STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155617	A. BUILDING 00 B. WING	01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS OF CHESTERFIELD SKILLED NURSING FACILITY	524 ANDERSON RD CHESTERFIELD, IN 46017

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: January, 16, 17, 18, 19, and 22, 2024 Facility number: 000524 Provider number: 155617 AIM number: 100267090 Census Bed Type: SNF/NF: 45 Total: 45 Census Payor Type: Medicare: 5 Medicaid: 22 Other: 18 Total: 45 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed Janaury 30, 2024.	F 0000	Preparation and/or execution of this plan of correction in general, or this corrective action does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. Facility's date of alleged compliance is February 20, 2024. The facility is respectfully requesting paper compliance for all deficiencies in this POC.	
F 0656 SS=E Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly Locke	HFA	02/14/2024

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	following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	Based on interview and record review, the facility failed to ensure care plans had measurable goals and individualized approaches for 4 of 14	F 0656	F656 Develop/Implement Comprehensive Care Plan What corrective action will be	02/20/2024

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	residents reviewed for care plan development (Residents 44, 45, 4, and 19) Findings include: 1. Resident 44's clinical record was reviewed on 1/18/24 at 11:15 a.m. Current diagnoses included anxiety disorder, insomnia, hypertension, malaise, and acquired absence of right leg above the knee. An 11/2/23, quarterly, Minimum Data Set (MDS) assessment indicated the resident had no cognitive limitation, understood others and was understood by others, and displayed no maladaptive behaviors during the assessment period. The resident had a current, 11/2/23, care plan problem/need regarding insomnia. The goal to this problem was to achieve 6-8 hours of restful sleep. During an interview on 1/19/24 at 10:20 a.m., the Social Services Designee (SSD) indicated the facility did not have a method to measure restful sleep. 2. Resident 45's clinical record was reviewed on 1/17/24 at 11:25 a.m. Current diagnoses included lupus, bipolar disorder, schizophrenia, depression, and anxiety. An 11/29/23, admission, Minimum Data Set (MDS) assessment indicated the resident had no cognitive limitations, had self-reported moderate depression, understood others and was understood by others, used antipsychotic/ antidepressant and antianxiety medications daily, believed it was important to make decisions about her daily life, and displayed no maladaptive		accomplished for those residents found to have been affected by the deficient practice: It is the policy of this facility to ensure care plans have measurable goals and individualized approaches. Resident #4, 19, 44 and 45 care plans were updated by Social Services or designee on 2/17/24 with measurable goals and individualized approaches. 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 currently reside in the facility have the potential to be affected by the alleged deficient practice. The Social Service Director or designee will complete a facility wide audit on 2/17/24 to update all current resident's care plans related to social services and behavior management with measurable goals and individualized approaches. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The Administrator educated the Social Service Director on 2/13/24 on the care plan process and on the facility's behavior management system. Additionally, any employee who fails to comply with	

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	behaviors during the assessment period. The resident had a current, 11/28/23, care plan problem/need regarding at risk for behavioral disturbance due to a diagnosis of schizophrenia. A goal for this problem was the resident will have no episodes of behavior related to the diagnosis daily. The identified behaviors associated with the resident's schizophrenia were not identified in the care plan or within the resident's clinical record. The goal was not assessed to identify if the resident displaying "no episodes" of the major mental illness schizophrenia was an obtainable or a medically appropriate goal. The resident had a current,11/25/23, care plan problem/need regarding a diagnosis of bipolar disorder. A goal for this problem was the resident will be free from signs and symptoms of bipolar disorder. The identified behaviors associated with the resident's bipolar disorder were not identified in the care plan or within the resident's clinical record. The goal was not assessed to identify if the resident displaying "no episodes" of the major mental illness bipolar disorder was an obtainable or medically appropriate goal. The resident had a current, 11/28/23, care plan problem/need regarding a diagnosis of depression and a risk of decline in mood. The goal for this problem was to have no "decline in mood" daily. How to identify a "decline in mood" associated with depression was not listed in the care plan or in the clinical record. The resident had a current, 11/25/23, care plan problem/need regarding the potential to express signs and symptoms of anxiety. The goal for this problem was "Resident will verbalize feelings		the points of the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place: The “F656 – Develop and Implement Comprehensive Care Plan Audit” will be completed on 5 random residents weekly for 4 weeks, on 3 random residents weekly for 4 weeks, and 3 random residents monthly x3 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed.	

