machines and Cleaning Schedules. Additionally, all cleaning and temperature logs are posted. The Dining Service Manager will audit the dishwasher temperature log 5 days a week for 2 months, 2 times a week for 2 months and 1 time week for 2 months. Any issues identified will be addressed and corrected; it warranted additional training will be conducted. If any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	

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	indicate the appropriate temperature was achieved during the cleaning process. The Kitchen Manager attempted to perform a test to check for sanitizer concentration during the cleaning process but did not use the correct test strips. She indicated she did not normally run the dishwasher and did not normally perform the chem (chemical) test or document the dishwasher temperature when she ran the dishwasher. CNA (Certified Nurse Aide) 14 was in the dish room and indicated she sometimes helped with the dishes. CNA 14 indicated she had not used a chem test strip to test sanitization. A "Dishmachine Log" was hanging on a clipboard on the wall near the dishwasher. The log was from June 2023, and had multiple blanks for the dishwasher temperatures and chem tests that were to be monitored three times a day. The Kitchen Manager did not know if additional logs were filled out with any regularity. On 01/04/24 at 11:00 A.M., the Administrator indicated the facility would be using disposable dishware until they could get someone out to address the issues with the dishwasher. On 01/04/24 at 2:00 P.M., the dishwasher service technician replaced the temperature gauge on the dishwasher and supplied the appropriate test strips to check chemical sanitization. The dishwasher temperature and level of sanitizer was tested and was appropriate. The Administrator indicated the facility could provide no additional logs of temperature monitoring or chem strip testing. On 01/10/24 at 11:45 A.M., the steam table/serving area of the kitchen was observed with the Kitchen Manager. The following was observed: - a round fan in the ceiling directly above the			

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	steam table was covered in a visible layer of gray dust, - a rectangular vent in the ceiling above the serving table had visible gray dust on the actual vent and a spray of gray dust on the ceiling around each corner of the vent, and - two square vents in the ceiling above the serving area and in the main kitchen were covered in a visible layer of gray dust. During an interview on 01/10/24 at 11:45 A.M., the Kitchen Manager indicated she was not sure who was supposed to clean the vents and fans in the kitchen. Everyone in the kitchen just knew what was supposed to be cleaned. There were no documented cleaning schedules or cleaning logs. The current facility policy, titled "Storage of Foods under Sanitary Conditions", dated 06/2018, was provided by the Administrator on 01/08/24 at 12:02 P.M. The policy indicated, "...All food items stored in the refrigerator must be labeled and dated if NOT scheduled to be served at the next meal...All food items should be placed in containers with tight-fitting lids..." The current facility policy, titled "Recording Temperature of Dish Machine", dated 06/2018, was provided by the Administrator on 01/08/24 at 12:02 P.M. The policy indicated, "...At least daily, record gauge temperatures for the wash and rinse cycles..." The current facility policy, titled "Testing Sanitizer Concentration in Low Temperature Dish Machines", dated 06/2018, was provided by the Administrator on 01/08/24 at 12:02 P.M. The policy indicated, "...At least daily, test sanitizer			

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	concentration by using the designated testing strip provided by the chemical vendor or ordered with supplies...Write testing strip results on the form kept in the Dietary Department..." The current facility policy, titled "Cleaning Schedule", dated 06/2018, was provided by the Regional Director of Operations on 01/10/24 at 1:26 P.M. The policy indicated, "...Daily cleaning duties should be listed on the individual job procedure or master cleaning schedule...A new cleaning schedule is posted weekly or monthly with cleaning assignments for each employee...it is initialed and dated by the employee who completed the job..." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0881 SS=E Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on record review and interview the facility failed to track antibiotic use for 3 of 6 residents reviewed for antibiotic stewardship. (Residents D, 6, 32, and 16) Findings include: 1. The clinical record for Resident D was reviewed on 01/09/24 at 10:36 A.M. A Quarterly MDS	F 0881	This facility does implement their protocol for antibiotic use. Resident D: On 1/30/24 the November Antibiotic Stewardship tracking and trending records were updated to include the antibiotic of Clindamycin. Resident 6: On 1/30/24 the October Antibiotic Stewardship	02/16/2024

