STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155767	A. BUILDING 00 B. WING	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRINGHURST HEALTH CAMPUS	628 N MERIDIAN RD GREENFIELD, IN 46140

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: February 20, 21, 22, 23, 24, and 27, 2023 Facility number: 005954 Provider number: 155767 AIM number: 201068810 Census Bed Type: SNF/NF: 26 SNF: 26 Residential: 51 Total: 103 Census Payor Type: Medicare: 19 Medicaid: 18 Other: 15 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 28, 2023	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted February 20 – 27, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of April 1, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marshall Hopkins	Executive Director	03/17/2023

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

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	(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on interview and record review, the facility failed to provide Resident 207 with a Notification of Medicare Non-Coverage (NOMNC) at least two calendar days prior to discharge from Medicare Part A services for 1 of 3 beneficiary notices reviewed. Findings include: The clinical record for Resident 207 was reviewed on 2/23/2023 at 1:15 p.m. Resident 207 started Medicare Part A services on 11/29/2022 and the last covered day of Part A services was 1/3/2023. A NOMNC with a last covered day of Medicare Part A services was dated for 1/3/2023 and was signed by Resident 207 on 1/3/2023. An interview with the Executive Director on 2/24/2023 at 3:57 p.m., indicated the facility was unable to provide a notice that Resident 207 was aware of Medicare Part A services to be discontinued prior to the NOMNC and he was unable to explain why Resident 207 was not given the NOMNC sooner. A policy entitled, "NOMNC Completion SOP [Standard Operating Procedure]", was provided by the Clinical Support on 2/24/2023 at 11:05 a.m. The policy indicated, " ...For residents being notified of discontinuation of their Medicare	F 0582	**F582 – Medicaid/Medicare Coverage/Liability Notice** *"Facility failed to provide Resident 207 with a Notification of Medicare Non-Coverage (NOMNC) at least two calendar days prior to discharge from Medicare Part A services for 1 of 3 beneficiary notices reviewed."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Residents 207 was affected by the alleged deficient practice with no adverse effects noted. - Residents was given NOMNC on last covered day. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All Medicaid/Medicare covered residents have the potential to be affected by the alleged deficient practice. - Social Services was educated on presenting the	04/01/2023

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	coverage, the NOMNC is requested to be issues 2 calendar days prior to the actual discharge from Medicare ..." 3.1-12(a)(15)		NOMNC to appropriate residents at least 2 calendar days before coverage termination. - All inhouse residents currently receiving Medicare/Medicaid coverage were audited on 3.10.2023 by the Social Services/designee for NOMNC timeliness. No residents qualified for documentation change. Education provided: o Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - Social Services/designee will ensure weekly accuracy review of all residents NOMNC through the program monitoring tool to ensure that any residents appropriate for NOMNC issuance does so at least 2 days prior to services ending and for proper monitoring weekly for 4 weeks, biweekly for 8 weeks, and monitored monthly in QAPI for 6 months. **4: 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?** - DHS/Social Services will	

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			be responsible for the NOMNC issuance program, monitoring compliance of the weekly procedure for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.			

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	§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on record review and interview, the facility failed to provide written bed hold information for 1 of 2 residents reviewed for hospitalization. (Resident 15) Findings include: Resident 15's record was reviewed on 2/22/23 at 1:23 p.m. The record indicated Resident 15 had diagnoses that included, but were not limited to, liver disease, type 2 diabetes mellitus, urinary tract infection, heart failure, heart disease, anxiety and depression. A Quarterly Minimum Data Set (MDS) assessment, dated 1/4/2023, indicated Resident 15 was cognitively intact. Progress notes, dated 12/26/22 at 12:33 a.m., indicated Resident 15 was transported to a local hospital. Census documentation indicated the resident was sent to the hospital on 12/26/22 and returned on 12/30/22. There was no documentation in the clinical record that indicated a bed hold notice was provided to the resident or family upon discharge to the hospital. During an interview, on 2/24/23 at 2:45 p.m., the	F 0625	**F625 – Notice of Bed Hold Policy Before/Upon Trnsfr** *"The facility failed to provide written bed hold information for 1 of 2 residents reviewed for hospitalization. (Resident 15)."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Residents 15 was affected by the alleged deficient practice with no adverse effects noted. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - One of two residents were affected by the alleged deficient practice. - IDT and nursing staff were reeducated on the Bed Hold policy and procedure. - All discharges within the past 30 days were audited for bed hold notification. No residents required bed hold notification. Education provided: o Bed Hold Policy	04/01/2023

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	Director of Health Services indicated she could not find any documentation that a bed hold notice had been issued. A policy for "Bed Hold Notification" was provided by the Director of Health Services on 2/24/23 at 3:00 p.m. The policy included, but was not limited to, "Overview: Residents and Responsible Parties have a right to be notified verbally and in writing on reserve bed payment policy per the state plan when someone goes out to the hospital or on a therapeutic leave. Before a nursing facility transfers a resident to a hospital or the resident goes on a therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies the duration of the state bed hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; the reserve bed payment policy in the state plan if any; the nursing facility's policies regarding bed-hold periods permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed hold policy...." 3.1-12(a)(6)(A)		**3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - DHS/designee will ensure monitoring of all discharged residents through the clinical care meeting to ensure discharged residents have appropriate bed hold documentation weekly for 4 weeks, biweekly for 8 weeks, and monitored monthly in QAPI for 6 months. **4: 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?** - DHS/Designee will be responsible for the for ongoing compliance and monitoring for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	

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F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care 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 complete a care plan meeting for 1 of 1 resident's reviewed for care plan meetings (Resident 43). Finding include: During an interview with Resident 43 on 2/20/23 at 2:04 p.m., indicated he had not had care plan	F 0657	**F657 – Care Plan Timing and Revision** *"Facility failed to complete a care plan meeting for 1 of 1 resident's reviewed for care plan meetings (Resident 43)."* **1: What corrective action(s) will be accomplished for those residents found to have**	04/01/2023

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	meeting where the facility talked to him about his goals and needs. Review of the record of Resident 43 on 2/23/23 at 11:20 a.m., indicated the resident's diagnoses included, but were not limited to, severe sepsis with septic shock, acute kidney failure, pulmonary fibrosis, Parkinson disease, hypertension, type two diabetes mellitus, low back pain, right and left knee contractures, prostate cancer, chronic pain, insomnia, muscle weakness and urinary retention. The Annual Minimum Data Set (MDS) assessment for Resident 43, dated 11/11/22, indicated the resident was cognitively intact for daily decision making. During an interview with the Director Of Health Services (DHS) on 2/23/23 at 11:55 a.m., indicated Resident 43 had not had a care plan meeting since April 2022. The DHS indicated she was unsure how the resident's care plan meeting got missed and the standard of the facility was resident's were suppose to have a care plan meeting quarterly. The resident first meeting guidelines provided by Clinical Support on 2/23/23 at 1:30 p.m., indicated the purpose was to facilitate communication and participation regarding the resident's plan of care, medical condition and care needs between the resident, family, resident representative and care givers. Resident first meetings should be conducted at a minimum of quarterly. 3.1-35(C)(2)(B)		**affected by the deficient practice?** - Residents 43 was affected by the alleged deficient practice. Meeting was immediately scheduled as per resident/family availability. **2: How other residents having the 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 affected by the alleged deficient practice. - Social Service Representative was reeducated on the Resident Care Plan Meeting (Resident First Meetings). - All inhouse residents audited on 3.10.2023 by SSR for appropriate and timely care plan meetings. Further care plan meetings were scheduled if qualified. Education provided: o Resident First Meeting Guidelines **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - DHS/SSR/designee will ensure weekly monitoring during clinical care meeting (CCM) to ensure that any residents who needs a care plan meeting is	

