STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00391587, IN00393836 and IN00394299. Complaint IN00391587 - Substantiated. Federal deficiency related to the allegations is cited at F695. Complaint IN00393836 - Substantiated. Federal deficiency related to the allegations is cited at F677. Complaint IN00394299 - Substantiated. No deficiency related to the allegations were cited. Unrelated deficiencies are cited. Survey dates: November 14, 15, 16, & 17, 2022 Facility number: 000124 Provider number: 155219 AIM number: 100266730 Census Bed Type: SNF/NF: 62 Total: 62 Census Payor Type: Medicare: 5 Medicaid: 55 Other: 2 Total: 62 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed 11/29/22.	F 0000	We do not submit this plan of correction as admittance or denial of the alleged incidents. Please accept the following as a request for a desk review in lieu of of an onsite Post Survey Revisit. All consideration for a desk review would be much appreciated. If there are any additional documents that are needed, please reach out right away.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Franklin Ekete	Executive Director	12/15/2022

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

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F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to report and allegation of abuse for 1 of 3 residents reviewed for abuse. (Resident K) Finding includes: On 11/15/2022 at 11:30 A.M. a phone call was	F 0609	**F 609** **Reporting of Alleged Violations.** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	12/15/2022

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MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

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	received from the Ombudsman. She indicated she was looking into a 911 phone call placed from a resident at the facility. She indicated she was waiting on a report from the facility. She indicated she had visited the facility on Monday/Tuesday of last week and talked with Resident K. Resident K had communicated to her that a night nurse had argued with her and pulled her phone out of her hand and hurt her hand. The Ombudsman indicated she had communicated the allegation to the Administrator. She stated the Administrator indicated the resident's phone was not working and the resident had called 911, but there was no incident. The Ombudsman indicated she had questioned the Administrator if the alleged incident was reported to the state, which he replied they do write things up, but the reports were in the Director of Nursing's office and it was locked. The Ombudsman asked for the report to be emailed to her. The Ombudsman indicated she had called the facility after talking with the Administrator and was put through to the Social Service staff. The Social Service staff indicated to the Ombudsman she had the reports in a binder and they are always in her office. The Ombudsman indicated she still had not received any state report of the allegation as of 11/15/2022. During an interview, on 11/15/2022 at 11:30 A.M., Resident K indicated she had an accident a week ago with a night nurse. She indicated she usually had the door opened and the window cracked in order to get air ventilation in her room. On Sunday night, the door was closed she had put on her call light for someone to open up her door. She indicated she was yelling and screaming to get help. She indicated she could not breathe and called 911. The firemen and medical staff came in and talked with her and the staff and had instructed them to clean me up. After they had		**practice;** a. ED and DNS were educated on the abuse policy by the Regional Nurse Consultant and Regional Vice President of Operations which includes reporting, time frame of reporting, and the investigation process. b. Education of ED, DNS, and all facility staff on Preventing, Recognizing, and Reporting Abuse. c. Resident A was assessed and had no negative psychosocial outcomes, all abuse allegations were investigated and reported to IDOH per policy. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. (Resident K) b. All residents were interviewed by ED/ DNS or designee regarding any concerns or allegations that may need to be investigated and/or reported. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. Abuse education of all staff	

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	left, Resident K indicated the nurse came back to her room and grabbed her phone away from her so she could not call 911 again. Resident K indicated the nurse "physically fought me" for the phone and ended up getting it away from her. Resident K indicated she had skinned up her finger on the right hand when it happened and had talked with the Administrator on Monday and informed him of what had happed. Resident K indicated the Administrator stated he would try to find the phone and who it was who took the phone. During an interview, on 11/15/2022 at 11:55 A.M., the friend listed on Resident K's chart, indicated he "had only received 2 phone calls on Monday the 7th. First call was from EMS and the second one from the facility. "He indicated he had asked what had happened, but was not given any information. He indicated he visited the facility on Monday 11/7/2022 and talked with the Administrator. The friend stated the "Administrator communicated to him they were investigating it and would try to verify if an aide or someone did abuse her". During an interview, on 11/15/2022 at 12:09 P.M., the Administrator indicated if there was an allegation of abuse he would send the staff home immediately, get statements by the staff, do a resident assessment, interview residents and staff who were working and up date the care plans. A list of reportable's from the past 6 months was requested on 11/15/2022. No reportable regarding the alleged incident occurring on 11/7/2022 for Resident K was provided. During an interview, on 11/16/2022 at 2:39 P.M., the Administrator indicated he did not report anything on Resident K for the phone issue. He		was completed by ED/ DNS and will be an ongoing every 6months and as needed. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. QAPI tool Abuse will be completed weekly X4, bi-weekly x 2 and monthly X4 by ED. If 100% threshold is not achieved, an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting. b. The ED is responsible for ensuring implementation of the plan of correction and that compliance is maintained. **5. By what date the systemic changes for each deficiency will be completed.** a. 12/15/2022	

