STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155275	A. BUILDING 00 B. WING	08/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF PRINCETON, THE	1020 W VINE ST PRINCETON, IN 47670

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00415004. Complaint IN00415004 - Federal/state deficiencies related to the allegations are cited at F812 and F921. Survey dates: August 21, 22, 23, 24, 25, 28 2023. Facility number: 000175 Provider number: 155275 AIM number: 100274440 Census Bed Type: SNF/NF: 55 Total: 55 Census Payor Type: Medicare: 4 Medicaid: 48 Other: 3 Total: 55 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 8, 2023.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular does not constitute and admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is September 27, 2023. This provider respectfully request that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after September 27, 2023.	
F 0657 SS=E 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.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katherine Seibel	HFA	09/21/2023

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	(ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to schedule care plan conferences and revise care plans for 12 of 12 residents reviewed. (Resident 14, Resident 16, Resident 20, Resident 22, Resident 24, Resident 25, Resident 30, Resident 36, Resident 38, Resident 39, Resident 43, and Resident 47). Findings include 1. On 8/23/23 at 9:20 A.M., Resident 14's clinical record was reviewed. Diagnoses included but were not limited to, Chronic Obstructive Pulmonary Disease and anxiety. The most recent MDS (Minimum Data Set) Assessment dated 7/27/23 indicated that the resident was cognitively	F 0657	**Tag# F 657 Care Plan Timing and Revision** **It is the policy of this facility to schedule care plan conferences and revise care plans.** **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** **Residents 14,24,25,30,36.16,38,39,20,22,43, and 47 have had care plan conferences conducted with IDT Team, Resident and or**	09/28/2023

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	intact. The progress notes lacked documentation of a care plan conference being conducted. The MDS care plan binder lacked documentation of care plan conference. During an interview on 8/21/23 at 3:51 P.M., Resident 14 indicated she had never been asked to come to a care plan conference 2. On 8/23/23 at 1:47 P.M., Resident 24's clinical record was reviewed. Diagnoses included but were not limited to atrial fibrillation and coronary artery disease. The most recent quarterly MDS Assessment dated 6/15/23 indicated Resident 24 was cognitively intact. The progress notes lacked documentation of a care plan conference being conducted. The MDS care plan binder lacked documentation of a care plan conference. During an interview 8/21/23 at 10:29 A.M., Resident 24 indicated she did not know anything about conferences and if they were required. 3. On 08/23/23 at 11:25 A.M., Resident 25's clinical record was reviewed. Diagnoses included but were not limited to generalized epilepsy and unspecified intellectual disabilities. Orders include a Do Not Resuscitate order from (Name of)Hospice dated 8/2/23. The most current significant change MDS Assessment dated 8/24/23 that the resident was cognitively impaired.		**family member by 9/21/2023. Resident #25 had her DNR code status and Care plan updated on 8-17-2023.** **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** **All residents have the potential to be affected by this deficient practice.** **MDS coordinator and SSD will conduct a facility wide audit to assure all Residents and or Family members have had care plans reviewed with them and are up to current date. Social Services and MDS audited residents Advance Directive Care Plan for accuracy completed on 9-25-2023.** **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not reoccur.** **The Administrator in-serviced the MDS Coordinator and Social Services on the "Baseline Care Plan Assessment Policy on 9-21-2023. Additionally, any staff that fails to comply with the points of the this in-service will be further educated/disciplined as**	

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	Resident 25's code status was changed on 8/2/23. A care plan dated 6/22/23 indicated Resident 25 was a full code. The current care plan lacked the documentation of the update. 4. On 8/23/23 at 8:33 A.M., Resident 30's clinical record was reviewed. Diagnoses included but were not limited to myocardial infarction and hypertension. The most current quarterly MDS Assessment dated 7/25/23 indicated that Resident 30 was cognitively intact. The progress notes lacked documentation of a care plan conference being conducted. The MDS care plan binder lacked documentation of a care plan conference. During on interview on 8/21/23 at 2:52 P.M., Resident 30 indicated he was not aware of care plan conferences and neither did his family. 5. On 8/23/23 at 10:18 A.M., Resident 36's clinical record was reviewed. Diagnoses include but were not limited to polyarthritis and schzioaffective disorder bipolar type. A current quarterly MDS Assessment dated 6/15/23 indicated that Resident 36 is cognitively intact. The progress notes lacked documentation of care plan conferences being conducted. The MDS care plan binder lacked documentation of care plans conference. During an interview on 8/21/23 at 3:27 P.M., Resident 36 indicated that she was not included in care conferences. 6. During an interview with Resident 16 on 8/22/23 at 9:20 A.M., he indicated he thought he went to a		**indicated.** **MDS and SSD will keep a log with all care plan invites and sign in sheets , these will be discussed 5 x weekly in Morning meeting with IDT team.** **How the corrective actions will be monitored to ensure the deficient practices will not recur:** **MDS or SSD will audit care plan conferences 5 x a week x 4 weeks, then 3 x a week x 4 weeks, then weekly x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped, Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Plan will be monitored by the Administrator weekly until resolved.** **DOC: 9-28-2023**	

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	couple of care planning meetings when he first got to the facility but hasn't gone for a long time. He added that he doesn't even know when they're going to have one. They find out by word of mouth. He indicated he would like to go and talk about things in general. On 8/23/23 at 1:05 P.M., Resident 16's clinical records were reviewed. No documentation of quarterly care planning meetings was found. Resident 16's diagnoses included, but were not limited to: chronic obstructive pulmonary disease (COPD), alcoholic cirrhosis of the liver, cerebral infarction unspecified, diabetes, depression, chronic kidney disease. The most recent quarterly Minimum Data Set (MDS) Assessment, dated 6/7/23, indicated resident had moderate cognitive impairment, and required extensive assistance of 2 for bed mobility, transfers, and toileting, supervision and setup for eating, and was totally dependent for bathing. 7. During an interview with Resident 38 on 8/21/23 at 2:18 P.M., she indicated she does not know about any quarterly care planning meetings. On 8/24/23 at 9:54 A.M., Resident #38's clinical record was reviewed. Resident 38's diagnoses included, but were not limited to: COPD, abnormalities of gait and mobility, history of falling, dementia, type 2 diabetes. The most recent annual MDS, dated 7/14/23, indicated the resident has moderate cognitive impairment and requires extensive assist of 2 for bed mobility, transfers, and toileting, supervision			