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	appropriately and will demonstrate effective coping behaviors." The care plan did not address the resident's decline to use in house psychiatric services. The care plan and clinical record lacked definition of how the resident would "verbalize feeling appropriately" or "demonstrate effective copying behaviors." During an interview with the Administrator, Director of Nursing, Assistant Director of Nursing and Social Services Designee on 1/19/24 at 3:45 p.m., the Administrator indicted Resident 45's plan of care lacked means to define the ability to reach the resident's goals. 3. Resident 4's clinical record was reviewed on 1/17/24 at 11:33 a.m. Current diagnosis included Alzheimer's disease, major depressive disorder, anxiety disorder, and unspecified psychosis. A 12/16/23, quarterly, Minimum Data Set (MDS) assessment indicated the resident had mild cognitive limitations, understood others and was understood by others, had moderate self-reported depression, received antipsychotic medication, antianxiety medication, and antidepressant medication daily, and displayed no maladaptive medications during the assessment period. The resident had a current, 5/31/22, care plan problem/need regarding cognitive impairment due to dementia. An approach to this problem was "Unless hard of hearing" talk softly in a normal tone. This approach originated 2/28/22. The resident had a current, 5/31/22, care plan problem/ need, regarding anxiety. A goal to this problem was, "will accept reassurance during periods of anxiety upon immediate staff intervention."		February 20, 2024	

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	The resident had a current, 6/23/22, care plan problem/need regarding "attention seeking." A goal to this problem was, "I will have a reduction in episodes of manipulative behaviors." The resident had a current, 3/13/23, care plan problem/need regarding mood decline due to depression. A goal to this problem was "Will have no decline in mood daily." The resident had a current, 3/13/23, care plan problem/need regarding a risk of behavioral disturbances related to a psychotic disorder. A goal to this problem was to have no episodes to behavior related to this diagnosis. The resident had a current 3/13/23, care plan problem/need regarding anxiety. A goal for this problem was to have a decline in episodes of anxious behavior. During an interview on 1/19/24 at 3:45 p.m., the Administrator indicated the above goals were not measurable or well defined. Approaches should be individualized, such as the facility should be aware if the resident could hear. 4. Resident 19's clinical record was reviewed on 11/17/24 at 11:31 a.m. Current diagnosis included bipolar disorder, major depressive disorder, and diabetes mellitus. A 12/2/23, quarterly, Minimum Data Set (MDS) assessment indicated the resident did not have cognitive limitations, had self-reported moderate depression, understood others and was understood by others, received an antidepressant medication, and displayed no maladaptive behaviors during the assessment period.			

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	The resident had a current, 3/1/23, care plan problem/need regarding a diagnosis of bipolar. The goal for this problem was to be free of signs and symptoms of bipolar and depression. The resident had a current, 3/1/23, care plan problem regarding anxiety. The goal for this problem was to demonstrate increased control over anxious behaviors as evidenced by [left blank with no added information]. During an interview with the Administrator, Director of Nursing, Assistant Director of Nursing and Social Services Designee on 1/19/24 at 3:45 p.m., the Administrator indicated there should not be blanks in the care plan, the goals, or the approaches. The residents goals were not measurable. A current, undated, facility policy, titled "Baseline Care Plan Assessment/ Comprehensive Care Plan", which was provided by the Administrator in 1/22/24 at 12:57 p.m., indicated: "...using the 'Person Centered' plan of care approach for each resident that includes measurable objectives...." 3.1-35(a)			
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.			