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	indicated he had been informed of the residents phone not working and the staff had put in a maintenance request for the phone and there was no other issues. He indicated he was not aware of the allegation of abuse from the nurse. The Administrator indicated that was not the information he was given by the Ombudsman when she had visited on Monday or Tuesday last week. The Administrator indicated he should have investigated the alleged incident and reported it to the state. On 11/16/2022 at 3:01 P.M., the Administrator provided the policy titled," Abuse Prevention Program", dated March 2021, and indicated the policy was the one currently used by the facility. The policy indicated"...Employees, facility consultants and/or attending Physician's must immediately report any suspected abuse or incidents of abuse to the Administrator... When an alleged or suspected (reasonable cause) case of mistreatment, neglect, exploitation, injuries of unknown source, or abuse is reported, the facility Administrator, DON, or individuals designated will immediately (not to exceed 24 hours if the event does not result in serious bodily injury). No later than 2 hours if the event is an allegation of abuse or where there is significant injury, or neglect where there is serious bodily injury) notify the following persons or agencies of such incident: 1. The State licensing/certification agency (Ohio Department of Aging) responsible for surveying/licensing the facility; 2. The Resident's Representative (Sponsor) of Record...." 3.1-28(c)			
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of			

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	abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview, and record review, the facility failed to investigate an allegation of abuse for 1 of 3 residents reviewed for abuse. (Resident K) Finding includes: On 11/15/2022 at 11:30 A.M., a phone call was received from the Ombudsman. She indicated she was looking into a 911 phone call placed from a resident at the facility. She indicated she was waiting on a report from the facility. She indicated she had visited the facility on Monday/Tuesday of last week and talked with Resident K. Resident K had communicated to her that a night nurse had argued with her and pulled her phone out of her hand and hurt her hand. The Ombudsman indicated she had communicated the allegation to the Administrator. She stated the Administrator indicated the resident's phone was not working and the resident had called 911, but there was no incident. The Ombudsman indicated she had questioned the Administrator if the alleged	F 0610	**F 610** **Investigate, Prevent, and Correct Alleged Violations.** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. ED and DNS were educated on the abuse policy by the Regional Nurse Consultant and Regional Vice President of Operations which includes reporting, time frame of reporting, and the investigation process. b. Education of ED, DNS, and all facility staff on Preventing, Recognizing, and Reporting Abuse. c. Resident A was assessed and had no negative psychosocial	12/15/2022

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	incident was reported to the state, which he replied they do write things up, but the reports were in the Director of Nursing's office and it was locked. The Ombudsman asked for the report to be emailed to her. The Ombudsman indicated she had called the facility after talking with the Administrator and was put through to the Social Service staff. The Social Service staff indicated to the Ombudsman she had the reports in a binder and they are always in her office. The Ombudsman indicated she still had not received any state report of the allegation as of 11/15/2022. During an interview, on 11/15/2022 at 11:30 A.M., Resident K indicated she had an accident a week ago with a night nurse. She indicated she usually had the door opened and the window cracked in order to get air ventilation in her room. On Sunday night, the door was closed she had put on her call light for someone to open up her door. She indicated she was yelling and screaming to get help. She indicated she could not breathe and called 911. The firemen and medical staff came in and talked with her and the staff and had instructed them to clean me up. After they had left, Resident K indicated the nurse came back to her room and grabbed her phone away from her so she could not call 911 again. Resident K indicated the nurse "physically fought me" for the phone and ended up getting it away from her. Resident K indicated she had skinned up her finger on the right hand when it happened and had talked with the Administrator on Monday and informed him of what had happed. Resident K indicated the Administrator stated he would try to find the phone and who it was who took the phone. During an interview, on 11/15/2022 at 11:55 A.M., the friend listed on Resident K's chart, indicated he "had only received 2 phone calls on Monday		outcomes, all abuse allegations were investigated and reported to IDOH per policy. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. (Resident K) b. All residents were interviewed by ED/ DNS or designee regarding any concerns or allegations that may need to be investigated and/or reported. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. Abuse education of all staff was completed by ED and will be ongoing every 6months and as needed. **4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. QAPI tool Abuse will be completed weekly X4, bi-weekly X2, and monthly X4 by ED. If 100% threshold is not achieved,	