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	and assist of 1 for eating, and is totally dependent for bathing. No documentation of quarterly care planning meetings was found. 8. During an interview with Resident 39 on 8/22/23 at 9:48 A.M., he indicated he doesn't go to care planning meetings as he doesn't know when they are. On 8/23/23 at 1:44 P.M., Resident 39's clinical records were reviewed. Resident 39's diagnoses included, but were not limited to, COPD, diabetes, schizoid personality disorder, opioid dependence, opioid abuse. The most recent quarterly MDS, dated 8/7/23, indicated resident is cognitively intact, requires limited assistance of 1 for bed mobility, transfers, and toileting, supervision and setup for eating, and needs physical help with part of bathing. No documentation of quarterly care planning meetings was found. 9. On 8/23/23 at 9:31 A.M., Resident 20's clinical record was reviewed. Resident 20 was admitted on 10/10/16. Diagnoses included, but were not limited to, dementia, dysphagia, and chronic kidney disease. The most recent quarterly Minimum Data Set (MDS) Assessment was completed on 6/15/23. The MDS assessment indicated resident 20 was severely cognitively impaired, and required extensive assistance for mobility, transfers, toileting, and bathing. A review of care conferences held during the last year for Resident 20 indicated a single care conference was held on 6/15/2023 at 12:23 P.M.			

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	10. On 8/23/23 at 1:15 P.M., Resident 22's clinical record was reviewed. Resident 22 was admitted on 12/7/16. Diagnoses included, but were not limited to, Alzheimer's disease, chronic obstructive pulmonary disorder, and diabetes mellitus. The most recent quarterly Minimum Data Set (MDS) Assessment was completed on 7/10/23. The MDS assessment indicated resident 22 was moderately cognitively impaired, and required extensive assistance for mobility, transfers, and toileting. Care conferences held during the past year for Resident 22 were requested and unable to be provided. 11. On 8/23/23 at 2:00 P.M., Resident 43's clinical record was reviewed. Resident 43 was admitted on 10/25/22. Diagnoses included, but were not limited to,dementia, diabetes mellitus, and atrial fibrillation. The most recent quarterly Minimum Data Set (MDS) Assessment was completed on 7/31/23. The MDS assessment indicated resident 43 was severely cognitively impaired, and required extensive assistance for mobility, transfers, and toileting. Care conferences held during the past year for Resident 43 were requested and unable to be provided. 12. On 8/23/23 at 10:08 A.M., Resident 's 47's clinical record was reviewed. Resident 47 was admitted on 9/16/21. Diagnoses included, but were not limited to, dementia, hypertension, and			

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	hyperlipidemia. The most recent quarterly Minimum Data Set (MDS) Assessment was completed on 6/14/23. The MDS assessment indicated resident 47 was severely cognitively impaired, and required assistance for mobility, transfers, and toileting. Care conferences held during the past year for Resident 47 were requested and unable to be provided. During an interview on 8/23/23 at 9:00 A.M., the social worker indicated care plan conferences are done quarterly with MDS update, significant changes,and upon admission. The family is invited by a phone call after the resident is asked to see if which one should be called. This is documented in the social services notes progress notes. During an interview on 8/24/23 at 9:00 A.M., the MDS coordinator indicated there was a binder for the care plan meetings. This binder is filled out for every care plan meeting. The care plans meetings have not been done recently. She really did not know it the care plans were to be done with every MDS. She indicated that she recently found out that they should be done again. On 8/24/23 at 10:00 A.M., a current nondated policy "Baseline Care Plan Assessment/ Comprehensive Care Plans indicated ...the facility Social Service Director will notify the resident's responsible by letter or phone call of the scheduled care plan conference to include the date and time. This notification will continue for subsequent care plan conferences. These notifications will be documented for reference... the resident will invited and encouraged to attend.			

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	These notifications will be documented for reference. 9... the care plans will be reviewed and and updated quarterly at a minimum. The facility may need to review... more often based on resident condition and/or newly developed health... issues." 3.1-35(d)(2)(B) 3.1-35(e)			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview, observation, and record review, the facility failed to ensure safety or supervision of a resident for 1 of 1 residents reviewed for falls resulting in major injury. This deficient practice resulted in a fall with a fractures requiring hospitalization. (Resident 43) Findings include: Resident 43's clinical record was reviewed on 8/23/23 at 2:21 P.M. Diagnoses included, but were not limited to, displaced fracture of second cervical vertebra. Resident 43's most recent Quarterly Minimum Data Set (MDS) Assessment, dated 7/31/23, indicated the resident was severely cognitively	F 0689	F 689 Free of Accident Hazards/Supervision/Devices It is the policy to ensure safety or supervision of the residents to prevent accidents. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident 43's care plan was reviewed and updated with fall interventions and one person assist, CNA assignment sheet was updated to reflect resident was a two person assist/hoyer lift on 9-18-2023 by DON. How other residents having the	09/28/2023

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	impaired and required extensive assistance of two people for mobility, transfers, and toileting. Resident 43's care plan dated 10/27/22 included, but was not limited to, Resident is at risk of falls due to history or recent fall, staff to assist with transfers, and staff to assist with toileting. A nursing progress note dated 8/8/23 at 20:22 (8:22 P.M.) indicated Resident 43 "Depends upon staff for ADL care. All transfers by staff assist. Taken to BR (bathroom) prn (as needed) by staff." A Nursing progress note dated 8/9/23 at 6:32 A.M. indicated resident was being toileted when they stood up and fell. Resident had a laceration on their forehead that was bleeding. Resident was transported to the hospital for evaluation. A nursing note dated 8/9/34 at 9:19 A.M. indicated the hospital had called the facility to report Resident 43 had sustained an acute fracture of the cervical spine, and was being transferred to another hospital. An IDT (integrated disciplinary team) note dated 8/9/23 at 12:15 P.M. indicated a CNA (certified nurse aide) was assisting Resident 43, left the Resident alone in the bathroom to go find the Resident's clothes, and the resident fell to the floor. The intervention noted was for a medication review to be completed. A progress note dated 8/11/23 at 10:42 A.M. indicated Resident 43 was unable to ambulate, having difficulty moving extremities, and a request for an increase in pain medication was made. A physician's order dated 8/11/23 indicated a C collar (cervical support brace) was to be worn as		potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents have the potential to be impacted by this deficient practice. An audit was completed on all resident's care plan to reflect assistance required and CNA assignment sheet were updated with residents current assistance needed on 9-18-2023 by DON/Designee. C -collar discontinued . What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur. The nursing staff was in-serviced by the DON/Designee on policy Incident/Accidents/Falls and supervision requirements on 9-25-2023. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place. The Assignment Sheet/Assist Needed Audit Tool will be done on 10 random residents weekly x 4 weeks then 5 random residents weekly x 4 weeks, then 3 random residents weekly x 4 months by the DON/ Designee. If the facility is within 95% compliance at the end of the 6 months; then	