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	(Minimum Data Set), dated 12/20/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, dementia, anemia, heart failure, hypertension, non-Alzheimer's dementia, anxiety, depression, and psychotic disorder. The November 2023 EMAR/ETAR (Electronic Medication Administration Record/Electronic Treatment Administration Record) indicated the resident had received Clindamycin (an antibiotic) 600 mg (milligrams), twice a day from 11/02/23 through 11/08/23. The Antibiotic Stewardship tracking and trending records for November 2023 were provided by the Administrator on 01/08/24 at 3:07 P.M. The records lacked documentation of the prescribed antibiotic of Clindamycin for the resident. 2. The clinical record for Resident 6 was reviewed on 01/09/24 at 10:36 A.M. An Admission MDS assessment, dated 08/02/23, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, diabetes, renal insufficiency, and obstructive uropathy. The resident had a urinary tract infection within the last 30 days. The October 2023 EMAR/ETAR indicated the resident received the following medications: - Macrobid (an antibiotic) 100 mg, twice a day from 10/25/23 through 10/26/23, and - Augmentin (an antibiotic) 875 mg, twice a day from 10/28/23 through 11/01/23. The Antibiotic Stewardship tracking and trending records for October 2023 were provided by the Administrator on 01/08/24 at 3:07 P.M. The		tracking and trending records were updated to include Macrobid and Augmentin. Resident 32: On 1/30/24 the November Antibiotic Stewardship tracking and trending records were updated to include Azithromycin and Cefdinir. Resident 16: On 1/30/24 the October and November Antibiotic Stewardship tracking and trending records were updated to include Macrobid and Bactrim All residents with infections have the potential to be affected by this alleged deficient practice. A facility wide audit was completed listing anyone with an infection and surveillance logs were updated accordingly. The ABT binder is current and update to date currently. On 1-23-2024 the Director of Nursing re-educated the Infection Preventionist on the Establishment of an Antibiotic Stewardship Program. The DON or designee will review the Infection Control/ABT use binder weekly for 2 months, then every other week times 2 months and then monthly times 2 months to ensure surveillance forms and protocol are kept up to date. Any concerns will be addressed as discovered. If any patterns are identified at the monthly QAPI meeting and action plan will be written by the committee and any written action	

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	records lacked documentation of the above mentioned prescribed antibiotics for the resident. 3. The clinical record for Resident 32 was reviewed on 01/03/24 at 2:35 P.M. A Quarterly MDS assessment, dated 11/10/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, pneumonia and wound infection. The resident was taking an antibiotic and an indication was noted. The October 2023 EMAR was provided by the Administrator on 01/08/24 at 3:07 P.M., and indicated the resident had received the following antibiotics: - Azithromycin 500 mg one time a day related to Huntington's disease with a start date of 11/04/23 and a discontinued date of 11/06/23, - Azithromycin 500 mg one time a day related to Huntington's disease with a start date of 11/07/23 and a discontinued date of 11/10/23, and - Cefdinir 300 mg two times a day related to pneumonitis with a start date of 11/03/2023 and a discontinued date of 11/06/23. The Antibiotic Stewardship tracking and trending records for November 2023 were provided by the Administrator on 01/08/24 at 3:07 P.M. The records lacked documentation of the prescribed antibiotics of Azithromycin and Cefdinir for the resident. 4. The clinical record for Resident 16 was reviewed on 01/09/24 at 1:38 .P.M. A Significant Change MDS assessment, dated 10/11/23, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, Huntington's Disease, anemia, and UTI (Urinary		plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved at 95% or greater.	

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	Tract Infection) in the last 30 days. The October 2023 EMAR was provided by the MDS Coordinator on 01/09/24 at 2:31 P.M., and indicated the resident had received the following antibiotics: - Macrobid 100 mg at bedtime for preventative for bacterial UTI infection with a start date of 09/30/23 and a discontinued date of 12/10/23. The November 2023 EMAR was provided by the MDS Coordinator on 01/09/24 at 2:31 P.M., and indicated the resident had received the following antibiotics: - Macrobid 100 mg at bedtime for preventative for bacterial UTI infection with a start date of 09/30/23 and a discontinued date of 12/10/23, and - Bactrim 800-160 mg two times a day for a wound infection for 13 administrations with a start date of 11/21/23. The Antibiotic Stewardship tracking and trending records for October and November 2023 were provided by the Administrator on 01/08/24 at 3:07 P.M. The records lacked documentation of the prescribed antibiotics of Macrobid and Bactrim for the resident. During an interview on 01/04/24 at 10:42 A.M., the DON (Director of Nursing) indicated the Infection Control tracking and trending records were current. During an interview on 01/08/24 at 2:35 P.M., LPN (Licensed Practical Nurse) 6 indicated for Antibiotic Stewardship the Administrative staff went through the new physician orders during the			