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	(B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on interview and record review, the facility failed to review and revise care plans for 1 of 14 resident reviewed for care plan revision (Resident 4). Findings include: Resident 4's clinical record was reviewed on 1/17/24 at 11:33 a.m. Current diagnosis included Alzheimer's disease, major depressive disorder, anxiety disorder, and unspecified psychosis. A 12/16/23, quarterly, Minimum Data Set (MDS) assessment indicated the resident had mild cognitive limitations, understood others and was understood by others, had moderate self-reported depression, received antipsychotic medication, antianxiety medication, and antidepressant medication daily, and displayed no maladaptive	F 0657	F657 Care Plan Timing and Revision What corrective action will be accomplished for those residents found to have been affected by the deficient practice: It is the policy of the facility that the facility will review and revise comprehensive care plans, quarterly, annually and with change in conditions as needed. Resident #4 care plans were revised on 2/17/24 related to behavior management. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	02/20/2024

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	medications during the assessment period. The resident had a current, 5/31/22, care plan problem/need regarding cognitive impairment due to dementia. An additional approach to this visit was for the SSD to visit weekly and as needed. This approach originated 2/28/22. The resident had a current, 2/27/22, care plan problem/need depression, which contained a 6/23/22 note which indicated the resident stated she would be better off dead. An approach to this problem was ""Fifteen minutes checks (11/22/22)". The resident had a current, 5/31/22, care plan problem/ need, regarding anxiety. An approach to this problem was "Offer talk therapy" During an interview with the Administrator, Director of Nursing, Assistant Director of Nursing and Social Services Designee on 1/19/24 at 3:45 p.m., the Administrator indicated the above care plan approaches had not been reviewed and revised. The Social Service Director indicated she was unaware of the weekly visit. All three managers indicated the psychiatric services provider named had not provided services in the facility for years. A current, undated, facility policy, titled "Baseline Care Plan Assessment/ Comprehensive Care Plan", which was provided by the Administrator in 1/22/24 at 12:57 p.m., indicated: "...As the resident remains in the Nursing Home, additional changes will be made to the resident's plan of care...The Comprehensive Care Plan will be reviewed and updated every quarter..." 3.1-35(e)		action will be taken: All residents that currently reside in the facility have the potential to be affected by the alleged deficient practice. The Social Service Director or designee completed a facility wide audit on 2/17/24 to update all current resident's care plans related to behavior management. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The Administrator educated the Social Service Director on 2/13/24 on the care plan process and on the facility's behavior management system. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place: The "F657 - Care Plan Timing and Revision Audit" will be completed on 5 random residents weekly for 4 weeks, 3 random residents weekly for 4 weeks, and 3 random residents monthly for 3 months. If	

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			the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. February 20, 2024	
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;			

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	§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 record review, interview, and observation, the facility failed to assess a resident at risk for nutritional decline and weight loss and failed to implement weight loss interventions for 1 of 3 resident reviewed for nutrition. (Resident 27) Findings include: The clinical record for Resident 27 was reviewed on 1/17/24 at 2:43 p.m. Diagnosis included nontraumatic subdural hemorrhage, essential hypertension, and Alzheimer's disease with early onset. Current physician's orders included pureed diet (may have oatmeal) (4/23/21) and house shake with meals for supplement- Give one container/serving by mouth, record percentage consumed (1/26/23). The resident's monthly weight record indicated the following: On 9/6/23 the resident weighed 131.6 pounds. On 10/1/23 the resident weighed 132.1 pounds. On 1/5/24 the resident weighed 117.0 pounds. (A loss of 15.1 pounds since the resident's last recorded weight 3 months prior.) The monthly weight record lacked a weight for November 2023 and December 2023. The resident's clinical record lacked a dietary progress note since he had resumed monthly weights in September 2023, after hospice services	F 0692	F692 Nutrition/Hydration Status Maintenance What corrective action will be accomplished for those residents found to have been affected by the deficient practice: It is the policy of the facility to assess residents at risk for nutritional decline and weight loss and to implement weight loss interventions as needed. Resident #27 was assessed on 2/12/24 for nutritional declines and weight loss interventions were implemented. 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 currently reside in the facility have the potential to be affected by the alleged deficient practice. The Director of Nursing or designee completed a facility wide audit on 2/12/24 to verify all current residents have up-to-date monthly/weekly weights and that all weight concerns are addressed by the Physician or Nurse Practitioner. The Dietary Manager or designee completed a facility wide audit on 2/12/24 to verify all current residents have up-to-date dietary progress notes, verify physician orders for prescribed	02/20/2024