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			scheduled to do so, weekly for 4 weeks, biweekly for 8 weeks, and monitored monthly in QAPI for 6 months, refusals are being documented when applicable. **4: 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?** - DHS/SSR/designee will be responsible for the for ongoing compliance and monitoring for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, interview and record review the facility failed to provide showers as scheduled for dependent residents for 2 of 2 reviewed for Activities Of Daily Living (ADL) (Resident 30 and Resident 9). Findings include:	F 0677	**F677 – ADL Care Provided for Dependent Residents** *"Facility failed to provide showers as scheduled for dependent residents for 2 of 2 reviewed for Activities of Daily Living (ADL) (Resident 30 and Resident 9)."*	04/01/2023

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	1.) During an interview with Resident 30 on 2/20/23 at 11:46 a.m., the resident indicated she was not receiving two showers a week like she was suppose to. The resident indicated she used wipes to clean herself the best she could. The resident indicated she had not had her hair washed for seven days. During an interview with Resident 30 on 2/23/23 at 1:58 p.m., the resident indicated when she was home she took at least three showers a week. The resident indicated she would be glad when she was able to give herself a shower so she wasn't a burden on the staff. I did get a shower on Monday. Review of the record of Resident 30 on 2/23/23 at 2:10 p.m., indicated the resident's diagnoses included, but were not limited to, hypertensive heart disease, occlusion of arteries, peripheral vascular disease, chronic obstructive pulmonary disease, lack of coordination, unspecified fall, pain in right knee, muscle weakness, age related osteoporosis and left femur fracture. The profile care guide for Resident 30, dated 1/19/23, indicated the resident was to receive a shower two times a week on Mondays and Thursday. The Admission Minimum Data Set (MDS) assessment for Resident 30, dated 1/23/23, indicated the resident was cognitively intact for daily decision making. The resident required extensive assistance of one person for dressing. The resident was totally dependent of one person for bathing. It was very important to the resident to receive her preference of a shower.		**1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Resident 30 and resident 9 was affected by the alleged deficient practice. - Residents were immediately approached for a shower. Refusals documented as applicable. **2: How other residents having the 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 affected by the alleged deficient practice. - All residents were assessed for appropriate orders and documentation of shower preference. - Nursing staff was reeducated on assessments and implementation of showers, including but not limited to, the resident shower preference. Additional education was provider for documentation practices and the necessity to document refusals if applicable. Education provided: o Guidelines for Bathing Preference o Standard documentation practices r/t refusals of care.	

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	Review of the showers/bathing for Resident 30 indicated in the last 37 days the resident had received 4 showers. 2.) During an observation on 2/21/23 at 11:02 a.m., Resident 9 was sitting in her wheelchair. The resident's hair was greasy and dirty. The resident's fingernails were long and jagged. During an observation on 2/23/23 at 11:10 a.m., Resident 9 was sitting in her wheelchair in the dining room. The resident's hair was greasy and dirty. The resident's fingernails were long and jagged. Review of the record of Resident 9 on 2/22/23 at 11:56 a.m., indicated the resident's diagnoses included, but were not limited to, dementia, depression, anxiety, difficulty walking, abnormal posture, repeated falls, lack of coordination, muscle weakness and chronic pain. The Quarterly Minimum Data Set (MDS) assessment for Resident 9, dated 11/17/22, indicated the resident was severely cognitively impaired for daily decision making. The resident had no behaviors of rejecting care. The resident had no behaviors of physical aggression or verbal aggression. The resident required extensive assistance of two people for personal hygiene and total dependent for bathing. The profile care guide for Resident 9, dated 3/17/22, indicated the resident was to receive a shower twice a week. Review of the shower/bathing for Resident 9, dated 11/22/23 to 2/22/23, the resident received two showers and two complete bed baths in the past three months.		**3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - DHS/designee will ensure random weekly monitoring to ensure that residents are receiving their bathing preference, or documentation of refusal of bathing, twice a week for 4 weeks, weekly for 8 weeks, and bi-monthly for 2 months and monitored monthly in QAPI for 6 months. **4: 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?** - DHS/designee will be responsible for the for ongoing compliance and monitoring for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview with the Director Of Health Services (DHS) on 2/23/23 at 11:50 a.m., indicated it was the responsibility of the CNA to provide residents with their showers/baths, if the resident refuses then the protocol was to reproach at a later time and if the resident continues to refuse the CNA was to report it to the nurse and the nurse would attempt to provide the resident with a shower. The bathing policy provided by the DHS on 2/24/23 at 11:15 a.m., indicated the bathing shall occur at least twice a week. 3.1-38(a)(2)(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 observation, interview, and record review the facility failed to ensure collaboration with a hospice provider regarding coordination of care related to laboratory work, medication form changes, wound assessments, and Registered Dietitian (RD) recommendations for 1 of 1 resident reviewed for hospice services (Resident 17), 1 of 5 residents reviewed for pressure ulcers (Resident 22), and 1 of 1 resident reviewed for nutrition	F 0684	**F684 – Quality of Care** *"Facility failed to ensure collaboration with a hospice provider regarding coordination of care related to laboratory work, medication form changes, wound assessments, and Registered Dietitian (RD) recommendations for 1 of 1 resident reviewed for hospice services (Resident 17), 1*	04/01/2023

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	(Resident 26). The facility also failed to ensure a device was in place, per physician orders, in regard to limited range of motion (ROM) for 1 of 1 resident reviewed for impaired mobility (Resident 22). Findings include: 1a. The clinical record for Resident 17 was reviewed on 2/24/23 at 11:26 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety disorder, chronic kidney disease, and unspecified convulsions. A safety care plan, revised 2/17/23, indicated Resident 17 was at risk for seizures related to diagnosis of unspecified convulsions. The approach was listed to do any laboratory work per physician orders and give medication per physician orders. A fall care plan, revised 2/17/23, indicated Resident 17 was at risk for falls due to history of falls, tremors, decreased mobility, increased weakness, and assistance needed with activities of daily living. A physician order, dated 3/18/22, was noted for Keppra (antiseizure medication/anticonvulsant medication) A fall event, dated 2/1/23, indicated Resident 17 was sitting in her broda chair and appeared agitated. Resident 17 slid assisted from the broda chair. The root cause was listed as Resident 17 having a history of being cold and shivering. The intervention was to offer a blanket when up in broda chair and due to reported seizure-like activity, the facility was to inquire with hospice about obtaining a Keppra level to ensure		*of 5 residents reviewed for pressure ulcers (Resident 22), and 1 of 1 resident reviewed for nutrition (Resident 26). The facility also failed to ensure a device was in place, per physician orders, regarding limited range of motion (ROM) for 1 of 1 resident reviewed for impaired mobility (Resident 22)."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Residents 17, 22, and 26 was affected by the alleged deficient practice. - Hospice was immediately contacted for collaboration regarding Resident 22 pressure ulcers, Resident 26 nutrition, and resident 17 for laboratory work, and medication changes wound assessments and RD recommendations. - ROM device was immediately retrieved for Resident 22 and implemented. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents receiving hospice services or ROM devices have the potential to be affected by the alleged deficient practice. - IDT was reeducated on	

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	therapeutic level. There was no previous physician order for February 2023 for a Keppra level for Resident 17 in the clinical record. 1b. A progress note, dated 2/15/23, indicated the following, ""...Hospice in to see resident...also medications discussed to change resident to liquid meds [medications]; resident does not take whole medications and tends to spit or not take meds when they are crushed; per hospice nurse "will have MD [Medical Director] review medications and see about changing meds to liquids due to resident taking liquids better than solids" hospice nurse will call and discuss with daughter; daughter in earlier and this nurse had spoke with daughter as well; daughter stated "that liquid meds would be fine with her"...." There was no follow up in the clinical record in regard to changing Resident 17's medications from pills/capsules to liquid. The medication list for Resident 17, dated 2/14/23 at 11:28 a.m., indicated orders for medications by mouth that were not liquid. These medications included docusate sodium capsule, Keppra tablet, nitrofurantoin capsule (antibiotic), buspirone tablet (anxiety medication), hydroxyzine tablet (antihistamine), acetaminophen capsule, and Ativan (anxiety medication) tablet. An interview conducted with the Director of Health Services (DHS), on 2/24/23 at 12:18 p.m., indicated the facility requested another Keppra level. The previous one taken, in 2022, was within normal limits. The DHS had made a call out to hospice and waiting to hear back from one of the case managers about the request for a Keppra		Hospice services communication with concentration on, but not limited to, assessing residents for medication appropriateness, wound measurements, ROM devices, RD recommendations, adhering to orders by the physician, and laboratory work. - All inhouse residents currently receiving Hospice services were audited on 3.10.2023 by the DHS/designee. Residents receiving Hospice services were discussed with Hospice representative. Education provided: o Hospice Communication. o Following physician orders for ROM devices. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - DHS/designee will ensure weekly monitoring for Hospice communication adherence for residents including, but not limited to, wound assessments, medication reviews, RD recommendations, ROM devices and laboratory work. Proper monitoring will occur weekly for 4 weeks, biweekly for 8 weeks, and monitored monthly in QAPI for 6 months. **4: How the corrective action will be monitored to ensure the**	