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	needed for comfort. During an observation on 8/21/23 at 12:06 P.M., Resident 43 was observed sitting at the dining table with bruising to the face, appeared agitated, and was yelling out. Staff attempted to console Resident 43 by moving away from the table to look out the glass doors in the dining room. Resident 43 was not wearing a C collar during the observation. During an interview on 8/24/23 at 8:52 A.M., the Director of Nursing (DON) indicated Resident 43 had been transferred and toileted by one CNA during the fall that occurred on 8/9/23 due to the resident being "impulsive" at times. The DON agreed that the IDT note stating the Resident had been transferred then left alone was accurate. The DON indicated the MDS information regarding how many staff is recommended for assistance should be reflected on the CNA assignment record provided at the beginning of each day to the CNA's, and the assignment records are reviewed, before being released to staff, during morning meetings with the Administrator, Director of Nursing, and Assistant Director of Nursing. A document titled "CNA Assignment Sheet" was provided on 8/24/23 at 11:02 A.M. by LPN (licensed practical nurse) 19. Resident 43 was listed as assist of 1. An undated policy titled incidents/accidents/falls was provided by the Administrator on 8/25/23 at 1:09 P.M. and indicated information collected will be used to implement corrective actions to include any needed training and "the CNA information sheet will be updated as indicated to reflect the plan of care."		monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. Date:9-28-2023	

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	3.1-45(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 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	F 0690	**Tag# 690 Bowel Bladder**	09/28/2023

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	failed to attempt to obtain labs, indicate clinical signs of a UTI (urinary tract infection), or ensure the proper antibiotic was prescribed prior to administering an antibiotic for behaviors for 1 of 1 residents reviewed for current antibiotic use. (Resident 47) Findings include: During an interview on 8/22/23 at 1:07 P.M., LPN (licensed practical nurse) 19 indicated that resident 47 had been prescribed an antibiotic by hospice, due to agitated behaviors, without attempting to obtain a urine specimen for lab review of a possible urinary tract infection. On 8/23/23 at 1:07 P.M. Resident 47's clinical record was reviewed. Diagnoses included, but were not limited to, severe dementia with mood disturbances and major depressive disorder with severe psychotic symptoms. A quarterly MDS (Minimum Data Set) Assessment, dated 6/14/23, indicated resident 47 was severely cognitively impaired and required assistance for mobility, transfers, toileting, and bathing. A progress note, dated 8/18/23 at 12:30 P.M. indicated hospice had given an order for Macrobid (antibiotic) 100 mg (milligrams) daily for 7 days for a possible UTI. A physician's order, for Macrobid 100 mg daily for 7 days, indicated a start date of 8/19/23 and an end date of 8/26/23. Resident 47's care plan, dated 9/19/21, indicated dementia with behavioral disturbances was a common and frequent occurrence for this resident. The care plan indicated resident demonstrates verbally abusive behaviors at times, including yelling and cursing at staff and wife, r/t Dementia,		**incontinence ,catheter, UTI** **It is the policy of this facility to ensure that labs are obtained as ordered, document clinical signs of urinary tract infections and obtaining a urine sample prior to administering an antibiotic.** **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** **Resident #47 was assessed, and no negative outcome noted from this deficient practice on 8-29-2023 by DON.** **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** **All Residents receiving an antibiotic for a urinary tract infection have the potential to be affected by this deficient practice, an audit was completed by the IP nurse for residents currently on antibiotics for urinary tract infections and completion of Urinalysis on 9-21-2023.** **What measures will be put in place and what systemic changes will be made to ensure that deficient practice:** **The Hospice provider completed and education with their nurses on 9-26-2023. The**	

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	MDD, and Poor impulse control. This is typically connected with rejections of care or demands to leave. The clinical record lacked an order to collect a urine specimen prior to the start of the antibiotic, or indication of an attempted urine specimen collection prior to the administration of an antibiotic. A request for documentation containing an attempt to collect a urine specimen was requested and not provided. The clinical record lacked symptoms indicating a possible infection such as recorded temperature for the resident. During an interview on 8/25/23 at 2:16 P.M., the infection prevention nurse indicated antibiotics are prescribed by physicians when there are clinical signs and symptoms present, and the appropriate antibiotic is determined by obtaining a urine specimen for culture and sensitivity. This nurse indicated a resident being on hospice does not exclude them from the antibiotic stewardship program, which is used to determine appropriate antibiotic use to prevent antibiotic resistance. An undated policy, provided by the administrator on 8/21/23 following the entrance conference, was reviewed on 8/25/23 at 1:50 P.M., titled Antibiotic Prescribing Guidelines indicated "a. Prior to the initiation of an antibiotic regimen, a laboratory/culture result should be available... to ensure the infection is a true infection." and "c. When requesting antibiotic orders, the nurse should verify that the antibiotic being prescribed is sensitive and/or appropriate... making sure to remain an advocate for the resident against unnecessary medications." 3.1-48(a)(4)		**DON/Designee in-serviced nursing staff on 9-25-2023 the policy Antibiotic Prescribing Guidelines on 9-25-2023 . Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplines as indicated.** **How the corrective actions will be monitored to ensure the deficient practices will not recur:** **IP nurse or designee will audit new antibiotic orders 5 x a week x 4 weeks, then 3 x a week for 4 weeks, then weekly x 4 months for clinically indicated signs and symptoms and completion of urinalysis. If the facility is with 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified, any needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved** **DOC:9-28-2023**	

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure that a resident who needs respiratory care is provided such care consistent with professional standards of practice for 1 of 1 residents reviewed for respiratory care (Resident 38). Findings include: During an observation on 8/21/23 at 2:05 P.M., Resident 38's oxygen was observed to be on at 2.5 liters per minute (lpm) per nasal cannula (nc), without humidification. During an interview with the resident at the same time, she indicated the oxygen dries her nose out bad. The top of the oxygen concentrator was covered with a white powdery substance, the external filter had small amount of white powdery substance, inside filter had a larger amount of white powdery substance. Tubing was dated 8/20/23. On 8/24/23 at 11:41 A.M., the resident was observed asleep with oxygen on at 2+ lpm per nc, without humidification. The concentrator was covered with white powdery substance, external filter has small amount of white powdery substance, inside filter has more white powdery	F 0695	**Tag# 695** **Respiratory/Tracheostomy care and suctioning** **It is the policy of this facility to ensure residents who need respiratory care is provided such care consistent with professional standards of practice.** **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** **Resident #38 had humidification added to her oxygen tank on 8-28-2023, the order was changed to check her 02 sats daily and the concentrator was cleaned on 8-27-2023. Order changed on 9-15-2023.** **How other residents having the potential to be affected by the same deficient practices will be identified and what**	09/28/2023