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	morning meeting. She added them to the tracking and trending if there were new antibiotics prescribed. If a resident returned from the hospital already on an antibiotic, she added them to the tracking and trending records. During an interview on 01/09/24 at 2:15 P.M., the MDS Coordinator indicated all antibiotics administered in the facility should be listed on the Antibiotic Stewardship tracking and trending even if they were given as a preventative measure. The current "ESTABLISHMENT OF AN ANTIBIOTIC STEWARDSHIP PROGRAM" was provided by the DON on 01/09/24 at 1:45 P.M. The policy indicated, "...The facility will create and implement surveillance tools for tracking infections and antibiotic use trends in the facility..." The current "Surveillance for Infections" policy, with a revised date of July 2016, was provided by the Regional Director of Operations on 01/05/24 at 11:25 A.M. The policy indicated, "...The Infection Preventionist or designated infection control personnel is responsible for gathering and interpreting surveillance data..."			
F 0887 SS=D Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized;			

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	(ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks			

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	associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). Based on record review and interview, the facility failed to provide a COVID-19 immunization in a timely manner for 1 of 6 residents reviewed for immunizations. (Resident 64) Findings include: The clinical record for Resident 64 was reviewed on 01/10/24 at 10:16 A.M. The resident was admitted on 06/19/23. A Quarterly MDS (Minimum Data Set) assessment, dated 10/24/23, indicated the resident was moderately cognitively impaired. The diagnoses included, but were not limited to, Huntington's disease, anxiety, and depression. The "CONSENT TO COVID-19 VACCINE" record, signed by the resident's representative on 06/19/23, indicated the resident had received a copy of the most current COVID-19 Emergency Use Authorization. The resident's representative understood the benefits and risks associated with the vaccine and consented to receive the vaccination as determined by current CDC guidelines. The clinical record lacked documentation the resident had received a COVID-19 vaccine since admission on 06/19/23. The Progress Notes, from 06/14/23 to present, lacked documentation the resident had been offered a COVID-19 vaccine.	F 0887	This facility practices to provide COVID-19 immunization in a timely manner to their residents. Resident 64: On 1-31-2024 the DON contacted the provider to receive the order of covid-19 vaccine and contacted the pharmacy to retrieve the vaccine for administration. All new admissions have the potential to be affected by this alleged deficient practice. An Audit was completed on all admission over the past 90 days to ensure covid-19 immunization consents are implemented. Any discrepancies identified will be addressed and corrected. On 1-24-24 the Director of Nursing re-educated all licensed staff; including, the Infection Preventionist on the Consent to COVID-19 Vaccine process and Chosen Healthcare COVID-19 Vaccine Policies and Procedures. The Director of Nursing/designee will audit new admissions COVID-19 Immunization Consents to ensure the process is followed and the vaccine administered. The new COVID-10 immunization consents will be monitored with	02/16/2024

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R 0000	During an interview on 01/09/24 at 3:10 P.M., the Director of Nursing (DON) indicated if a resident requests a vaccine, an order would be obtained from the physician and the pharmacy would be notified. When the vaccine was the delivered from the pharmacy the vaccine would be given and the resident monitored for side effects for 72 hours. Vaccines are documented in the electronic health record. There was no documentation indicating Resident 64 had received a COVID-19 vaccine. A CDC (Centers for Disease Control) press release, dated 09/12/23, indicated, "... Updated COVID-19 vaccines from Pfizer-BioNTech and Moderna will be available later this week. Vaccination remains the best protection against COVID-19-related hospitalization and death. Vaccination also reduces your chance of suffering the effects of Long COVID, which can develop during or following acute infection and last for an extended duration. If you have not received a COVID-19 vaccine in the past 2 months, get an updated COVID-19 vaccine to protect yourself this fall and winter..." The current facility policy, titled "CHOSEN HEALTHCARE COVID-19 VACCINE POLICIES AND PROCEDURES" was provided by the Administrator on 01/02/24 at 12:35 P.M. The policy indicated"...The COVID-19 vaccine will be ordered from either our LTC (Long Term Care) pharmacy or local or state health agency or arrangements will be made with a vaccine provider to administer the vaccine to staff or residents..." 3.1-18(b)(1)		each new admission for 6 months and any issues identified will be addressed and corrected immediately. If any patterns are identified at the monthly QAPI meeting and action plan will be written by the committee and any written action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved at 95% or greater.	