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	level. She also reached out about the request for liquid medication. The floor nurse was supposed to contact hospice and obtain an order for the Keppra level as well as a request for the liquid medication. 2a. The clinical record for Resident 22 was reviewed on 2/22/23 at 11:23 a.m. The diagnoses included, but were not limited to, dementia, contracture to right hand, dysphagia, and pain. The Wound Management Detail Report, dated 2/24/23, indicated that Resident 22 had a pressure ulcer to her right big toe that was identified on 12/22/22 and her coccyx that was identified on 12/6/22. Weekly wound assessments were conducted, per the Wound Management Detail Report, but there appeared to be a gap with a delay in obtaining weekly wound assessments from 12/27/22 to 1/24/23. An interview conducted with the DHS, on 2/24/23 at 2:40 p.m., indicated she had reached out to hospice to inquire about the weekly wound measurements for the weeks that appear to be missing from the Wound Management Detail Report due to the Assistant Director of Health Services (ADHS) being ill during that time period. 2b. A physician order, dated 10/14/22, indicated for Resident 22 to utilize a carrot in right hand at all times, except for hygiene or if causing pain/discomfort, as tolerated. A care plan for ROM, revised 12/29/22, indicated Resident 22 had limited ROM to the right hand. The approach was to utilize a carrot device to the rand hand per orders and as tolerated.		**deficient practice will not recur i.e., what quality assurance program will be put into place?** - DHS/designee will be responsible for the for ongoing compliance and monitoring for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	

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The following observations were conducted to where Resident 22 did not have a carrot or device to her right hand:

2/22/23 at 11:06 a.m.,
2/22/23 at 11:36 a.m.,
2/22/23 at 2:30 p.m., &
2/22/23 at 3:36 p.m.

An interview conducted with the DHS, on 2/24/23 at 12:40 p.m., indicated the expectations are for staff to following physician orders and the residents care plans as written.

3. The clinical record for Resident 26 was reviewed on 2/22/23 at 12:44 p.m. The diagnoses included, but were not limited to, history of COVID-19, history of pneumonia, congestive heart failure (CHF), dysphagia, anemia, and cerebrovascular disease.

A care plan for nutritional status, revised 2/18/23, indicated Resident 26 was malnourished and/or at risk for malnutrition related to diagnoses, inadequate nutrient/energy intakes, and/or metabolic demands. The approach was to have the Dietitian to re-evaluate as indicated and provide diet, supplements, medications, and adaptive equipment as ordered.

A Registered Dietitian (RD) note, dated 2/21/23 at 3:26 p.m., indicated the following, "...Noted COVID+ [positive] on 2/6/23 with decline. Noted significant weight loss since 2/6/23 with poor meal intake. Noted new impairments to coccyx and bilateral buttocks on 2/20/23. Dxs [diagnoses]: CHF, CKD 3 [chronic kidney disease; stage 3], dysphagia, lymphedema. Noted recent weight history: 2/21/23: 165.8 lbs, 2/20/23: 167.2 lbs,

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	2/19/23: 169.2 lbs, 2/18/23: 170.2 lbs, 2/6/23: 182.2 lbs, 2/1/23: 186 lbs, IBW: 136 lbs, BMI: 26.76. Weighed daily per order. Continues Lasix 40 mg qday [daily] with no changes since 1/4/23. Receiving regular diet with food preferences honored as requested. Ordered protein drink qday and ProStat AWC Sugar Free TID [three times a day]. Will recommend d/c [discontinue] protein drink and giving Ensure supplement TID between meals and fortified shakes at meals. Will recommend MVI [multivitamin] with minerals 1 po[by mouth] qday[every day] to aid in skin integrity. Careplan initiated [sic]...." As of 2/24/23 at 11:11 a.m., there were no physician order for an Ensure supplement in Resident 26's clinical record. An interview conducted with the DHS, on 2/24/23 at 2:40 p.m., indicated she was going to follow up with hospice in regard to the RD recommendation. A policy titled "Guidelines for Weight Tracking", revised 1/16/21, was provided by Clinical Support on 2/24/23 at 2:57 p.m. The policy indicated the facility dietitian or representative will review the resident's nutritional status, usual body weight and current weight to implement a nutritional program when warranted. It also stated residents with a significant weight change can be added to Clinically At Risk. A Hospice Services Agreement, dated 6/12/17, was provided by the DHS on 2/24/23 at 3:20 p.m. The document indicated the following, "...Plan of Care [POC]: a written individualized Plan of Care and services necessary to meet the patient-specific needs. It includes all patient care physician orders, and planned interventions for problems identified during patient assessments, to			

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	ensure that care and services are appropriate to the severity level of each patient and family needs...TERMS AND CONDITIONS...1.2 Plan of Care...The Plan of Care will be written in collaboration with the Hospice IDT [interdisciplinary team], the Facility Staff, the Hospice Patient or the Hospice Patient's Representative and the physician, based on the needs of the Hospice Patient. Any change in the POC will be discussed with the Hospice Patient or the Hospice Patient's representative, and the Facility representatives, and must be approved by Hospice before implementation...." 3.1-37(a)			
F 0686 SS=D 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 ensure weekly measurements were conducted of pressure ulcers, provide treatment as ordered by the physician, and ensure a resident with a history of pressure	F 0686	**F686 – Treatment/Svcs to Prevent/Heal Pressure Ulcer** *"Facility failed to ensure weekly measurements were conducted of pressure ulcers, provide treatment as ordered by the physician, and*	04/01/2023

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	ulcers didn't stay in the same position for an extended period of time for 2 of 5 residents reviewed for pressure ulcers. (Resident 17 and Resident 22) Findings include: 1. The clinical record for Resident 17 was reviewed on 2/22/23 at 10:50 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, unspecified protein-calorie malnutrition, anxiety disorder, and unspecified convulsions. A progress note, dated 2/15/23 at 3:44 p.m., indicated Resident 17 had an area to the left hip that appears to look like an old scar. A new red blanchable area was noted on her right hip. Resident was very thin and has multiple bony prominences noted. The hospice nurse was present and verbalized to continue to change position. A care plan for skin integrity, revised 2/21/23, indicated Resident 17 was at risk for pressure ulcers related to decreased mobility and incontinent of bowel and bladder. The approach was to conduct a systematic skin inspection by nurse weekly, keep bony prominences from direct contact with one another, and turn and reposition frequency. An observation conducted on 2/22/23 at 11:12 a.m. of Resident 17 sitting in her broda chair with the head lowered with appearance of sleep. An observation conducted on 2/22/23 at 2:35 p.m. of Resident 17 sitting in the same position in her broda chair. She appeared to be attempting to move herself to slide down in her broda chair.		*ensure a resident with a history of pressure ulcers didn't stay in the same position for an extended period of time for 2 of 5 residents reviewed for pressure ulcers. (Resident 17 and Resident 22)."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Residents 17 and 22 was affected by the alleged deficient practice. - Resident 17 was immediately repositioned. - Resident 22 had her wound treatment completed. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents with skin impairment have the potential to be affected by the alleged deficient practice. - Nursing staff was reeducated on preventative measures and order sets for skin conditions with concentration on, but not limited to, repositioning and weekly documentation of wound treatments. - All inhouse residents were audited on 3.10.2023 by the DHS/designee. Preventative interventions were placed where applicable and measurements	