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	substance. Tubing dated 8/20/23. During an interview with Registered Nurse (RN) 15 on 8/24/23 at 11:41 A.M., she indicated the nurses check the oxygen rate every shift and make sure it's on and the resident has order for it. During an interview on 8/24/23 at 11:45 A.M., with Director of Nursing (DON), she indicated if resident's oxygen flow rate is greater than 2 lpm they humidify it. On 8/25/23 at 2:14 P.M., the resident's clinical record was reviewed. Diagnoses included, but were not limited to: chronic obstructive pulmonary disease (COPD), dementia, anxiety, depression. The current annual Minimum Data Set (MDS) Assessment, dated 7/14/23, indicated the resident had moderate cognitive impairment and required extensive assistance of 2 for bed mobility, transfers, and toileting, supervision and assistance of 1 for eating, and was total dependence for bathing. The MDS failed to document the physician's order for oxygen. Current physician orders included, but were not limited to: Oxygen at 2-3 lpm per nc as needed for shortness of breath, maintain O2 sats above ( ) [sic.); Change & date O2 tubing weekly on Sunday night shift. (4/23/23). Lacked order for humidification. Care plan included alteration in respiratory status related to COPD, may use oxygen as needed 2-3 lpm per nc (4/19/23). Interventions included: 1. Elevate head of bed (HOB) as indicated (4/19/23) 2. Labs as ordered (4/19/23) 3. Lung assessment as indicated (4/19/23)		**corrective action will be taken: All Residents on oxygen had the potential to be affected. DON or designee conducted an audit on all residents with oxygen to ensure that O2 sats are checked daily and concentrators cleaned. Audit completed on 9-21-2023.** . **What measures will be put in place and what systemic changes will be made to ensure that deficient practice: The DON/Designee in-serviced nursing staff on policy Oxygen Administration, monitoring O2 Saturations and maintenance and cleaning of oxygen concentrators and portable oxygen tanks on 9-25-2023. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated.** **How the corrective actions will be monitored to ensure the deficient practices will not recur:** **DON or designee will audit residents receiving oxygen for humidification, O2 sats, and cleaning of equipment 5 x a week x 4 weeks, then 3 x a week x 4 weeks, the weekly x 4 months.** If the facility is within 95% compliance at the end of the 6 months; then monitoring can be	

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	4. Maintain elevation of HOB in order to facilitate breathing and prevent shortness of breath (SOB) (4/19/23) 5. Observe vital signs and oxygen saturation as needed (4/19/23) 6. Oxygen as ordered (4/19/23) 7. Respiratory treatment as ordered (4/19/23) Oxygen saturation was checked one time during the month of August, on August 24, when it was 95% at 3 lpm per nc. On 08/25/23 at 2:14 P.M., the oxygen administration policy, undated, indicated that residents with oxygen orders, routine or as needed (prn) will have oxygen saturation levels measured by oximetry and documented no less than daily. If MD order states "to maintain sat" then oxygen saturation will be checked and documented every shift. The policy lacked recommendations for maintenance and cleaning of oxygen concentrators and/or portable oxygen tanks. 3.1-47(a)(6)		stopped Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **DOC:9-28-2023**	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed			

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	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 available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, interview and record review, the facility failed to ensure the complete and accurate staffing records were posted for 6 of 6 days reviewed during the survey (8/21/23, 8/22/23, 8/23/23, 8/24/23, 8/25/23, 8/28/23). Findings include: 1. On 8/21/23 at 2:35 P.M., a nurse staffing record was observed hanging in a container on a wall in the main dining room, with a binder, next to the activity board. The posted nurse staffing record included the facility name and the current date. The record included, but was not limited to, the	F 0732	**Tag# 732 Posted Nurse staffing information** It is the policy of the facility to post the nurse staffing data daily at the beginning of each shift. Data must be posted in a clear and readable format in a prominent place readily accessible to residents and visitors. **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** No residents were affected by this	09/28/2023

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	following information: Number of RN (Registered Nurse), LPN (Licensed Practical Nurse), QMA (Qualified Medication Aide), and CNA (Certified Nursing Assistant) scheduled for the day. Number of hours scheduled for RN, LPN, QMA, and CNA for each shift for the day. The record was missing the actual number of hours worked for each discipline, the total number of staff scheduled, the total number of hours scheduled, and the total actual number of hours scheduled.. On 8/24/23 at 2:04 P.M., copies of the daily nurse staffing records for 8/21/23 through 8/24/23 were received from QMA 5. At that time, QMA 5 indicated they had not known how to fill out the forms until the regional director had shown them the day before. On 8/28/23 at 10:10 A.M., the posted nurse staffing records for 8/25/23 and 8/28/23 were received. All the nurse staffing records were reviewed and found to contain the following information: On 8/21/23 the posted nurse staffing record was observed to list an incorrect facility census of 57. There were no total actual hours worked listed for any of the disciplines, total number of staff scheduled for the disciplines, the total number of hours scheduled, nor the total actual number of hours worked. On 8/22/23 the posted nurse staffing record was observed to be missing the facility census. There were no total actual hours worked listed for any of the disciplines, nor total number of staff scheduled for the disciplines, the total number of hours scheduled, nor the total actual number of		deficient practice. **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** Residents who reside in the facility have the potential to be affected by this finding. An audit was completed by Administrator/Designee to ensure proper posting and storage of previously posted daily staff information was present on 9-20-2023. Any changes or corrections were addressed and changed as indicated. **What measures will be put in place and what systemic changes will be made to ensure that deficient practice.** At an in-service held by the Administrator/Designee on 9-21-2023 for the ADON and Staffing Coordinator the following was reviewed: 1. Policy and procedure for posting daily staffing information Any staff who fail to comply with the points of the in-service will be further educated and or progressively disciplined as indicated. **How the corrective actions will be monitored to ensure the deficient practices will not**	

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	hours worked. On 8/23/23 The posted nurse staffing record included only 7.5 hours actual hours worked for the day shift LPN, no other disciplines were totaled for actual hours worked. The total number of staff scheduled was listed incorrectly at 154. The total number of hours worked was listed incorrectly at 55, with 822.5 hours listed for 3 CNA's who worked 7.5-hour shifts. The total number of actual hours worked was listed incorrectly at 2.8. On 8/24/23 The posted nurse staffing record lacked actual hours worked for all disciplines. The total number of staff scheduled was listed incorrectly at 154. The total number of hours scheduled was listed incorrectly at 55. The total actual number of hours worked was listed incorrectly at 2.8. On 8/25/23 The posted nurse staffing record lacked actual hours worked for all disciplines. The total number of staff scheduled was listed incorrectly at 184.5. The total number of hours scheduled was listed incorrectly at 56. The total actual number of hours worked was listed incorrectly at 3.2. On 8/28/23 at 1:22 P.M., a census summary report that indicated the facility census was 55 on 8/20/23 through 8/23/23, and increased to 56 on 8/24/23 through 8/28/23 was received from the Business Office Manager (BOM). The facility's BIPA Staffing Posting Requirement policy, undated, indicated the facility must post daily the specific shift schedule for the 24-hour period, the number and category of nursing staff employed or contracted by the facility for each		**recur:** DON/Designee will monitor the daily staffing posting 5 days a week x 4 weeks, then 3 days a week x 4 weeks, then weekly x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **DOC:9-28-2023**	