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	were discontinued. A current nutrition risk care plan, updated 8/11/23, indicated the resident was at increased risk of malnutrition. The care plan interventions included the following: 2 Cal (a nutritional supplement) with meals, Remeron (an antidepressant) for appetite stimulant, and monitor weights. During an interview, on 1/19/23 at 9:30 a.m., the DON indicated the resident recently been removed from hospice services and weights were re-started when this occurred in August. She was not able to locate weights taken in November 2023. The facility had a COVID-19 outbreak in December 2023 and there were no weights taken for residents during that month. The resident's weight loss was discovered with the weight taken on January 5th, 2024. During an observation and interview, on 1/22/24 at 1:11 p.m., Resident 27 was seated in the cafeteria, being assisted with his meal by a nursing staff member. The lunch plate contained pureed chicken and mashed potatoes. There was one cup containing fruit punch and one cup containing tea. The resident meal card indicated a pureed diet and had symbols (a picture of silverware and the letter S on a cup) printed at the top. The DON, seated across from Resident 27, indicated she was not sure what the symbols on the top of this meal card meant. During an interview on 1/22/24 at 1:13 p.m., the Dietary Manager indicated the symbols at the top of meal cards indicated any specialty items to be delivered with each meal. The letter S on the cup indicated the resident was to receive a supplement with this meal.		diet and supplements, update tray card system, and ensure that nutrition care plans are updated and are current with physician orders. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The Administrator educated the Director of Nursing and Dietary Manager on 2/13/24 on the care plan process related to nutrition, weight management program, and on dietary tray card usage. The Administrator educated the facility staff on 2/13/24 the weight management program and dietary card usage. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place: The “F692 – Nutrition/Hydration Status Maintenance Audit - Nursing” will be completed on 5 random residents weekly for 4 weeks, 3 random residents weekly for 4 weeks, 3 random residents monthly for 3 months. The “F692 – Nutrition/Hydration Status Maintenance Audit – Dietary” will	

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WATERS OF CHESTERFIELD SKILLED NURSING FACILITY	524 ANDERSON RD CHESTERFIELD, IN 46017

(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 a follow-up interview on 1/22/24 at 2:30 p.m., the DON indicated the facility had run out of pre-packaged house shakes and the kitchen was making those individually for residents. During an interview, on 1/19/24 at 11:42 a.m., the DON indicated there was not a specific weight loss or nutrition policy, and the facility utilized the Skin and Weight Assessment Team, or S.W.A.T. Program, to manage weight concerns. This program was a meeting to review the clinical record and consider potential issues or situations impacting individual resident appetite. 3.1-46(a)(1)		be completed 5x weekly for 4 weeks, 2x weekly for 4 weeks, then 1x weekly for 4 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. February 20, 2024	
F 0745 SS=E Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on observation, interview, and record review, the facility failed to offer medically related social services to residents with a diagnosis of a major mental illness in relation to behavior monitoring, behavior management, updating care plans, and provision of personalized care for mental and behavioral health for 4 of 4 residents reviewed for provision of medically related social services (Residents 44, 45, 4 and 19)	F 0745	F745 Provision of Medically Related Social Services What corrective action will be accomplished for those residents found to have been affected by the deficient practice: It is the policy of the facility that the facility must provide medically related social services to attain or maintain the highest practicable	02/20/2024