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	An observation conducted on 2/22/23 at 3:35 p.m. of Resident 17 still in the same position in her broda chair. Her eyes were closed, and she appeared to be sleeping. An interview conducted with the Director of Health Services (DHS), on 2/24/23 at 12:40 p.m., indicated her expectations are for staff to follow the plan of care and follow physician orders as written. 2a. The clinical record for Resident 22 was reviewed on 2/22/23 at 11:23 a.m. The diagnoses included, but was not limited to, dementia, contracture of right hand, anxiety disorder, dysphagia, and muscle weakness. A care plan for pressure, dated 12/6/22, indicated she had a pressure ulcer to her coccyx. The approach was to assess the wound, include measurement and observation of the pressure ulcer, record such, and provide treatment as ordered. A physician order, dated 1/24/23, indicated to cleanse coccyx with normal saline or wound cleanser, pat dry, apply Medihoney to area, and cover with foam dressing. Change every 5 days and PRN (as needed) for soilage. The special instructions for the physician order was "to be changed by hospice nurse 1 day a week and facility nurse x 6 days a week". The order was discontinued on 2/20/23. The electronic medication administration record (EMAR) for January of 2023 and February of 2023 indicated the physician order for Medihoney to Resident 22's coccyx was signed off, as administered, on the following day(s):		entered as appropriate. Education provided: o Guidelines for General Wound and Skin Care. o Preventative skin order set **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - DHS/designee will ensure weekly monitoring new admissions with risk for skin breakdown and implementation of preventive skin interventions including, but not limited to, reposition, float heels, and pressure reducing mattress. Proper monitoring will occur 3 times a week for 4 weeks, biweekly for 8 weeks, and bimonthly for 12 weeks. Then monitored monthly in QAPI for 6 months. **4: 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?** - DHS/designee will be responsible for the for ongoing compliance and monitoring for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The	

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	1/24/23, 1/29/23, 2/3/23, 2/8/23, 2/13/23, and 2/18/23. A physician order, dated 2/20/23, indicated the use of Medihoney to coccyx, cover with foam, and change every 3 days. 2b. The Wound Management Detail Report for Resident 22's coccyx indicated there were no measurements from the assessment on 12/27/22 until 1/31/23. An interview conducted with the Director of Health Services (DHS), on 2/24/23 at 2:40 p.m., indicated she was following up with hospice on weekly wound assessments due to the Assistant Director of Health Services (ADHS) being ill during the time period of late December to late January. The hospice nurse was conducting wound rounds during that time period. A policy titled "Guidelines for General Wound and Skin Care", dated 12/31/22, was provided by Clinical Support on 2/23/23 at 1:30 p.m. The policy indicated the following, "...PROCEDURE...2. Turn/reposition residents who are immobile according to their care plan requirements...14. Perform the wound treatment...Reevaluate the wound's response to the prescribed treatment...20. Document type of wound, location, stage (if applicable), length, width, depth in centimeters, base, drainage, periwound tissue, and treatment of the wound weekly using the wound/skin treatment flowsheet...." 3.1-40(a)(2)		facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

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	§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 observation, interview, and record review, the facility failed to ensure fall interventions were in place per the care plan and ensure a fall follow-up included completed neurological checks for 3 of 4 residents reviewed for accidents. (Resident 17, 31, and 9) Findings include: 1a. The clinical record for Resident 17 was reviewed on 2/22/23 at 10:50 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, malnutrition, anxiety disorder, and unspecified convulsions. A fall care plan, revised 2/17/23, indicated Resident 17 was at risk for falling with the approach to provide resident with a blanket while up in broda chair and staff to recline broda chair after meals. An observation conducted, on 2/23/23 at 12:35 p.m., of Resident 17 being assisted by a staff member in her broda chair and set her in her broda chair in the common area on the hallway where she resided in front of the television. The broda chair was not positioned in a recline position and Resident 17 was sitting upwards. An observation conducted, on 2/24/23 at 10:00	F 0689	**F689 – Free of Accidents Hazards/Supervision/Devices** *"Facility failed to ensure fall interventions were in place per the care plan and ensure a fall follow-up included completed neurological checks for 3 of 4 residents reviewed for accidents. (Resident 17, 31, and 9)."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Residents 17, 31, and 9 was affected by the alleged deficient practice. - Resident 17 immediately had her Broda chair positioned in a reclining position. - Resident 31 immediately was transferred to recliner. - Resident 9 was assessed for neurological impairment. None noted. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.**	04/01/2023

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	a.m., of Resident 17 up in her broda chair, reclined back, but no blanket nor cover was in place while she was up in her broda chair. 1b. A fall event, dated 12/26/22, indicated Resident 17 fell out of her chair and onto floor in common area. The fall was unwitnessed. There were no neurological checks conducted for two 15-minute follow ups, four 30-minute follow ups, four 1 hour follow ups, and three 4 hour follow ups after the fall event. 2. The clinical record for Resident 31 was reviewed on 2/23/23 at 11:48 a.m. The diagnoses included, but were not limited to, dementia, heart disease, atrial fibrillation, anemia, and major depressive disorder. A fall care plan, revised 2/20/23, indicated Resident 31 was at risk for falling with the approach to place resident in recliner after meals. An observation conducted of Resident 31, on 2/23/23 at 2:50 p.m. of him sitting up in his wheelchair with appearance of sleep. An observation conducted of Resident 31, on 2/23/23 at 3:50 p.m., of him sitting up in his wheelchair. 3.) Review of the record of Resident 9 on 2/22/23 at 11:56 a.m., indicated the resident's diagnoses included, but were not limited to, dementia, depression, anxiety, difficulty walking, abnormal posture, repeated falls, lack of coordination, muscle weakness and chronic pain. The Quarterly Minimum Data Set (MDS) assessment for Resident 9, dated 11/17/22, indicated the resident was severely cognitively impaired for daily decision making. The resident has had one fall with injury since the last		- Residents with fall interventions have the potential to be affected by the alleged deficient practice. - Nursing staff was reeducated on fall interventions and neurological checks with concentration on, but not limited to, repositioning, transferring residents to recliner, and neurological checks as indicated after unwitnessed fall. - All inhouse residents were audited on 3.10.2023 by the DHS/designee. Fall interventions were placed if applicable. Education provided: o Falls Management Program Guidelines o Guidelines for Neurological Checks **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - DHS/designee will ensure random weekly monitoring of implementation of fall interventions. Proper monitoring will occur 3 times a week for 4 weeks, biweekly for 8 weeks, and bimonthly for 12 weeks. Then monitored monthly in QAPI for 6 months. **4: How the corrective action will be monitored to ensure the deficient practice will not recur**	

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	assessment. The fall event for Resident 9, dated 11/2/22, indicated the resident had an unwitnessed fall in the bathroom. The resident had an moderate amount of pain in her right knee. The resident's neurological checks were not complete for the last 4 neurological checks required. The fall event for Resident 9, dated 12/27/22, indicated the resident had an unwitnessed fall out of her bed. The resident only received on neurological check after the fall. The fall event for Resident 9, dated 2/6/23, indicated the resident had an unwitnessed fall from her wheelchair in the dining room. The resident had right hip pain. The resident only received one neurological check after the fall. An interview conducted with the Director of Health Services (DHS), on 2/24/23 at 12:40 p.m., indicated her expectations are for staff to follow the care plan and/or physician orders as written. A policy titled "Falls Management Program Guidelines", review date of 3/16/22, was provided by Clinical Support on 2/23/23 at 1:30 p.m. The policy indicated the following, "...4. Any orders received from the physician should be noted and carried out...5. The resident care plan should be updated to reflect any new change in interventions...6. Nursing staff will monitor and document continued resident response and effectiveness of interventions for 72 hours...." A policy titled "Guidelines for Neurological Checks", review date of 12/31/22, was provided by the DHS on 2/24/23 at 12:17 p.m. The policy indicated the following, "...PURPOSE...To		**i.e., what quality assurance program will be put into place?** - DHS/designee will be responsible for the for ongoing compliance and monitoring for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	