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	24-hour period, as well as the total number of hours worked by licensed and licensed nursing staff who are directly responsible for resident care..The posted data must include the current census.			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently 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, interview, and record review, the facility failed to ensure that all drugs and biologicals used in the facility were stored under proper temperature controls for 1 of 2 medication storage refrigerators reviewed during	F 0761	**Tag# 761** It is the policy of the facility to ensure Medications and biological are stored safely, securely, and properly following the manufacturer	09/28/2023

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	the survey, and that medications refused by a resident were disposed of properly (Resident 16, West hall, East Hall). Findings include: 1. During observation of the medication cart on the east hall on 8/23/23 at 11:00 A.M., loose pills were observed in the drawers of the medication cart. These included: 2 small white pills, 3 oblong white pills, 1 large yellow round pill, and 1 small yellow round pill. The pills were removed by QMA 5, who indicated they are supposed to dispose of them in the sharps container attached to the cart. 2. During observation of the medication cart on the west hall on 8/23/23 at 11:20 A.M., loose pills were observed in the drawers of the medication cart. These included: 1 oblong white pill, 2 medium yellow pills, one gold gel pill, 1 large white triangular pill, 3 small pink pills, 4 small white oblong pills, 5 white round pills, one oblong orange pill, 1/2 small white round pill x 2, 3 round pink pills, 2 large white round pills, 1 oval yellow pill, 1 small oval white pill. The pills were removed by the Assistant Director of Nursing (ADON) who was passing the medications and disposed of in the sharps container attached to the cart. 3. During interview with the Assistant Director of Nursing (ADON) on 8/23/23 at 11:40 A.M., she indicated that she and Director of Nursing (DON) destroy loose pills together. 4. During observation of medication pass on the east hall on 8/23/23 at 10:30 A.M., QMA 5 mixed a laxative powder in 8 oz. of water for Resident 16. The resident refused the medication. She then set it on the hand rail outside the resident's room and		or supplier recommendations. The Medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** The DON/Designee audited medication carts for loose pills and any loose pills were disposed of appropriately on 9-19-2023. The DON/Designee educated QMA 5 on deposing of medications that residents refuse and not to leave mixed medications with water on the handrails on 9-21-2023. The DON/Designee placed a thermometer and temperature log on the medication refrigerator and disposed of medications that were stored in the refrigerator related to temperate above threshold on and disposed of Resident 16's Risperdal on 9-1-2023. **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** All residents have the potential to be affected by this deficient practice. **What measures will be put in place and what systemic changes will be made to**	

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	walked away. The medicine remained stored on the hand rail as follows: At 9:57 A.M., the medication was observed in the same place. At 10:47 A.M., the same was observed. 5. During observation of the west medication room on 8/23/23 at 8:45 A.M., the medicine refrigerator temperature was 50 degrees F. The refrigerator contained vaccines and resident medications. A box of Risperdal was wet and the label was unreadable. The ADON indicated they only have one resident on that drug (Resident 16). The resident's record indicated the drug was discontinued on 2/15/23. During an interview with QMA 5 on 8/23/23 at 10:51 A.M., she indicated that when a resident refuses a medication, they dispose of it in the sharps container. If the medication is a narcotic, they get another nurse to witness and destroy it in the medication room. They both sign the destruction form. On 8/25/23 at 11:00 A.M., the facility's medication administration policy, undated, was reviewed. The policy lacked recommendations for the disposal of medications refused by residents. On 8/25/23 at 11:05 A.M., The facility medication storage policy, undated, was reviewed. The policy indicated that outdated, contaminated, or deteriorated drugs and those in containers which are cracked, soiled, or without secure closures will be immediately withdrawn from stock. They will be disposed of according to drug disposal procedures...medications requiring "refrigeration" or temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit are kept in a refrigerator. Medications requiring storage "in a		**ensure that deficient practice:** The DON/Designee in-serviced that nursing staff and QMA's on the policy medication storge and medication administration on 9-25-2023. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplines as indicated. **How the corrective actions will be monitored to ensure the deficient practices will not recur:** DON or designee will audit medication carts and medication refrigerator 5 x a week x 4 weeks, then 3 x a week x 4 weeks, then weekly x 4 months for loose pills and monitoring of temperature and discontinued medications and proper disposal of refused medications. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **DOC:9-28-2023**	

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	155275	A. BUILDING 00 B. WING	08/28/2023

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	cool place" are refrigerated unless otherwise specified on the label. The policy lacked recommendations related to proper drug labeling. 3.1-25(m) 3.1-25(n)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interviews and record review the facility failed to store, prepare and serve food in accordance with professional standards for food service for 1 of 2 kitchen observations. Food was served on dishes that were not thoroughly sanitized, emergency use of paper goods was delayed for 55 of 55 residents served meals in the facility. The facility failed to	F 0812	**Tag# 812 Food Procurement, Store/prepare/serve -sanitary** It is the policy of this facility to store, prepare and serve food in accordance with professional standards for the food service. **What corrective actions will be**	09/28/2023