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Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaints IN00425296, IN00424607, IN00424285, IN00423795, IN00423420, and IN00422985. Complaint IN00425296- State/Federal deficiency related to the allegation is cited at F686. Complaint IN00424607- No deficiencies cited. Complaint IN00424285- No deficiencies cited. Complaint IN00423795- No deficiencies cited. Complaint IN00423420- No deficiencies cited. Complaint IN00422985- No deficiencies cited. Survey Dates: January 2, 3, 4, 5, 8, 9, and 10, 2024. Facility number: 000115 Residential Census: 8 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 18, 2024.	R 0000	Preparation and or the execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or executed solely as required.	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and			

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	simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.			
	Based on record review and interview the facility failed to regularly conduct fire drills for 4 of the 12 months reviewed. (April, September, October, and December 2023) Findings include: The fire drill records were provided by the Consultant on 01/10/24 at 11:20 A.M. The records lacked documentation the required fire drills were conducted for the following months: - April 2023, - September 2023, - October 2023, and - December 2023. During an interview on 01/10/24 at 11:31 A.M., the Consultant indicated the fire drills should be conducted monthly and she was not able to locate the fire drills for April, September, October, and December 2023.	R 0092	The facility does maintain a written fire and disaster preparedness plan to assure continuity of care of residents in case of an emergency. It is the practice of this facility to hold fire drills monthly, at least quarterly on each shift. All residents have the potential to be affected; however, there was no actual harm to any resident. ON 1-10-2024 the Administrator in-serviced the Maintenance Director on frequency of fire drills. The times of fire drills will be monitored by the Administrator or designee monthly for 6 month. The Maintenance Director will report the results to the QAPI Committee Monthly for 6 months. If any patterns are identified at the monthly QAPI meeting an action	02/16/2024

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	The current facility policy titled, "Fire Safety/Disaster Plan" with a revision date of 9/17 was provided by the Regional Director of Operations on 01/10/24 at 11:39 A.M. The policy indicated, "...It shall be the policy of this facility to maintain a plan for fire safety and response to fire which will protect the residents and staff of the facility..."		plan will be written by the committee. Any action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved at 95% or greater.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, the facility failed to store food safely, monitor the dishwasher, and provide a clean kitchen environment for 3 of 3 kitchen observations. This deficient practice had the potential to effect 8 of 8 residents that resided in the facility. Findings include: During an initial tour of the kitchen on 01/04/24 at 10:48 A.M., the following areas of concern were observed: The walk-in refrigerator contained the following: - an undated, five pound bag of shredded cheddar cheese, 1/3 full. The bag was open to air. - an undated, gallon sized bag of sliced Swiss cheese. The bag was open to air, several slices of cheese were dry around the edges, and	R 0273	It is the practice of this facility to ensure all food preparation and serving areas are maintained in accordance with state and local sanitation and safe food handling standards. The following areas were corrected on 1-4-24: 1 The Undated open bag of cheese was discarded. 2 The ground beef was moved to the bottom shelf. 3 The refrigerator in the serving was cleaned. 4 The undated bag of bologna was discarded. 5 The undated package of sliced deli turkey was discarded. 6 The updated package of Swiss cheese was discarded. 7 The dishwasher service technician replaced the temperature gauge, supplied the	02/16/2024