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	evaluate the level of consciousness, evaluate pupil response, motor function, and vital signs that may alert staff for potential for head injury or seizure activity...PROCEDURES...3. Neuro-checks for 24 hours should be completed within the Fall Event Form...." 3.1-45(a)(1) 3.1-45(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on interview and record review, the facility failed to follow up with a Registered Dietitian (RD) recommendations for a supplement for a resident who experienced significant weight loss for 1 of 1 resident reviewed for nutrition. (Resident 26)	F 0692	**F692 – Nutritional/Hydration Status Maintenance** *"Facility failed to follow up with a Registered Dietitian (RD) recommendations for a supplement for a resident who*	04/01/2023

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	Findings include: The clinical record for Resident 26 was reviewed on 2/22/23 at 12:44 p.m. The diagnoses included, but were not limited to, history of COVID-19, history of pneumonia, congestive heart failure (CHF), dysphagia, anemia, and cerebrovascular disease. A care plan for nutritional status, revised 2/18/23, indicated Resident 26 was malnourished and/or at risk for malnutrition related to diagnoses, inadequate nutrient/energy intakes, and/or metabolic demands. The approach was to have the Dietitian to re-evaluate as indicated and provide diet, supplements, medications, and adaptive equipment as ordered. A Registered Dietitian (RD) note, dated 2/21/23 at 3:26 p.m., indicated the following, "...Noted COVID+ [positive] on 2/6/23 with decline. Noted significant weight loss since 2/6/23 with poor meal intake. Noted new impairments to coccyx and bilateral buttocks on 2/20/23. Dxs [diagnoses]: CHF, CKD 3 [chronic kidney disease; stage 3], dysphagia, lymphedema. Noted recent weight history: 2/21/23: 165.8 lbs, 2/20/23: 167.2 lbs, 2/19/23: 169.2 lbs, 2/18/23: 170.2 lbs, 2/6/23: 182.2 lbs, 2/1/23: 186 lbs, IBW: 136 lbs, BMI: 26.76. Weighed daily per order. Continues Lasix 40 mg qday [daily] with no changes since 1/4/23. Receiving regular diet with food preferences honored as requested. Ordered protein drink qday and ProStat AWC Sugar Free TID [three times a day]. Will recommend d/c [discontinue] protein drink and giving Ensure supplement TID between meals and fortified shakes at meals. Will recommend MVI [multivitamin] with minerals 1 po[by mouth] qday[every day] to aid in skin		*experienced significant weight loss for 1 of 1 resident reviewed for nutrition. (Resident 26)."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Resident 26 was affected by the alleged deficient practice. - Resident 26 was immediately referred to Hospice for RD recommendation. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - Residents with RD recommendations have the potential to be affected by the alleged deficient practice. - IDT was reeducated on RD recommendations with concentration on, but not limited to, supplements, multivitamins and desirable body weight. - All inhouse residents were audited on 3.10.2023 by the DHS/designee for RD recommendations and addressed as appropriate. Education provided: o Guidelines for Weight Tracking **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

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	integrity. Careplan initiated [sic]...." As of 2/24/23 at 11:11 a.m., there were no physician order for an Ensure supplement in Resident 26's clinical record. An interview conducted with the DHS, on 2/24/23 at 2:40 p.m., indicated she was going to follow up with hospice in regard to the RD recommendation. A policy titled "Guidelines for Weight Tracking", revised 1/16/21, was provided by Clinical Support on 2/24/23 at 2:57 p.m. The policy indicated the facility dietitian or representative will review the resident's nutritional status, usual body weight and current weight to implement a nutritional program when warranted. It also stated residents with a significant weight change can be added to Clinically At Risk. 3.1-46(a)(1)		**practice does not recur?** - DHS/designee will ensure weekly monitoring of RD recommendations in morning CCM meeting. Proper monitoring will occur 3 times a week for 4 weeks, biweekly for 8 weeks, and bimonthly for 12 weeks. Then monitored monthly in QAPI for 6 months. **4: 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?** - DHS/designee will be responsible for the for ongoing compliance and monitoring for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	
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			

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	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 store oxygen nasal cannula and C- PAP mask in a bag for infection control purposes and failed to date oxygen tubing for 2 of 2 residents reviewed for respiratory care (Resident 45 and Resident 163). Findings include: 1.) During 2/20/23 at 11:03 a.m., Resident 45 was sitting in her wheelchair with oxygen on via oxygen concentrator with a nasal cannula. The resident's C - pap mask was not in a bag and not dated. oxygen concentrator on 2 liters tubing on either one was not dated. The portable oxygen on back of wheelchair nasal cannula not bagged and touching the back on the wheelchair, the tubing was not dated. During an observation and interview on 2/22/23 at 11:07 a.m., Resident 45 indicated the staff do not always put the C-PAP mask in a bag, it depended on who was working. The resident's oxygen nasal cannula was laying on the floor from her portable oxygen tank, not in a bag. Review of the record of Resident 45 on 2/24/23 at 2:00 p.m.., indicated the resident's diagnoses included, but were not limited to, acute respiratory failure with hypoxia, pneumonia, chronic obstructive pulmonary disease, obstructive sleep apnea and dependence on supplemental oxygen. The Admission Minimum Data Set (MDS) assessment for Resident 45, dated 12/14/22, indicated the resident was cognitively intact for	F 0695	**F695 – Respiratory/Tracheostomy Care and Suctioning** *"Facility failed to store oxygen nasal cannula and C- PAP mask in a bag for infection control purposes and failed to date oxygen tubing for 2 of 2 residents reviewed for respiratory care (Resident 45 and Resident 163)."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Resident 45 and 163 was affected by the alleged deficient practice. - Resident 45 immediately had CPAP mask placed in bag and oxygen tubing dated. - Resident 163 immediately had oxygen tubing dated. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - Residents receiving respiratory interventions have the potential to be affected by the alleged deficient practice. - IDT was reeducated on proper respiratory dating and storage with concentration on, but	04/01/2023

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	daily decision making. The resident received oxygen therapy. 2.) During an observation on 2/20/23 at 11:17 a.m., Resident 163's was sitting in her wheelchair with oxygen therapy via nasal cannula, oxygen concentrator tubing was not dated. The resident had a portable oxygen tank on the back of her wheelchair, the oxygen tubing was not dated and nasal cannula was not in bag and was laying in the back of wheelchair pocket. Review of the record of Resident 163 on 2/23/23 at 11:30 a.m.., indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia and dependence on supplemental oxygen. The Admission Minimum Data Set (MDS) assessment for Resident 163, dated 2/9/23, indicated the resident was moderately impaired for daily decision making. The resident received oxygen therapy. During an interview with the Director Of Health Services (DHS) on 2/24/23 at 12:35 p.m., indicated her expectations were that residents oxygen nasal cannula and C-PAP mask would be stored in a plastic bag when not in use for infection control purposes. The DHS indicated it was the nurses responsibility to date the oxygen tubing when it was changed. The administration of oxygen policy provided by Clinical Support on 2/23/23 at 1:30 p.m., indicated oxygen tubing would be dated with the day it was initiated and changed monthly.		not limited to, oxygen tubing, nasal cannulas, and CPAP/BiPap devices. - All inhouse residents receiving respiratory interventions were audited on 3.10.2023 by the DHS/designee for proper storage and dating of as appropriate. Education provided: o Administration of Oxygen Policy **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - DHS/designee will ensure random weekly monitoring of respiratory interventions. Proper monitoring will occur 3 times a week for 4 weeks, biweekly for 8 weeks, and bimonthly for 12 weeks. Then monitored monthly in QAPI for 6 months. **4: 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?** - DHS/designee will be responsible for the for ongoing compliance and monitoring for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The	