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	ensure that the temperature of unit refrigerators were with acceptable range in 3 of 3 refrigerators observed. (Kitchen, East Hall Nourishment Pantry) Findings include: 1. During the initial kitchen tour on 8/21/23 starting at 8:58 A.M., the Dietary Manager indicated that the temperature gauge on the dishwasher was not functioning properly and he had been using a digital thermometer to record temperatures. At that time, a load of dishes including, but not limited to, trays and plate covers was being ran through the dishwasher. The Dietary Manager used his digital thermometer to take the temperature of the wash water. The thermometer read 112 degrees Fahrenheit (F). At that time, the Dietary Manager indicated that the temperature of the wash was supposed to be 120F. A Dish Log Record was observed next to the dishwasher and temperatures and final rinse checks had not been recorded for the breakfast and lunch shifts on 8/17, no shifts on 8/18, breakfast and lunch shifts on 8/19, and breakfast and lunch shifts on 8/20. At that time, the Dietary Manager indicated that the information was not recorded because the dishwasher was broken and [name of company] had been in over the weekend, had ordered parts to fix it, and the parts should be in sometime this week. On 8/21/23 at 9:45 A.M., a dishwasher cycle was observed. Kitchen Staff 9 used a chemical strip to test the ppm (parts per million) of hypochlorite (chlorine). The chemical sanitization strips showed 0 ppm. Kitchen Staff 9 indicated she expected the strip to read between 25-50 ppm. At that time, the Dietary Manager indicated the sanitization liquid ran out, but has been ordered		**accomplished for those residents found to be affected by the deficient practice:** All residents have the potential to be affected by this deficient practice, residents were assessed by the DON/Designees and no negative outcomes were noted on 8-21-2023. **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** All residents had the potential to be affected. Audit completed on 8-22-2023 indicates no residents were affected. Paper products were utilized until chemicals could be procured on 8-22-2023 to properly sanitize Dinning utensils and accessories. Thermometers and temperature logs were placed on the unit refrigerators and temperatures obtained on 9-1-2023 and by Dietary Manager. Unit refrigerators were cleaned and food items were disposed of on 8-28-2023 and by Dietary Manager related to temperature above threshold.. **What measures will be put in place and what systemic changes will be made to ensure that deficient practice.** The Administrator/Designee in-serviced the dietary department and nursing department on sanitizing dishes and utensils,	

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	and should be here in 3 to 5 business days. On 8/21/23 at 11:34 A.M., staff was observed plating food for lunch. Food was being plated on regular plates using metal scoops and ladles. On 8/21/23 at 12:02 P.M., lunch was observed in the main dining room. Residents were served food on regular plates and used silverware. On 8/21/23 at 2:03 P.M., the Dietary Manager indicated that the thermometer on the dishwasher started fluctuating while reading temperatures 3 weeks ago and he had been using a digital thermometer to take the wash temperature for those 3 weeks. He indicated a replacement thermometer had been ordered and should be here in 3 to 5 business days. The Dietary Manager indicated that the sanitization liquid ran out last Wednesday (8/16/23) and he placed an order for sanitization supplies on Friday (8/18/23). He indicated he was currently using bleach to sanitize the dishes. The Dietary Manager indicated that the staff was supposed to check the bleach levels every 2 hours to ensure there was bleach in the tub. He indicated there was no log to show who checked off on the bleach levels. The Dietary Manager indicated he was out of town over the weekend, but when he left on Friday the bleach tub was full and he was unaware it was empty until the test strip did not register any ppm of chlorine this morning. The Dietary Manager indicated the emergency preparedness plan called for paper plates if the dishwasher wasn't functioning properly. When asked to provide work orders and invoices for supplies ordered, the Dietary Manager indicated that he called [name of company] himself because the maintenance staff member who usually takes care of equipment breakdown was out of town.		monitoring temperatures for refrigerators, emergency use of paper goods for meals service on 8-28-2023. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **How the corrective actions will be monitored to ensure the deficient practices will not recur:** The dietary manger/designee will audit the Dish Log Record for temperatures and test chemical in dishwasher daily x 6 months. The DON/Designee will audit unit refrigerator temperatures 5 days a week x 4 weeks, then 3 days a week for 4 weeks, then weekly x 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **DOC:9-28-2023**	

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	On a follow-up tour of the kitchen on 8/21/23 at 3:00 P.M., the Dietary Manager indicated that the dishwasher sanitization operated on three chemicals, Detergent All Purpose, Rinse Additive In, and UltraSan Solution. The [name of company] UltraSan solution was out and staff had been adding bleach to this bucket every 2 hours in place of that solution. On 8/21/23 at 3:10 P.M., a dishwasher cycle was observed. Kitchen Staff 16 used a chemical strip to test the ppm (parts per million) of hypochlorite (chlorine). The chemical sanitization strips showed 0 ppm. Kitchen Staff 16 indicated she would record that result as 10 ppm. On 8/21/23 at 10:40 A.M., the Infection Preventionist indicated there were no residents in the facility with communicable diseases, including hepatitis. On 8/22/23 at 10:35 A.M., Resident 46's clinical record was reviewed. Diagnosis included, but was not limited to, viral hepatitis C. On 8/22/23 at 10:39 A.M., a current Machine Dishwashing policy, developed 4/2017, indicated "a test kit will be ...used to accurately measure the sanitizer concentrations and water temperature per manufacturer's recommendations". On 8/22/23 at 9:15 A.M., a dishwasher manufacturer manual was requested and not provided. On 8/22/23 at 9:45 A.M., documentation related to sanitation supplies orders and work orders was requested and not provided.			

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	2. On 8/23/23 at 8:45 A.M., the East Hall nourishment panty refrigerator was observed to be 44 degrees F and also contained perishable foods: applesauce, yogurt in bowls and protein shakes. On 8/28/23 at 2:24 P.M., a current nondated policy " Unit (Resident Room) Refrigerators indicated... the policy of the facility is to assure that perishable food requiring refrigeration is store at the proper temperatures...2. each refrigerator will be provided a thermometer to ensure that ...it was maintained between 35 degrees and 40 degrees Fahrenheit." This Federal tag relates to Complaint IN00415004. 3.1-21(i)(2) 3.1-21(i)(3)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 4 of 6 resident rooms, 1 of 2 medication storage rooms, 1 of 1 pantries, and 4 of 4 units reviewed for environment. Floors were sticky and dirty, there were holes in the walls, sticky substances were on surfaces, drawers were missing, dressers were in disrepair, and clutter was present (2 east halls, 1 west hall, 1 locked unit, west medication room, east pantry, and Room 219, Room 220, and Room 227). Findings include:	F 0921	**Tag# F 921** It is the policy of this facility to ensure a safe, functional, sanitary, and comfortable environment for the residents, staff and public. **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** The hallway outside of Kitchen tile will be replaced on 9-27-2023. The floor was cleaned on 9-26-2023. By Housekeeping. The Dining room floor and East	09/28/2023