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	Findings include: 1. During a resident group interview on 1/17/24 at 10:30 a.m., Resident 44 indicated he suffered from insomnia and liked to sleep whenever he can. Staff woke him up for showers and such. When he said no he'd rather sleep, they say he refused care. During an interview on 1/22/23 at 11:08 a.m., Resident 44 indicated he had never told the facility he wanted to sleep at night. He had told the facility he wanted to sleep whenever he could sleep. Resident 44's clinical record was reviewed on 1/18/24 at 11:15 a.m. Current diagnosis included anxiety disorder, insomnia, hypertension, malaise, and acquired absence of right leg above the knee. A 10/28/23 , "Social Services Evaluation" indicated the resident desired to return home with home health after rehabilitation. The January 2024 "Treatment Administration Record" indicated the resident had behavior monitoring each shift for "anxiety", "ineffective coping skills", and "resistance to care". Resident specific information describing what behavioral symptoms the resident displayed when anxious or displaying "ineffective copying skills" were not included in the behavior monitoring record. Ten approaches to redirect the monitored behaviors were listed on the behavior monitoring record. The approaches were not resident specific and were as follows: attempt redirection, snack, fluid offered, activity for diversion, toileting, change in environment, pain assessment, offer nap/rest period, provide comfort measures, and "other" with no resident specific approaches listed.		physical, mental and psychosocial well-being of each resident. Care plans for residents #4, 19, 44, and 45 were updated on 2/17/24 to indicate medically related social service needs and behavior monitoring. 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 currently reside in the facility have the potential to be affected by the alleged deficient practice. The Social Service Director or Designee completed a facility wide audit on 2/17/24 to verify that all current residents who have a diagnosis of a major mental illness, require personalized care for mental or behavioral health, or require Behavior Management Services are identified. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur: The Administrator educated the Social Service Director on 2/13//24 on identifying diagnoses of major mental illness, on resident's that require personalized care for mental or behavioral health, or residents that require Behavior Management Services. Additionally, any employee who fails to comply with the points of	

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	An 11/2/23, quarterly, Minimum Data Set (MDS) assessment indicated the resident had no cognitive limitation, understood others and was understood by others, and displayed no maladaptive behaviors during the assessment period. The resident had a current, 11/7/23, care plan problem/need regarding displayed behavioral symptoms related to: poor and/or ineffective coping skills, manifested by refusal of care. The resident was on a behavior management program. An 11/7/23 approach to this problem was to "conduct an evaluation of behavioral symptom(s) to determine what strengths, abilities & needs are communicated via the behaviors." The resident had a current, 11/2/23, care plan problem/need regarding insomnia. The goal to this problem was to achieve 6-8 hours of restful sleep. Approaches to this problem included to encourage the resident not to take naps during the day. During an interview on 1/18/24 at 3:40 p.m., the Administrator indicated many of the care plans discussed were not personalized and did not have measurable goals. During an interview on 1/19/24 at 10:20 a.m., the Social Services Designee (SSD) indicated the facility had a behavior monitoring system, but she was unaware of a behavior management plan for any resident. She had a list of residents who required behavior monitoring. There were not resident specific approaches to managing the behaviors. She did not keep a system that contained specific behavioral events or the dates and times they were displayed. There was not a		the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place: The “F745 - Provision of Medically Related Social Services Audit” will be completed on 5 random residentsweekly for 4 weeks, 3 random residents weekly for 4 weeks, and 3 random residents monthly for 3 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. February 20, 2024	