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	3.1-47(6)		facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	
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 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			

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	document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. Based on interview and record review, the facility failed to ensure a pharmacy recommendation was followed up with timely for 2 of 5 residents reviewed for unnecessary medications. (Resident 31 and Resident 9) Findings include: 1. The clinical record for Resident 31 was reviewed on 2/23/23 at 1:53 p.m. The diagnoses included, but were not limited to, dementia, heart disease, atrial fibrillation, anemia, and major depressive disorder. A physician order, dated 1/13/22, was noted for Acetaminophen PM (diphenhydramine-acetaminophen) tablet 25-500 milligrams at bedtime. A pharmacy recommendation, dated 9/22/22, indicated the following, "...He is receiving Tylenol PM QHS [at bedtime] for insomnia. Diphenhydramine is included in the Beers list for potentially inappropriate medications in the elderly due to the anticholinergic properties. Would it be possible to replace this with Trazodone 50mg [milligrams] QHS?" The document indicated the physician agreed with all	F 0756	**F756 – Drug Regimen Review, Report Irregular, Act On** *"Facility failed to ensure a pharmacy recommendation was followed up with timely for 2 of 5 residents reviewed for unnecessary medications. (Resident 31 and Resident 9)."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Resident 31 and 9 was affected by the alleged deficient practice. - Resident 31 was immediately addressed for pharmacy recommendation regarding nighttime medication. - Resident 9 immediately had nighttime medication changed to morning per pharmacy recommendation. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what**	04/01/2023

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	recommendations. Another pharmacy recommendation, dated 11/16/22, indicated the following, "...The pharmacy event from 9/22 was closed out with the documentation that the NP [Nurse Practitioner] agreed to make this change. Please review as he is still receiving Acetaminophen PM...." The document indicated the physician agreed with all recommendations. Another pharmacy recommendation, dated 12/13/22, indicated the following, "...He is receiving Tylenol PM QHS for insomnia. Diphenhydramine is included in the Beers list for potentially inappropriate medications in the elderly due to the anticholinergic properties. Would it be possible to replace this with Trazodone 50mg QHS?" The document indicated the Nurse Practitioner does not agree with pharmacy recommendation and will continue with the current regimen. 2.) Review of the record of Resident 9 on 2/22/23 at 11:56 a.m., indicated the resident's diagnoses included, but were not limited to, dementia, depression, anxiety, difficulty walking, abnormal posture, repeated falls, lack of coordination, muscle weakness and chronic pain. The Quarterly Minimum Data Set (MDS) assessment for Resident 9, dated 11/17/22, indicated the resident was severely cognitively impaired for daily decision making. The resident received an antidepressant for the past 7 days. The resident has had one fall with injury since the last assessment. The pharmacy recommendation for Resident 9, dated 12/28/22, indicated the pharmacist recommended changing zoloft to be giving in the morning. The pharmacist indicated zoloft could be		**corrective action will be taken.** - Residents with pharmacy recommendations have the potential to be affected by the alleged deficient practice. - IDT was reeducated on pharmacy recommendations with concentration on, but not limited to, medication review, and medication change. - All inhouse residents were audited on 3.10.2023 by the DHS/designee for pharmacy recommendations and addressed as appropriate. Education provided: o Consultant Pharmacist Reports o Pharmacy recommendations **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - DHS/designee will ensure weekly monitoring of pharmacy recommendations during morning CCM meeting. Proper monitoring will occur 3 times a week for 4 weeks, biweekly for 8 weeks, and bimonthly for 12 weeks. Then monitored monthly in QAPI for 6 months. **4: 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?** - DHS/designee will be	

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	a stimulating and contribute to nighttime restlessness and insomnia which also contributes to falls. The Physician Recapitulation (Recap) for Resident 9, dated February 2023, indicated the resident received zoloft (antidepressant) 25 milligrams (mg) for anxiety and depression one time a day at bedtime. During an interview with the Director Of Health Services (DHS) on 2/24/23 at 3:00 p.m., indicated it was the DHS and the Assistant Director Of Services (ADHS) to follow up on the pharmacy recommendations on 12/28/22. The DHS indicated the Nurse Practitioner changed the zoloft to morning time today. A policy titled "Consultant Pharmacist Reports", revised 11/18, was provided by the Director of Health Services (DHS), on 2/24/23 at 11:15 a.m. The policy indicated the following, "...MEDICATION REGIMEN REVIEW...The medication regimen review (MRR) includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and preventing or minimizing adverse consequences related to medication therapy. Findings and recommendations are reported to the Director of Nursing and the prescriber, and if appropriate, the Medical Director and/or the Administrator...Procedures...E. Recommendations are acted upon and documented by the facility personnel and/or the prescriber...." 3.1-23(i) 3.1-25(i)		responsible for the for ongoing compliance and monitoring for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	

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F 0790 SS=D Bldg. 00	483.55(a)(1)-(5) Routine/Emergency Dental Srvcs in SNFs §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the			

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	155767	A. BUILDING 00 B. WING	02/27/2023

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	extenuating circumstances that led to the delay. Based on observation, interview and record review the facility failed to provide routine dental services for a resident who had missing or broken teeth and difficulty chewing, for 1 of 2 residents reviewed for dental status (Resident 15). Findings include: During an interview, on 2/21/23, Resident 15 indicated he has several teeth that are broken or worn down and he has trouble eating, especially meat. Observation of the resident's teeth indicated he had several missing or broken upper and lower teeth. Resident 15's record was reviewed on 2/22/23 at 1:23 p.m. The record indicated Resident 15 had diagnoses that included, but were not limited to, liver disease, type 2 diabetes mellitus, heart failure, heart disease, anxiety and depression. A Quarterly Minimum Data Set (MDS) assessment, dated 1/4/2023, indicated Resident 15 was cognitively intact. A care plan, dated 12/8/22 indicated a problem for potential for mouth pain related to missing teeth. His goal was not to exhibit mouth pain or infection. Interventions included, but were not limited to, dental evaluation and intervention as needed Current Physician's orders indicated Resident 15 could see an audiologist, dentist, podiatrist, psychologies, or an optometrist as needed, dated 12/30/22.	F 0790	**F790 – Routine/Emergency Dental Srvcs in SNFs** *"Facility failed to provide routine dental services for a resident who had missing or broken teeth and difficulty chewing, for 1 of 2 residents reviewed for dental status (Resident 15)."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Resident 15 was affected by the alleged deficient practice. - Resident 15 was immediately scheduled for dental services. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - Residents with dental needs have the potential to be affected by the alleged deficient practice. - IDT was reeducated on dental services with concentration on, but not limited to, scheduling residents for dental services. - All inhouse residents were assessed on 3.10.2023 by the DHS/designee for needing dental services. Education provided: o Dental Services Including Repair, Replacement Policy	04/01/2023

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	A 5 day Nutrition Assessment, dated 12/06/2022, at 8:48 p.m., indicated Resident 15's diet is a controlled carbohydrate diet with regular thin liquids, and MDS documentation, noted he had complaints of difficulty chewing/swallowing. There was a recommendation to inform Speech Therapy. A Speech Therapy note, dated 1/03/2023 at 11:57 a.m., indicated a diet clarification for a controlled carbohydrate diet with mechanical soft texture, ground meats, and thin liquids. A 5 day nutrition assessment, dated 1/09/2023 at 8:35 a.m., indicated Resident 15's diet was controlled carbohydrate with mechanical soft ground meats, thin liquids, had average intakes of 80%, resident is working with speech, has coughing at meals and difficulty chewing/swallowing per resident report. During an interview, on 2/24/23 at 2:43 p.m., the Director of Health Services indicated she could not find any documentation of dental visits, that she talked to the resident who said he didn't feel it was necessary, he said he would like to go in the future. She said she talked to the Social Service Director who didn't have any documentation of Resident 15 refusing dental visits. On 2/24/23 at 3:00 p.m., the Director of Health Services indicated she spoke with the resident's wife and social services, and they are going to have him seen by the dentist. A policy for "Dental Services Including Repair, Replacement" was provided by the Director of Health Services on 2/24/23 at 3:12 p.m. The policy included, but was not limited to, "Overview: It is the practice of Trilogy Health Services to assist		**3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - DHS/designee will ensure random weekly monitoring of residents in need of dental services. Proper monitoring will occur 3 times a week for 4 weeks, biweekly for 8 weeks, and bimonthly for 12 weeks. Then monitored monthly in QAPI for 6 months. **4: 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?** - DHS/designee will be responsible for the for ongoing compliance and monitoring for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	

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	residents in obtaining routine and emergency dental care, per the resident request. The facility will assist by making appointments and/or by arranging for transportation to and from the dental services location. Procedure: 1. Clinical staff will assess teeth and gums upon admission, with each comprehensive assessment and as needed to identify pain, lost or broken teeth, visible signs of tooth decay and other chewing and swallowing problems. 2. The facility will ensure the delivery of emergency dental services to meet the resident needs...." 3.1-24(a)(1)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment			

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	conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.			