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	1. During observation on 8/21/23 at 10:00 A.M., the floor in the hallway next to the kitchen was observed to be dirty, with a 10"x 6" chunk out of the tile in front of the kitchen door. On 8/22/23 at 8:00 A.M. the same was observed. On 8/23/23 at 8:02 A.M. the same was observed. On 8/24/23 at 8:03 A.M. the same was observed. 2. During observation of the main dining area and the two east halls on 8/21/23 at 10:05 A.M., the floors were sticky and dirty. 3. During observation of the facility's front porch on 8/21/23 at 12:40 P.M., where the residents and visitors sit, the porch was littered with cigarette ashes, cigarette butts, dirt and crumbled leaves that had accumulated behind and around the furniture, and mulch from the landscaping. At the end of the porch was a large ant hill, plus weeds and dead plants in the landscaping. On 8/22/23 at 7:45 A.M., the same was observed. 4. On 8/21/23 at 9:45 A.M., the ladies restroom in the hallway by the kitchen was observed to have 2 large screws sticking about ½ inch out of the wall about 5 ft up on the wall next to the toilet, there were 2 1" x 1" holes in the wall next to the toilet paper and no paint where something had been removed from the wall, the drywall around the back of the sink was crumbling, there was a 14"x 6" patch of wall behind the toilet that was not painted. On 8/22/23 at 8:45 A.M., the same was observed. On 8/23/22 at 9:00 A.M., the same was observed. On 8/24/23 at 8:30 A.M., the same was observed. 5. On 8/23/23 at 8:30 A.M., the pantry on the east hall was observed to have the hand sanitizer container missing from the wall, the bracket that		hallways were cleaned on 8-22-2023, by housekeeping. The Front Porch area was cleaned of cigarette ashes, cigarette butts, dirt, crumbled leaves and mulch, the ant hill, weeds and dead plants were removed by housekeeping/landscaping company on 9-18-2023. The Ladies restroom in hallway by Kitchen has had nails removed and the walls will be patched and painted by Maintenance on 9-26-2023. The pantry on East hallway sanitizer bracket has been fixed. The walls will be patched a repainted. The snack refrigerator door was cleaned, boxes and cluttered were removed by Housekeeping/Maintenance on 9-27-2023. The West medication room will be repaired and cleaned, the cabinet was replaced on 9-27-2023, the cabinets were cleaned on sticky substance and the floor and counters were cleaned of boxes and clutter on 9-19-2023 by DON. Room 220 has been patched and painted on 9-27-2023 by Maintenance. The built in dresser will be replaced/repaired on 9-26-2023. Room 219-bathroom wall were be patched and painted on 9-26-2023 by Maintenance. The built in dresser will be replaced on 9-27-2023. Room 227 nails have been	

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	was supposed to hold it was still there, the walls had paint scrapes and holes in the wall around the bracket. There were 8 1" x 1" holes in the wall under the paper towel holder. The shelves in the snack refrigerator door had a yellowish sticky substance on them. Boxes and clutter were piled on the floor. 6. On 8/23/23 at 8:45 A.M., the west medication room was observed to have 2 large holes in the lower cabinet next to the sink, where 2 drawers were missing. The drawers were not in the room, but the front panel to one of them was on the floor at the far end of the room. Two lower cabinet doors at the far end of the room had a brownish sticky substance on them. The floor and counter was cluttered with boxes and the floor dirty. 7. On 8/23/23 at 8:34 A.M., room 220 was observed to have 6 patched holes scattered on the wall above bed A, ranging from 6 to 10 inches long, 3 above the television. The front of the built-in dresser on the wall opposite of the beds was scratched up from top to bottom. 8. On 8/22/23 at 9:57 A.M., in room 219, the bathroom wall across from toilet had a 1-1/2" dent to the left of the call light, a 1" x 1" and a 1.5" x 1.5" patch of paint missing, a 2" x 4" and 1.5" x 1.5" gouge out of the inside door frame to the left of the toilet, black scrapes on the wall under the toilet paper holder, a 1.5" x 1.5" patch of paint missing on inside of door frame in room 219. The bathroom is shared by rooms 219 and room 220. On 8/23/23 at 8:42 A.M., the built-in dresser on the wall opposite the beds in room 219 was observed to be scratched up from top to bottom. 9. On 8/21/23 at 1:54 P.M., room 227 was observed to have a large nail sticking out of the wall about		removed and the walls and ceiling have been patched and painted, Floor has been cleaned and the dresser knobs will be replaced and scratches cleaned on 9-27-2023 by Maintenance. Room 225 nails/screw removed, room has been touched up with new paint and the bathroom floors, toilet and sink have been cleaned on 9-27-2023 by Maintenance. **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** All residents had the potential to be affected. Administrator or designee will conduct a full facility audit on 9-25-2023 and will identify any Maintenance /Housekeeping concerns and will put on a list to be completed by December 31 2023. **What measures will be put in place and what systemic changes will be made to ensure that deficient practice does not reoccur.** The Administrator in-serviced the housekeeping department and maintenance department on ensuring a safe, functional, sanitary, and comfortable environment for residents, staff and visitors on 9-25-2023. Additionally, any staff that fails to comply with the points of this	

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	5' above side of bed, 4 .5" x 1.5" patches of paint peeled off about 3' above head of bed, paint scrape about 2' long and 2' up on left side of heating and air conditioning unit. Floor is sticky and dull, the built-in dresser opposite the bed was observed to be missing a knob on the top drawer and was scratched up from top to bottom. 10. On 8/21/23 at 8:28 A.M., room 225 was observed to have 3 large nails sticking out 1/2" of wall above the head of the resident's bed, 2 large screw heads sticking about of the wall under the light switch, with 6 areas of paint chipped off the wall with some patches on three of them, 1 large nail sticking out over an inch from wall next to bathroom door about 4 feet up. Bathroom floor is dirty, sink has black greasy-looking substance in bowl and on drain pipes under the sink. The toilet has black flecks all over the inside of the bowl, behind the bowl, and on the floor. 12. On 8/25/23 at 2:00 P.M., the facility housekeeping cleaning schedule for the month of August, 2023, indicated the west hall and dining room had the floors deep cleaned on 8/9/23 by HK17, the service hall was high speed sprayed and buffed on 8/10/23 by HK17, the east halls were deep-cleaned on 8/23/23 by HK17, the locked unit floors were deep cleaned on 8/26/23 by HK17. The "trash in front" was completed by HK18 on 8/27/23. A facility maintenance policy was requested and not received. This Federal tag relates to Complaint IN00415004. 3.1-19(f)		in-service will be further educated/disciplined as indicated. **How the corrective actions will be monitored to ensure the deficient practices will not recur:** The administrator/designee will audit 10 random rooms/bathrooms/hallways/mediations rooms/front porch 5 days a week for 4 weeks, then 5 random rooms/bathrooms/hallways/medication rooms/front porch 3 x a week for 4 weeks, then 10 random rooms/bathrooms/hallways/medication rooms/front porch monthly x 4 months for safe, functional, sanitary and comfortable environment. . If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **DOC9-28-2023**	