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	the 7th. First call was from EMS and the second one from the facility. "He indicated he had asked what had happened, but was not given any information. He indicated he visited the facility on Monday 11/7/2022 and talked with the Administrator. The friend stated the "Administrator communicated to him they were investigating it and would try to verify if an aide or someone did abuse her". During an interview, on 11/15/2022 at 12:09 P.M., the Administrator indicated if there was an allegation of abuse he would send the staff home immediately, get statements by the staff, do a resident assessment, interview residents and staff who were working and up date the care plans. A list of reportable's from the past 6 months was requested on 11/15/2022. No reportable regarding the alleged incident occurring on 11/7/2022 for Resident K was provided. During an interview, on 11/16/2022 at 2:39 P.M., the Administrator indicated he did not report anything on Resident K for the phone issue. He indicated he had been informed of the residents phone not working and the staff had put in a maintenance request for the phone and there was no other issues. He indicated he was not aware of the allegation of abuse from the nurse. The Administrator indicated that was not the information he was given by the Ombudsman when she had visited on Monday or Tuesday last week. The Administrator indicated he should have investigated the alleged incident and reported it to the state. On 11/16/2022 at 3:01 P.M., the Administrator provided the policy titled," Abuse Prevention Program", dated March 2021, and indicated the		an action plan will be developed. This information will be presented to the QAPI committee during the monthly meeting. b. The ED is responsible for ensuring implementation of the plan of correction and that compliance is maintained. **5. By what date the systemic changes for each deficiency will be completed.** a. 12/15/2022	

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	policy was the one currently used by the facility. The policy indicated"...Employees, facility consultants and/or attending Physician's must immediately report any suspected abuse or incidents of abuse to the Administrator... When an alleged or suspected (reasonable cause) case of mistreatment, neglect, exploitation, injuries of unknown source, or abuse is reported, the facility Administrator, DON, or individuals designated will immediately (not to exceed 24 hours if the event does not result in serious bodily injury). No later than 2 hours if the event is an allegation of abuse or where there is significant injury, or neglect where there is serious bodily injury) notify the following persons or agencies of such incident: 1. The State licensing/certification agency (Ohio Department of Aging) responsible for surveying/licensing the facility; 2. The Resident's Representative (Sponsor) of Record...." 3.1-28(d)			
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, record review and interview, the facility failed to ensure residents who were incontinent were kept clean, dry and odor free for 2 of 4 residents reviewed for incontinence care. (Resident G and H) Findings include: 1. During an observation, on 11/14/2022 at 12:02 P.M., Resident G was wearing pale orange pants with a darker orange color in the peri area which	F 0677	**F 677** **ADLs Provided for Dependent Residents** **1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. Education of all nursing staff on Quality of Care for all residents especially regarding ADLs.	12/15/2022