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	Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure medications were not handled by bare hands during a medication administration observation. This affected 1 of 3 residents observed for a medication pass. (Resident 45) Findings include: During a medication administration observation, on 2/20/23 at 7:25 a.m. RN 1 was observed as she prepared Resident 45's morning medications. The following medications were set up for Resident 45: amiodarone 200 milligrams (mg) 1 tablet, aspirin 81 mg 1 tablet, Eliquis 5 mg 1 tablet, Ferrous sulfate 325 mg 1 tablet, hydroxychloroquine 200 mg 1 tablet, Mucinex 600 mg 1 tablet, pantoprazole 40 mg 1 tablet, potassium chloride 20 milieu, 2 tablets given to equal 40 mg, sildenafil 20 mg 1, torsemide 20 mg 1, Prednisone 10 mg 1, and oyster shell calcium 500 mg with vitamin D 200 units, 1 tablet. RN 1 was observed to pop the pills out of the package onto her ungloved hands before she placed them in a medication cup, then crushed the pills and placed them in applesauce. A capsule for Keflex 500 milligrams, and a capsule for cardizem 180 milligrams, were opened and sprinkled on top of the applesauce with ungloved hands prior to administering the medications to Resident 45.	F 0880	**F880 – Infection Prevention & Control** *"Facility failed to ensure medications were not handled by bare hands during a medication administration observation. This affected 1 of 3 residents observed for a medication pass. (Resident 45)."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - Resident 45 was affected by the alleged deficient practice. - Resident 45 was immediately assessed for adverse effects. None noted. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All residents that have medications administered by facility staff have the potential to be affected by the alleged deficient practice. - IDT and nursing staff was reeducated on infection control	04/01/2023

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	During an interview, on 2/20/23 at 9:13 a.m., the Director of Health Services said it is an expectation to place medications directly into a med cup when passing medications. A policy for "Medication Administration General Guidelines" was provided by the Director of Health Services on 2/27/23 at 11:27 a.m. The policy undiluted, but was not limited to: "Policy...Preparation: 1) Medications are prepared only by licensed nursing, medical, pharmacy or other licensed personnel authorized by state laws and regulations to prepare and administer medications. 2) Handwashing and Hand Sanitization: The person administering medications adheres to good hand hygiene, before beginning a medication pass, prior to handling any medication...." 3.1-48(c)(2)		practices with concentration on, but not limited to, hand hygiene practices. Education provided: o Medication Administration General Guidelines **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - DHS/designee will ensure random weekly monitoring of medication administration. Proper monitoring will occur 3 times a week for 4 weeks, biweekly for 8 weeks, and bimonthly for 12 weeks. Then monitored monthly in QAPI for 6 months. **4: 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?** - DHS/designee will be responsible for the for ongoing compliance and monitoring for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	

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F 9999 Bldg. 00	Based on interview and record review, the facility failed to complete required pre-employment screening, orientation, and training for 10 of 10 staff members reviewed for employee records. Findings include: Employee records were reviewed on 2/27/2023 at 10:15 a.m. Activities Assistant 3 was hired on 8/31/2021. No indication of annual tuberculosis risk assessment, annual Mantoux test, or education for resident rights, dementia, or abuse in the last 12 months were present in the employee record. Resident Care Assistant 4 (RCA) was hired on 10/26/2022. No indication of general orientation, specific orientation, or dementia training present in the employee record. Certified Resident Care Assistant 5 (CRCA) was hired on 10/12/2022. No indication of personal/professional references, general orientation, specific orientation, or education for abuse, resident rights, or dementia were present on the employee record. RN 6 was hired on 8/18/2018. No indication of annual tuberculosis risk assessment, annual Mantoux test, or education for resident rights, dementia, or abuse in the last 12 months were present in the employee record. Cook 7 was hired on 10/19/2017. No indication of annual tuberculosis risk assessment, annual Mantoux test, or education for resident rights,	F 9999	**F9999 – Final Observations** *"Facility failed to complete required pre-employment screening, orientation, and training for 10 of 10 staff members reviewed for employee records."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - 10 of 10 employees were found to be missing part of requirements for employment. - Employees were immediately notified and are required to provide documents. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All newly hired employees have the potential to be affected by the alleged deficient practice. - ED/designee were reeducated on hiring process with concentration on, but not limited to, background checks, tuberculosis risk assessment, general orientation, references, and/or education. Education provided: o New Employee Onboarding Workflow/Checklist o State File Checklist	04/01/2023

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	dementia, or abuse in the last 12 months were present in the employee record. Licensed Practical Nurse 8 (LPN) was hired on 8/23/2021. No indication of annual tuberculosis risk assessment, annual Mantoux test, or education for resident rights, dementia, or abuse in the last 12 months were present in the employee record. CRCA 9 was hired on 11/22/2022. No indication of personal/professional references, general orientation, specific orientation, or education for abuse, resident rights, or dementia were present on the employee record. RCA 10 was hired on 11/22/2022. No indication of a criminal background check, personal/professional references physical examination prior to hire, job description, general orientation, specific orientation, or education for resident rights, abuse, or dementia were present on the employee record. CRCA 11 was hired on 12/21/2022. No indication of job description, specific orientation, or dementia training were present on the employee record. Environmental Services Assistant 12 was hired on 1/10/2023. No first and second step Mantoux test, job description, general orientation, specific orientation, or education for resident rights, abuse, or dementia training were present on the employee record. An interview with the Executive Direction on 2/27/2023 at 10:24 a.m. indicated there were lapses in the employee records requested and that they are currently doing quality compliance audits on		**3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - ED/AP Payroll/Designee will ensure monitoring of all new hires weekly for 4 weeks, biweekly for 8 weeks, and monitored monthly in QAPI for 6 months. **4: 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?** - Designee will be responsible for monitoring compliance of the weekly process for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	

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	all employee records. An interview with the Executive Director on 2/27/2023 at 11:19 a.m. indicated they were unable to provide any further information for the requested employees. A document entitled, "New Employee Onboarding Workflow/Checklist", was provided by the Executive Director on 2/27/2023 at 11:45 a.m. It indicated prior to extending an offer of employment, the prospective employee should complete resident rights and abuse education. Within 24 hours of accepting a job offer, the following should be schedule/completed: Mantoux testing, physical examination. Within 1 week prior to employment, the facility should initiate the background check and reference checks. A document entitled "State File Checklist", was provided by the Executive Director on 2/27/2023 at 11:45 a.m. He indicated it is the expectation to have this completed for every employee. This document included: criminal background check, two reference checks, employee health exam, 1st step tuberculosis testing, 2nd step tuberculosis testing, annual tuberculosis, general orientation checklist, job specific checklist, resident rights training for the current year, abuse training for the current year, job description to be signed during onboarding, and three hours of dementia certification and/or current year three hours of dementia training. 410 IAC 16.2-3.1-14 Personnel (k) There shall be an organized ongoing inservice education and training program planned in advance for all personnel. This training shall			

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	include, but not be limited to, the following: (1) Residents' rights. (2) Prevention and control of infection. (3) Fire prevention. (4) Safety and accident prevention. (5) Needs of specialized populations served. (6) Care of cognitively impaired residents. (l) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel as follows. For nursing personnel, this shall include at least twelve (12) hours of inservice per calendar year and six (6) hours of inservice per calendar year for nonnursing personnel. (p) Initial orientation of all staff must be conducted and documented and shall include the following: (1) Instructions on the needs of the specialized population or populations served in the facility, for example: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) children; or (E) care of cognitively impaired; residents. (2) A review of residents' rights and other pertinent portions of the facility's policy manual. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures and universal precautions. (4) A detailed review of the appropriate job description, including a demonstration of equipment and procedures required of the specific position to which the employee will be assigned. (5) Review of ethical considerations and confidentiality in resident care and records. (6) For direct care staff, instruction in the particular needs of each resident to whom the employee will be providing care.			