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	- a box that contained a 20 pound plastic bag of ground beef on the third shelf up from the bottom of the rack. The box was dry and the seal on the plastic bag was intact, without leakage. The box was stored directly over a shelf that contained sealed packages of pre-cooked ham and deli turkey. During an interview on 01/04/24 at 10:50 A.M., the Kitchen Manager indicated the ground beef was thawing. The meat should have been placed on the lowest shelf in a shallow pan. It should never be stored above any other food. The Kitchen Manager moved the ground beef to the lowest shelf. The cheese should have been sealed properly and labeled with an opened on and use by date. The refrigerator in the serving room had a shelf inside the refrigerator door with an area approximately 5 inches in diameter of a sticky brown/green substance where the following items were stored: - an undated, gallon sized bag of bologna, - an undated package of sliced deli turkey. The meat in the package was pink with areas of brown around the edges, and - an undated package of Swiss cheese slices. The package was open to air, the cheese slices were dry around the edges. The dishwasher cleaning cycle was observed on 1/04/24 at 10:21 A.M., with the Kitchen Manager. The Kitchen Manager placed some items on a rack and started the dishwasher. The cover of the temperature gauge was very cloudy and difficult to read. The gauge did not seem to move to		appropriate test strips to check chemical sanitization; thus, the dishwasher temperature and level of sanitizer was tested and was appropriate. All residents have the potential to be affected by this affected deficient practice. On 1/4/24 The Administrator re-educated the Dining Service staff scheduled on Testing Sanitizer Concentration in Low Temperature Dish Machines and Cleaning Schedules. On 1-11-24 the Dietary Manager re-educated all dining service staff on Testing Sanitizer Concentration in Low Temperature Dish Machines and Cleaning Schedules. Additionally, all cleaning and temperature logs are posted. The Dining Service Manager will audit the dishwasher temperature log 5 days a week for 2 months, 2 times a week for 2 months and 1 time week for 2 months. Any issues identified will be addressed and corrected; it warranted additional training will be conducted. If any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	

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	indicate the appropriate temperature was achieved during the cleaning process. The Kitchen Manager attempted to perform a test to check for sanitizer concentration during the cleaning process but did not use the correct test strips. She indicated she did not normally run the dishwasher and did not normally perform the chem (chemical) test or document the dishwasher temperature when she ran the dishwasher. CNA (Certified Nurse Aide) 14 was in the dish room and indicated she sometimes helped with the dishes. CNA 14 indicated she had not used a chem test strip to test sanitization. A "Dishmachine Log" was hanging on a clipboard on the wall near the dishwasher. The log was from June 2023, and had multiple blanks for the dishwasher temperatures and chem tests that were to be monitored three times a day. The Kitchen Manager did not know if additional logs were filled out with any regularity. On 01/04/24 at 11:00 A.M., the Administrator indicated the facility would be using disposable dishware until they could get someone out to address the issues with the dishwasher. On 01/04/24 at 2:00 P.M., the dishwasher service technician replaced the temperature gauge on the dishwasher and supplied the appropriate test strips to check chemical sanitization. The dishwasher temperature and level of sanitizer was tested and was appropriate. The Administrator indicated the facility could provide no additional logs of temperature monitoring or chem strip testing. On 01/10/24 at 11:45 A.M., the steam table/serving area of the kitchen was observed with the Kitchen Manager. The following was observed: - a round fan in the ceiling directly above the			

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	155208	A. BUILDING 00 B. WING	01/10/2024

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	steam table was covered in a visible layer of gray dust, - a rectangular vent in the ceiling above the serving table had visible gray dust on the actual vent and a spray of gray dust on the ceiling around each corner of the vent, and - two square vents in the ceiling above the serving area and in the main kitchen were covered in a visible layer of gray dust. During an interview on 01/10/24 at 11:45 A.M., the Kitchen Manager indicated she was not sure who was supposed to clean the vents and fans in the kitchen. Everyone in the kitchen just knew what was supposed to be cleaned. There were no documented cleaning schedules or cleaning logs. The current facility policy, titled "Storage of Foods under Sanitary Conditions", dated 06/2018, was provided by the Administrator on 01/08/24 at 12:02 P.M. The policy indicated, "...All food items stored in the refrigerator must be labeled and dated if NOT scheduled to be served at the next meal...All food items should be placed in containers with tight-fitting lids..." The current facility policy, titled "Recording Temperature of Dish Machine", dated 06/2018, was provided by the Administrator on 01/08/24 at 12:02 P.M. The policy indicated, "...At least daily, record gauge temperatures for the wash and rinse cycles..." The current facility policy, titled "Testing Sanitizer Concentration in Low Temperature Dish Machines", dated 06/2018, was provided by the Administrator on 01/08/24 at 12:02 P.M. The policy indicated, "...At least daily, test sanitizer			