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	system which indicated resident specific approaches to manage behaviors. She had not completed an evaluation of the resident's sleeping patterns or needs, nor spoken to him about it. She had the times he went to bed at night and arose in the morning when at home. She had not completed a behavioral evaluation as mentioned in the plan of care. 2. Resident 45's clinical record was reviewed on 1/17/24 at 11:25 a.m. Current diagnosis included lupus, bipolar disorder, schizophrenia, depression, and anxiety. A 12/27/23 PASARR Level II report indicated the resident needed help thinking through and completing tasks at time and need supportive counseling services from facility staff. An 11/29/23, "Social Service Evaluation", indicated the resident was alert and oriented, and had been admitted to the facility for planned long term placement. The resident desired a short term placement to return living with her family, and these conflicting goals needed to be addressed during the next care plan meeting. A "Consent for Services" form indicated the resident declined in house psychiatric services on 10/24/23. The resident had previously seen a psychiatric services provider when living at home. The resident's stay at the facility would be short term and she would return to her previous provider upon discharge. The current January 2024 "Treatment Administration Record" indicated the resident had behavior monitoring each shift for "anxiety", "depression", "tearfulness", "self isolation", and "resistance to care". Resident specific			

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	information describing what behavioral symptoms the resident displayed when anxious or depressed was not included in the behavior monitoring record. Ten approaches to redirect the monitored behaviors were listed on the behavior monitoring record. The approaches were not resident specific and were as follows: attempt redirection, snack, fluid offered, activity for diversion, toileting, change in environment, pain assessment, offer nap/rest period, provide comfort measures, and "other" with no resident specific approaches listed. An 11/29/23, admission, Minimum Data Set (MDS) assessment indicated the resident had no cognitive limitations, had self-reported moderate depression, understood others and was understood by others, used antipsychotic/ antidepressant and antianxiety medications daily, believed it was important to make decisions about her daily life, and displayed no maladaptive behaviors during the assessment period. The resident had a current, 11/28/23, care plan problem/need regarding at risk for behavioral disturbance due to a diagnosis of schizophrenia. A goal for this problem was the resident will have no episodes of behavior related to the diagnosis daily. The identified behaviors associated with the resident's schizophrenia were not identified in the care plan or within the residents clinical record. The goal was "no episodes" of the major mental illness schizophrenia. The record lacked an assessment as to whether this was an obtainable or a medically appropriate goal. The resident had a current, 11/25/23, care plan problem/need regarding a diagnosis of bipolar disorder. A goal for this problem was the resident will be free from signs and symptoms of bipolar			

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	disorder. The identified behaviors associated with the resident's bipolar disorder were not identified in the care plan or within the resident's clinical record. The goal was not assessed to identify if the resident displaying "no episodes" of the major mental illness bipolar disorder was an obtainable or medically appropriate goal. The resident had a current, 11/28/23, care plan problem/need regarding a diagnosis of depression and a risk of decline in mood. The goal for this problem was to have no "decline in mood" daily. How to identify a "decline in mood" associated with depression was not listed in the care plan or in the clinical record. The resident had a current, 11/25/23, care plan problem/need regarding the potential to express signs and symptoms of anxiety. The goal for this problem was "Resident will verbalize feelings appropriately and will demonstrate effective coping behaviors." An approach to this problem was "May refer resident to mental health services including consultation with psychiatrist and psychotherapy services. The care plan did not address the resident's decline to use in house psychiatric services. The resident's clinical record lacked definition of how to "verbalize feeling appropriately" or "demonstrate effective copying behaviors." During an interview with the Administrator, Director of Nursing, Assistant Director of Nursing and Social Services Designee on 1/19/24 at 3:45 p.m., they indicated they were not aware of the facility identifying specific behavioral signs and symptoms of anxiety and depression, or if the goal of "no signs or symptoms" of schizophrenia was medically appropriate for Resident 45.			