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	(q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (1) The name and address of the employee. (2) Social Security number. (3) Date of beginning employment. (4) Past employment, experience, and education if applicable. (5) Professional licensure, certification, or registration number or dining assistant certificate or letter of completion if applicable. (6) Position in the facility and job description. (7) Documentation of orientation to the facility and to the specific job skills. (8) Signed acknowledgement of orientation to residents' rights. (9) Performance evaluations in accordance with the facility's policy. (10) Date and reason for separation. (t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For			

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	health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination; and (B) reports of all employment-related health examinations. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. (u) In addition to the required inservice hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days fo personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia.			
R 0000 Bldg. 00	This visit was for a State Residential Licensure	R 0000	Preparation or execution of this	

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	155767	A. BUILDING 00 B. WING	02/27/2023

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	Survey. This visit included a Recertification and State Licensure Survey. Survey date: February 27, 2023 Facility number: 005954 Residential Census: 51 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on February 28, 2023		plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Annual Survey conducted February 20 – 27, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of April 1, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance (d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility.			

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	(2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation. Based on interview and record review, the facility failed to complete a complete orientation for 2 of 5 employee records reviewed. Findings include: Employee records were reviewed on 2/27/2023 at 10:15 a.m. Resident Care Assistant 10 (RCA) was hired on 11/22/2022. No indication of general or specific orientation was present on the employee record. Certified Resident Care Assistant 9 (CRCA) was hired on 11/22/2022. No indication of general or specific orientation was present on the employee record. An interview with the Executive Direction on	R 0119	**R119 – Personnel - Noncompliance** *"Facility failed to complete a complete orientation for 2 of 5 employee records reviewed."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - 2 of 5 employees were found to be missing complete orientation. - Employees were immediately notified and are required to provide documents/orientation. **2: How other residents having the potential to be affected by**	04/01/2023

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	2/27/2023 at 10:24 a.m. indicated there were lapses in the employee records requested and that they are currently doing quality compliance audits on all employee records. An interview with the Executive Director on 2/27/2023 at 11:19 a.m. indicated they were unable to provide any further information for the requested employees. A document entitled "State File Checklist", was provided by the Executive Director on 2/27/2023 at 11:45 a.m. He indicated it is the expectation to have this completed for every employee. This document included: general orientation checklist and job specific checklist.		**the same deficient practice will be identified and what corrective action will be taken.** - All newly hired employees have the potential to be affected by the alleged deficient practice. - ED/designee were reeducated on hiring process with concentration on, but not limited to, general orientation. Education provided: o State File Checklist o General orientation checklist and job specific checklist **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - ED/AP Payroll/Designee will ensure monitoring of newly hired employees for 4 weeks, biweekly for 8 weeks, and monitored monthly in QAPI for 6 months. **4: 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?** - Designee will be responsible for monitoring compliance of the weekly process for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action	

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			plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location.			

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	(B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on interview and record review, the facility failed to have required dementia training for 5 of 5 employee records reviewed. Findings include: Employee records were reviewed on 2/27/2023 at 10:15 a.m. Resident Care Assistant 13 (RCA) was hired on 5/23/2012. No dementia training was indicated in the last 12 months on the employee record. RCA 10 was hired on 11/22/2022. Six hours of dementia training was not completed on the employee record after hire. Certified Resident Care Assistant 14 (CRCA) was hired on 1/16/2013. No dementia training was indicated in the last 12 months on the employee record. CRCA 9 was hired on 11/22/2022. Six hours of dementia training was not completed on the employee record after hire. Licensed Practical Nurse 15 was hired on 1/29/2008. No dementia training was indicated in the last 12 months on the employee record. An interview with the Executive Direction on 2/27/2023 at 10:24 a.m. indicated there were lapses in the employee records requested and that they	R 0120	**R120 – Personnel - Noncompliance** *"Facility failed to have required dementia training for 5 of 5 employee records reviewed."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - 5 of 5 employees were found to be missing dementia training. - Employees were immediately notified and are required to provide documents or complete training. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All newly hired employees have the potential to be affected by the alleged deficient practice. - ED/designee were reeducated on hiring process with concentration on, but not limited to, dementia training. Education provided: o State File Checklist o Dementia Training	04/01/2023

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	are currently doing quality compliance audits on all employee records. An interview with the Executive Director on 2/27/2023 at 11:19 a.m. indicated they were unable to provide any further information for the requested employees. A document entitled "State File Checklist", was provided by the Executive Director on 2/27/2023 at 11:45 a.m. He indicated it is the expectation to have this completed for every employee. This document included three hours of dementia certification and/or current year three hours of dementia training.		**3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - ED/AP Payroll/Designee will ensure monitoring of newly hired employees for 4 weeks, biweekly for 8 weeks, and monitored monthly in QAPI for 6 months. **4: 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?** - Designee will be responsible for monitoring compliance of the weekly process for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months. **5. Date of completion:** 4.1.2023	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin			

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	skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure staff had an annual Mantoux test	R 0121	**R121 – Personnel - Noncompliance** *"Facility failed to ensure staff had*	04/01/2023

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	and/or tuberculosis risk assessment for 3 of 5 employee records reviewed. Findings include: Employee records were reviewed on 2/27/2023 at 10:15 a.m. Resident Care Assistant 13 (RCA) was hired on 5/23/2012. No annual Mantoux test and/or tuberculosis risk assessment were completed in the last 12 months. Certified Resident Care Assistant 14 (CRCA) was hired on 1/16/2013. No annual Mantoux test and/or tuberculosis risk assessment were completed in the last 12 months. Licensed Practical Nurse 15 (LPN) was hired on 10/23/2007. No annual Mantoux test and/or tuberculosis risk assessment were completed in the last 12 months. An interview with the Executive Direction on 2/27/2023 at 10:24 a.m. indicated there were lapses in the employee records requested and that they are currently doing quality compliance audits on all employee records. An interview with the Executive Director on 2/27/2023 at 11:19 a.m. indicated they were unable to provide any further information for the requested employees. A document entitled "State File Checklist", was provided by the Executive Director on 2/27/2023 at 11:45 a.m. He indicated it is the expectation to have this completed for every employee. This document included annual tuberculosis.		*an annual Mantoux test and/or tuberculosis risk assessment for 3 of 5 employee records reviewed."* **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** - 3 of 5 employees were found to be missing tuberculosis risk assessment. - Employees were immediately notified and are required to provide documents or complete risk assessment. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** - All newly hired employees have the potential to be affected by the alleged deficient practice. - ED/designee were reeducated on hiring process with concentration on, but not limited to, tuberculosis risk assessment. Education provided: o State File Checklist. o Annual Tuberculosis Risk Assessments. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** - ED/AP Payroll/Designee will ensure monitoring of newly	

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			hired employees for 4 weeks, biweekly for 8 weeks, and monitored monthly in QAPI for 6 months. **4: 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?** - Designee will be responsible for monitoring compliance of the weekly process for 6 months. The results of these audits will be reviewed by the QA committee overseen by the Executive Director. If a threshold of 100% is not achieved, an action plan will be developed. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining substantial compliance for no less than 6 months.	