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	concentration by using the designated testing strip provided by the chemical vendor or ordered with supplies...Write testing strip results on the form kept in the Dietary Department..." The current facility policy, titled "Cleaning Schedule", dated 06/2018, was provided by the Regional Director of Operations on 01/10/24 at 1:26 P.M. The policy indicated, "...Daily cleaning duties should be listed on the individual job procedure or master cleaning schedule...A new cleaning schedule is posted weekly or monthly with cleaning assignments for each employee...it is initialed and dated by the employee who completed the job..."			
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, interview, and record review, the facility failed to complete documentation for medication administration for 1 of 5 residents reviewed. (Resident 323) Findings include: Medication administration was observed on 01/10/24 at 8:28 A.M., with LPN (Licensed Practical Nurse) 7. While administering medications to Resident 323, blank spaces were noted on the MAR (Medication Administration Record). The LPN indicated all medications should be signed out when administered. The clinical record for Resident 323 was reviewed on 01/10/24 at 1:30 P.M. The diagnoses included,	R 0296	It is the practice of this facility to maintain clear written policies and procedures on medication assistance and to provide on going training to ensure competence of medication staff. The Mar for Resident 323 contained blank spaces; such as dates and administration times. There was no negative impact to the resident. All residents receiving medications have the potential to be affected. The DON and or designee will complete a MAR audit on the assisted living starting Jan 1 2024 and if discrepancies are found the	02/16/2024

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	but were not limited to, insomnia, fracture, and pain. There was no documentation to indicate the resident was out of the facility from 01/05/24 through 01/09/24. The MAR was provided by the DON (Director of Nursing) on 01/10/23 at 9:15 A.M., and contained blank spaces for the following medications, dates, and administration times: - Aricept 10 mg (milligrams), on 01/07/24 at 7:00 P.M., - Melatonin 5 mg, on 01/07/24 at 7:00 P.M., - Acetaminophen 500 mg, on 01/07/24 and 01/09/24 at 7:00 P.M., - Calcium Carbonate 600 mg, on 01/06/24 at 9:00 A.M., 01/07/24 at 7:00 P.M., and 01/09/24 at 7:00 P.M., - Docusate Sodium 100 mg, on 01/07/24 and 01/09/24 at 7:00 P.M., - Namenda 10 mg, on 01/06/24, 01/07/24 and 01/09/24 at 7:00 P.M., and - Norco 5-325 mg, on 01/05/24 at 12:00 P.M., and 01/07/24 and 01/08/24 at 7:00 P.M. The sign that was taped to the outer cover of the MAR binder was provided by the DON on 01/10/24 at 9:15 A.M. The sign indicated, "...!!!!ATTENTION NURSES!!!! Please fill in any holes you have on Assisted Living MARs. This is going to be audited weekly and you will be accountable for your shifts..." The current undated "Medication Administration General Guidelines" policy was provided by the Regional Director of Operations on 01/10/24 at 9:32 A.M., and indicated, "...Medications are administered as prescribed in accordance with good nursing principles and practices...The resident's MAR is initialed by the person		resident will be immediately assessed and physician notified and staff educated associated with the identified medication error. On 1-24-2024 the DON re-educated all licensed nurses and QMAs on Medication Administration General Guidelines to ensure medications are administered as prescribed in accordance with nursing principles and practices, the resident's MAR is initialed by the person administering the medication, date and specific medication does is documented. The DON and/or designee will monitor the MAR 5 times a week for 2 months, 3 times a week for 2 months and then weekly for 2 months. Concerns will be addressed if noted and further education provided if needed. The results will be recorded on the MAR Documentation Audit tool. If any patterns are identified at the monthly QAPI meeting an action plan will be written by the committee. The action plan will be monitored by the administrator or designee monthly until resolved and substantial compliance is achieved 95% or greater.	

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	administering the medication, in the space provided under the date, and on the line for that specific medication dose administration..."			