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	No information regarding care planning, social services, and psychosocial needs was provided by the time of exit on 11/21/23 at 2:30 p.m. 3. During an interview on 1/17/24 at 10:15 a.m., Resident 4 indicated she often times was down or blue. Resident 4's clinical record was reviewed on 1/17/24 at 11:33 a.m. Current diagnosis included Alzheimer's disease, major depressive disorder, anxiety disorder, and unspecified psychosis. A 12/16/23, quarterly, Minimum Data Set (MDS) assessment indicated the resident had mild cognitive limitations, understood others and was understood by others, had moderate self-reported depression, received antipsychotic medication, antianxiety medication, and antidepressant medication daily, and displayed no maladaptive medications during the assessment period. The resident had a current, 5/31/22, care plan problem/need regarding cognitive impairment due to dementia. An approach to this problem was "Unless hard of hearing" talk softly in a normal tone. An additional approach to this visit was for the SSD to visit weekly and as needed. These approaches originated 2/28/22. The resident had a current, 2/27/22, care plan problem/need depression, which contained a 6/23/22 note which indicated the resident stated she would be better off dead. Approaches to this problem included, "Fifteen minutes checks (11/22/22)". The resident had a current, 5/31/22, care plan problem/ need, regarding anxiety. A goal to this problem was, "will accept reassurance during			

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	periods of anxiety upon immediate staff intervention." An approach to this problem was "Offer talk therapy care as allowed or desired." The resident had a current, 6/23/22, care plan problem/need regarding "attention seeking." A goal to this problem, "I will have a reduction in episodes of manipulative behaviors." The resident had a current, 3/13/23, care plan problem/need regarding mood decline due to depression. A goal to this problem was "Will have no decline in mood daily." The resident had a current, 3/13/23, care plan problem/need regarding a risk of behavioral disturbances related to a psychotic disorder. A goal to this problem was to have no episodes to behavior related to this diagnosis. The resident had a current 3/13/23, care plan problem/need regarding anxiety. A goal for this problem was to have a decline in episodes of anxious behavior. Resident 4 was observed in her room, watching TV, talking with visitors, and interacting with her roommate on 1/17/24 at 9:37 a.m., 1/17/24 at 1:46 p.m., and 1/18/24 at 9:29 a.m. During an interview on 1/19/24 at 3:45 p.m., the Administrator indicated approaches for 2022 should be reviewed and revised with care plan review. The resident was not on 15-minute checks and had not been on 15 minute checks since 2022. Care plan goals should be measurable and many of the care plan goal which were discussed could not be measured. Care plans should be personalized to the resident and should identify such issues as if the resident could hear.			

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	No information regarding care planning, social services, and psychosocial services were provided by the time of exit on 11/21/23 at 2:30 p.m. 4. Resident 19's clinical record was reviewed on 11/17/24 at 11:31 a.m. Current diagnosis included bipolar disorder, major depressive disorder, and diabetes mellitus. A 12/2/23, quarterly, Minimum Data Set (MDS) assessment indicated the resident did not have cognitive limitations, had self-reported moderate depression, understood others and was understood by others, received an antidepressant medication, and displayed no maladaptive behaviors during the assessment period. A 1/11/24, PASARR Level II report indicated the resident had trouble remembering things and needed help making decisions, does not really look forward to anything but visits with family and friends, and need supportive counseling from nursing home staff. The resident had a current, 3/1/23, care plan problem/need regarding a diagnosis of bipolar. The goal for this problem was to be free of signs and symptoms of bipolar and depression. The resident had a current, 3/1/23, care plan problem regarding anxiety. The goal for this problem was to demonstrate increased control over anxious behaviors as evidenced by [left blank with no added information]. An approach to this problem included teaching the resident anxiety/stress management techniques including meditation or relaxation tapes.			

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	The resident was resting quietly in his room on 1/17/24 at 1:36 p.m. and 1/18/24 at 9:27 a.m. During an interview with the Administrator, Director of Nursing, Assistant Director of Nursing and Social Services Designee on 1/19/24 at 3:45 p.m., they indicated they would check into what Resident 19's specific signs of bipolar and depression were, if no signs of these diseases was a measurable and achievable goal, and what meditation techniques the resident used. No additional information was provided prior to time of exit on 11/21/23 at 2:30 p.m. A current, undated, facility document titled "Behavior Monitoring" provided by the SSD on 1/19/23 at 10:09 a.m., indicated "...All new admits will get a Target Behavior Monitoring log on admission..." A current, undated, facility policy titled "Social Service Behavioral Monitoring", provided by the SSD on 1/19/24 at 10:09 a.m., indicated: "...The Social Service team will review the current Plan of Care and Social Service Comprehensive Assessment...Mood/Behavioral problems...Behavioral Management Program...The Social Services caseworker will update the care plan with new interventions..." 3.1-34(a)			
F 0804 SS=D Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides-			