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F 0940 SS=D Bldg. 00	483.95 Training Requirements §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- Based on interview and record review, the facility failed to ensure that staff received sufficient training to ensure resident safety and reduce the number of adverse events or other resident complications for 1 of 1 residents reviewed who use the mechanical lift. (Resident 37) Findings include: During an interview with Resident 37 on 8/21/23 at 3:55 P.M., the resident indicated that the day before yesterday the mechanical lift had tipped over with her in it. During an interview with the Director of Nursing (DON) on 8/25/23 at 2:20 P.M., she indicated she was not at work that day but was aware of the incident. She indicated there were no injuries. During an interview with the Assistant Director of Nursing (ADON) on 8/28/23 at 8:43 A.M., she indicated she was aware of the incident and there was no injury. She indicated that on 8/11/23 at 12:12 P.M., Certified Nursing Assistant (CNA) 10 and CNA 14 were re-educated on making sure the legs on the mechanical lift were fully spread before using it. She indicated they have a bunch	F 0940	**Tag# 940 training requirements** It is the policy of this facility to ensure staff receive sufficient training to ensure resident safety. **What corrective actions will be accomplished for those residents found to be affected by the deficient practice:** Resident #37 was not injured as verified by full body assessments via Nursing and self report on 8-10-2023. **How other residents having the potential to be affected by the same deficient practices will be identified and what corrective action will be taken:** All residents that require a stand aide/Hoyer lift have the potential to be affected. An audit was conducted on 9-21-2023 by DON, every resident that required a stand aide/Hoyer lift to determine if any had been affected and none where identified. An Audit of employee files was complete by	09/28/2023

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	of in-services annually. ADON indicated they train nursing staff on hire to use the lift. A list of annual in-services was requested and not received. The incident was documented on 8/10/23 at 3:58 P.M. and was listed as a fall with no injuries. During an interview with the DON on 8/28/23 at 8:51 A.M., she indicated CNA 10 started getting the resident ready to transfer from the chair to the bed by getting her into the lift, and was waiting on CNA 14 to come help her. CNA 14 went to get the nurse because resident had fallen out of the lift onto her bed. DON indicated they do re-freshers on using the lift as needed or if they get a new lift. She indicated she hadn't been real organized with having a place to document in-services and was unaware of their location. The in-services binder was requested and not received. On 8/28/23 at 9:22 A.M., the resident's clinical record was reviewed. The progress notes included: 8/10/2023 at 15:00 Note Text: called to resident's room per CNA. Noted resident hooked up to stand up lift and lift is turned over and half laying on bed. Resident is lying on floor at foot of bed. CNA was in room at time and says the resident did not hit head and that lift started slowly tipping over. Resident stated that ...she grabbed the foot of the bed to help ease herself to floor. Resident denies any pain or injuries at this time. Body assessment, range of motion (ROM) to ext w/out difficulty or pain... Notified Administrator (ADM), MD. vital signs 140/76-88-20-98.1. 8/11/2023 01:11 Nursing Progress Note. Text:: resident alert and oriented, able to make needs and wants known, denies any new discomfort, no		ABOM on 9-25-2023 for training on mechanical lifts, any staff without training were educated on 9-27-2023. **What measures will be put in place and what systemic changes will be made to ensure that deficient practice:** The DON/Designee in-serviced nursing staff on Mechanical Lift Policy and completed a Mechanical Lift Competency by 9-27-2023. Additionally, any staff that fails to comply with the points of this in-service will be further educated/disciplined as indicated. **How the corrective actions will be monitored to ensure the deficient practices will not recur:** The DON/Designee will audit new employee files for education/training/competencies x 6 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped Results of the monitoring will be reviewed at the monthly QAPI meetings. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI Committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. **DOC:9-28-2023**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155275	A. BUILDING 00 B. WING	08/28/2023

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	s/s of injury noted r/t fall from lift....resident resting quietly at this time, will continue to monitor 8/11/2023 12:12 IDT - General Note Late Entry: Note Text: fall reviewed by MDS, DON, Admin, SS, ADON. Resident was in stand aide and fell onto bed and floor, CNA's educated on ensuring legs of the base is spread out during transfer. 8/14/2023 23:04 Nursing Progress Note. Note Text: resident exhibits no signs or symptoms of injury related to fall on 8/10/23, denies pain, will monitor. On 8/28/23 at 10:04 AM CNA 10 and CNA 14's employee records were reviewed. CNA 10 was hired on 8/13/18. QMA/CNA New Hire Orientation skills checklist lacked an item for use of a mechanical lift to move a resident. There was no evidence that this employee attended any in-services on the use of a mechanical lift during her tenure in her position.. CNA14 was hired on 5/14/19. QMA/CNA Orientation skills checklist lacked an item for use of a mechanical lift to move a resident. There was no evidence that this employee attended any in-services on the use of a mechanical lift during her tenure in her position.. On 8/28/23 at 10:31 A.M. The resident's clinical record was reviewed. Diagnoses included, but were not limited to: hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic obstructive pulmonary disease (COPD), anxiety, depression, post-traumatic stress disorder (PTSD). Quarterly MDS dated 7/9/23 indicated resident has moderate cognitive impairment and requires extensive assist of 2 for bed mobility, transfers,			

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	and toileting, setup and assist of 1 for eating, and is totally dependent for bathing. Current physician orders included but were not limited to Resident may use stand-lift for transfers (6/13/22), Observe for side effects with antipsychotic use App = Mask like appearance, Dro = Drowsiness, Oth = Other see Nurses Notes), Stn = Stiff Neck TRM = Tremors every shift related to schizoaffective disorder (5/24/23). Care Care plan, dated 11/15/19, included resident has potential for falls R/T impulsive at times (8/26/2020). Interventions included: 1. Call light in reach (11/15/19) 2. Dycem placed in w/c Shows on Kardex. (11/4/2020) 3. Encourage to ask for assist with transfer or ambulation prn (11/15/19) 4. Ensure legs on base of lift are opened for transfers. (8/14/23/0 5. Give verbal cues during transfers to slow down and when to move foot. Shows on Kardex. 4/14/21) 6. Keep paths free of clutter (11/15/19) 7. Make sure pants are clear from w/c Shows on Kardex. 5/26/21) 8. Position res feet on floor Shows on Kardex. (4/7/2020) 9. Put rails on toilet in bathroom Shows on Kardex. (5/17/21) 10. Resident to be 2 assist for shower transfer Shows on Kardex. (8/24/20) 11. Resident to be 2 assist with toilet transfers Shows on Kardex. (8/26/21) 12. Therapy screen quarterly and prn (11/15/19) 13. To have containers with lids to prevent frequently used items from falling on floor. (2/8/21)			

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	A Facility Assessment, dated 4/20/23, indicated that required in-service training for nurse aides must be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. A training/in-service policy was requested but not received. 3,1-13(b)(1)(2) 3.1-14(k)			