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	indicated the pants were wet. An observation, on 11/14/2022 at 12:30 P.M., indicated the wet area extended from the peri area to the middle of her thighs. An observation, on 11/14/2022 at 1:50 P.M., indicated the wet area extended further down her thighs almost to her knees. An observation, on 11/14/2022 at 3:45 P.M., indicated the wet area extended from her waist to her knees. A clinical record review was completed for Resident G on 11/14/2022 at 2:17 P.M. Diagnoses included, but were not limited to, Paranoid Schizophrenia, Bipolar Disorder, Major Depressive Disorder, and Alzheimer's Disease. An Annual MDS Assessment dated 10/3/2022 indicated limited assist of 1 for transfers, extensive assist of 1 for toileting and personal hygiene, is always incontinent of bladder, and frequently incontinent of bowel. A Care Plan, dated 1/21/2022, indicated a problem: "...Resident has episodes of incontinence of bladder, bowels. Interventions included, but were not limited to, assist with routine toileting and as needed, check routinely for incontinence, and provide incontinence care as needed...." A Care Plan, dated 10/19/21, indicated: "...Resident needs assistance with activities of daily living related to Dementia, Alzheimer's, Paranoid Schizophrenia, Major Depressive Disorder, Hypertension. Interventions included, but were not limited to, continence - assist with		b. Full facility audit of all dependent residents who are unable to carry out activities of daily living. c. Increased rounding by facility utilizing Daily Qapi tool. d. Neither G or H had any negative outcomes and no skin issues noted. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. The IDT team reviewed and audited all dependent residents with ADL needs. b. Full facility audit of all dependent residents who are unable to carry out activities of daily living. c. Increased rounding by facility utilizing Daily Qapi tool. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. IDT team and managers' daily rounds which will be reviewed and audited weekly x4, bi-weekly x2, and monthly x3. **4. How the corrective**	

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	incontinent care; toilet use- limited assist of x1 staff. Staff to provide additional support as needed...." An ADL (Activities of Daily Living) Task sheet indicated, on 11/13/2022, Resident G was toileted at 2:04 A.M. The ADL Task sheet indicated, on 11/14/2022, the resident was toileted at 1:58 A.M. and 9:59 P.M. The ADL Task sheet indicated, on 11/15/2022, the resident was toileted at 1:25 A.M. and 12:46 P.M. The ADL Task sheet indicated, on 11/16/2022, the resident was toileted at 4:28 A.M., 12:44 P.M., and 7:38 P.M. During an interview, on 11/17/2022 at 3:30 P.M., CNA 10 indicated that she toilets Resident G every 2 hours and had just toileted her and changed her. Employee indicated that at times resident will refuse, but usually, if you talk calmly, the resident will allow care. 2. During an observation, on 11/15/2022 at 11:50 A.M., Resident H was observed sitting in the hall across from the nurses' station with a strong urine odor and wetness to the peri area. During an observation, on 11/15/2022 at 1:53 P.M., Resident H was observed sitting in the hall across from the nurses' station with a strong urine odor and a linen napkin covering her lap. A clinical record review was completed on 11/15/2022 at 2:20 P.M. Resident H's diagnoses included, but were not limited to: Dementia, hypertension, arthritis, and depression.		**action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. Weekly Qapi by the IDT team to review and audit weekly x4, bi weekly x2, and monthly x3. **5. Who is the "Team" that will review and audit? Who will oversee that the "Team" is conducting the audits and reviews as pledged?** a. All reviews and audits will be completed by the IDT team. The ED/ DNS followed by the MDS, SSD, Therapy Director, and Unit Manager will ensure that all audits and reviews are completed accurately and promptly. **6. By what date the systemic changes for each deficiency will be completed.** a. 12/15/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. BUILDING 00 B. WING	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF SOUTH BEND	52654 N IRONWOOD RD SOUTH BEND, IN 46635

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	A Quarterly MDS (Minimum Data Set) Assessment, dated 7/27/2022, indicated the resident required extensive assist of 2 staff for transfers and 1 staff for toilet use and was occasionally incontinent of bladder. A current care plan, dated 7/8/2020, indicated Resident H required staff assist with ADL's (activities of daily living). Interventions included but were not limited to: Toilet use: Limited assist, Staff to provide additional assistance as needed. During an observation, on 11/15/2022 at 3:58 P.M., Resident H was observed sitting in the hall across from the nurses' station with a strong urine odor and a linen napkin covering her lap. On 11/14/2022, at 3:43 P.M., the Director of Nursing was asked to remove the napkin from Resident H's lap. A large wet area to the resident's peri aera and extending down the pant legs was observed. During an interview, on 11/15/2022 at 3:44 P.M., the Director of Nursing indicated that Resident H should have been checked and changed every 2 hours. The Director of Nursing sought out the aide responsible for the resident and indicated the resident needed care immediately. On 11/17/2022, at 9:45 A.M., the corporate nurse provided a copy of a clinical protocol titled, "Urinary Incontinence - Clinical Protocol." The protocol indicated, " ...As appropriate, based on assessment of the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to improve the individual's continence status ...."			