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	§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure food was palatable for 5 of 5 residents interviewed in the Resident Council group interview. Findings included: During a meal service observation on 1/16/24 at 12:05 p.m., one hall tray cart had been prepared and sent to the halls for distribution. During an interview on 1/16/24 at 12:10 p.m., the dietary manager indicated he had forgotten to take food temperatures before serving the meals. During a meeting with the Resident Council group on 1/18/24 at 10:23 a.m., the following food - related concerns were expressed: 5 of 5 residents indicated hot food was served cold three times a week or more. The food being cold made it not enjoyable to eat. 4 of 5 residents indicated vegetables were overcooked and mushy three times a week or more. The fifth resident indicated they did not eat vegetables and therefore did not have an opinion. 5 of 5 residents indicated the food was bland, flat or without flavor three times a week or more. 5 of 5 residents indicated meat was hard, overcooked, or dry three times a week or more.	F 0804	F804 Nutritive Value/Appear, Palatable/Prefer Temp What corrective action will be accomplished for those residents found to have been affected by the deficient practice: It is the policy of the facility that the facility must provide each resident food prepared by methods that conserve nutritive value, flavor, and appearance. No specific residents were identified during this survey. 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 currently reside in the facility have the potential to be affected by the alleged deficient practice. The Dietary Manager completed a facility wide audit on 2/12/24 on all current residents to determine likes and dislikes and update the Tray Card system. An "Always Available Menu" will be implemented for menu options on 2/17/24. What measures will be put in place and what systemic changes	02/20/2024

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	The residents would talk about their displeasure with the food regularly, but nothing seemed to change. Food temperature logs for January 2024 were requested for review on 1/18/24 at 1:25 p.m. During an interview on 1/18/24 at 1:27 p.m., the Dietary Manager indicated the food temperature log had many "holes and blanks". During an interview on 1/18/24 at 1:30 p.m., the Dietary Manager indicated he did not have a method to ensure food satisfaction. He walked around the dining room and asked residents about their meal. The food temperature log for January 2024 had no temperatures recorded for 28 of 54 meals served. During an interview with the Administrator on 1/18/24 at 3:40 p.m., she indicated the facility did not have a method to assess and review for food satisfaction. The facility did not have a policy for food satisfaction. 3.1-21(a)(2)		will be made to ensure that the deficient practice does not recur: The Administrator educated the Dietary Manager on 2/13/24 on food temperature logs usage, safe food temperatures, and food palatability. The Administrator educated the dietary staff on 2/13/24 on food temperature logs usage, safe food temperatures, food palatability, and following recipes for cook times. The Administrator educated the facility staff on 2/13/24 on the Always Available Menu. Additionally, any employee who fails to comply with the points of the in-service may be further educated and/or progressively disciplined as indicated. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e what quality assurance program will be put into place: The “F804 – Food Satisfaction Audit” will be completed on 5 random residents for each meal service 5x weekly for 4 weeks, 3 random residents for each meal service 3x weekly for 4 weeks, then 3 random residents for each meal service monthly for 3 months. The “F804 – Food Temp Log Audit will be completed 5x weekly for 8 weeks, 3x weekly for	

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			4 weeks, then 1x weekly for 3 months. If the facility is within 95% compliance at the end of the 6 months; then monitoring can be stopped. Results of the monitoring will be reviewed at the monthly QAPI meeting. Any concerns will have been addressed. However, any patterns will be identified. Any needed Action Plan will be written by the QAPI committee. Any written Action Plan will be monitored by the Administrator weekly until resolved. By what date the systemic changes for each deficient will be completed. February 20, 2024	