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	On 11/17/2022 at 3:50 P.M., the corporate nurse provided a copy of a policy titled, "Urinary Incontinence - Assessment and Management." The policy indicated, " ...The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence ...." The policy also indicated, " ...If the resident does not respond and does not try to toilet, or for those with such severe cognitive impairment that they cannot either point to an object or say their own name, staff will use a 'check and change' strategy ...." The policy further indicated, " ...A 'check and change' strategy involves checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to protect the skin ...." 3.1-9(a) This Federal tag is related to Complaint: IN00393836			
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview the facility failed to ensure rooms where oxygen was being used and or stored were	F 0695	**F 695** **Respiratory/ Tracheostomy Care and Suctioning**	12/15/2022

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	155219	A. BUILDING 00 B. WING	11/17/2022

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	identified by oxygen signs for 10 of 12 resident rooms observed with oxygen. (Residents E, K, L, M, R, Q, U, V, W, and X) Findings include: 1. During an initial tour of the South hall with RN 4, on 11/14/2022 from 10:16 A.M. to 10:45 A.M., the following was observed: Room 101A: an oxygen tank was sitting on the floor along the wall. RN 4 indicated the Resident K used oxygen routinely. Room 102A: an oxygen concentrator in the room. RN 4 indicated Resident L used oxygen PRN (as needed). Room 103B: an oxygen concentrator in the room. RN 4 indicated Resident R used oxygen PRN. Room 106B: an oxygen concentrator was being used. RN 4 indicated Resident M used the oxygen routinely. Room 108A: an oxygen concentrator was in use. RN 4 indicated Resident Q used the oxygen routinely. Room 133B: an oxygen concentrator was in use. RN 4 indicated Resident E used the oxygen routinely. 2. During an initial tour of the North hall with QMA (Qualified Medication Aide) 2 from 10:47 A.M. to 11:02 A.M., the following was observed: Room 201B: an oxygen concentrator in the room in use. QMA 2 indicated Resident U used the oxygen routinely.		**1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** a. Resident rooms where oxygen was being used/ stored were properly identified with oxygen signs immediately upon finding. b. Education of all nursing staff on Respiratory Care to ensure proper handling and identification of resident rooms utilizing oxygen. **2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** a. All residents have the potential to be affected by the deficient practice. The nursing management team audited all resident rooms to ensure that oxygen room signages are placed appropriately. **3. What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** a. The IDT team will review and audit resident rooms to identify the ones utilizing oxygen weekly x4, bi weekly x2, and monthly x3.	

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	Room 202A: an oxygen concentrator in the room in use. QMA 2 indicated Resident V used the oxygen as needed. Room 212: an oxygen concentrator and a CPAP (continuous positive airway pressure) machine in the room. QMA 2 indicated Resident W used the oxygen PRN. Room 219: an oxygen concentrator in the room in use. QMA indicated Resident X used the oxygen routinely. During an interview, on 11/16/2022 at 3:20 P.M., the Director of Nursing indicated if residents were using oxygen, they should have an 02 sign on the door. On 11/17/2022 at 9:45 A.M., the Corporate Nurse provided the policy titled," Oxygen Administration", with a revision date of October 2010, and indicated the policy was the one currently used by the facility. The policy indicated"... Equipment and Supplies...4. "No Smoking/Oxygen in Use" signs...." 3.1-47(a)(6) This Federal tag relates to Complaint IN00391587.		**4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** a. The IDT team will utilize the Qapi audit tool to review and audit resident rooms to identify the ones using oxygen weekly x4, bi weekly x2, and monthly x3. **5. Who is the "Team" that will review and audit? Who will oversee that the "Team" is conducting the audits and reviews as pledged?** a. All reviews and audits will be completed by the IDT team. The ED/ DNS followed by the MDS, SSD, Therapy Director, and Unit Manager will ensure that all audits and reviews are completed accurately and promptly. **6. By what date the systemic changes for each deficiency will be completed.** a. 12/15/2022	