STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155670	A. BUILDING 00 B. WING	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF NEWBURGH	5233 ROSEBUD LANE NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: April 29, 30, May 1, 2, 3, 6, 8 & 9, 2024 Facility number: 011049 Provider number: 155670 AIM number: 200258520 Census Bed Type: SNF/NF: 93 Total: 93 Census Payor Type: Medicare: 7 Medicaid: 70 Other: 16 Total: 93 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed May 15, 2024.	F 0000	By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests that the plan of correction be considered our allegation of compliance effective 5/31/2024 to the annual survey completed on 5/8/2024. We respectfully request a paper review and will provide any additional information requested.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brandi Thompson	Executive Director	05/30/2024

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	physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			

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	Based on interview and record review, the facility failed to immediately notify the resident's family of a resident to resident altercation for 1 of 1 residents reviewed for notification of changes. (Resident 35) Finding includes: On 5/2/24 at 9:30 A.M., a family member indicated a previous roommate attacked Resident 35 with a walker and a drawer in February, and the facility did not contact her until 11:00 A.M. the next morning. On 5/3/24 at 8:44 A.M., Resident 35's clinical record was reviewed. The diagnoses included, but were not limited to, dementia and major depressive disorder. The most recent Annual Minimum Data Set (MDS) assessment, dated 4/23/24, indicated Resident 35 had severe cognitive impairment and had no behaviors during the assessment period. A late entry Social Services Note, dated 2/27/24 at 11:01 A.M., indicated that on the previous evening (2/26/24), Resident 35 was asleep in his bed when his roommate threw a walker and drawer from the nightstand at him resulting in bruising to Resident 35's hand. An Incident Note, dated 2/27/24 at 11:07 A.M., indicated the resident's family member was notified of the resident to resident altercation incident On 5/3/24 at 9:11 A.M., the Administrator indicated that a resident's family would be notified immediately if the resident experienced an emergency no matter what time it was. If a	F 0580	**F580 Notify of Changes** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 35 discharged from the facility on 5/6/2024. **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;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. All residents with reported incidents will be reviewed daily for family notification according to policy. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing staff was educated on family notification and change in condition notifications on 5/28/2024. Education is ongoing for all licensed and certified staff. All new nursing staff hired or assigned through agency will be educated prior to start of next shift. **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**	05/31/2024

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	non-emergent incident occurred after 10:00 P.M., the emergency contact would be notified by 7:00 A.M. the next morning. An emergency was defined as anything for which the resident would need to be sent out of the facility, any injury, and resident to resident altercations. On 5/6/24 at 9:15 A.M., the Director of Nursing (DON) indicated notifications to the family were documented as a progress note or in the change of condition form. On 5/6/24 at 1:36 P.M., the DON provided an incident note that indicated Resident 35's family was not notified of the incident that occurred on 2/26/24 at 11:05 P.M., until 2/27/24 at 11:07 A.M. On 5/2/24 at 1:00 P.M., the Administrator provided a "Change in Condition" policy, dated October 2019, that indicated "the responsible party or emergency contact will be notified per care profile that there has been a change in the resident's condition". 3.1-5(a)		**into place;** QAPI tool Family Notification will be completed daily X 4 weeks, weekly X 4, bi-monthly X 2 months, and monthly x 2 months by DNS/Designee. 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.	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record and interview the facility failed to ensure the MDS (Minimum Data Set) Assessment was completed accurately for 3 of 19 residents reviewed. Antipsychotic medications, dental status, and significant weight loss were coded inaccurately. (Resident 25, Resident 246, Resident 55) Findings include:	F 0641	**F641 Accuracy of Assessments** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 25 MDS reviewed and modified with accurate information. Resident 246 MDS reviewed and	05/31/2024

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	1. On 5/1/24 at 10:00 A.M., Resident 25's clinical record was reviewed. The diagnoses included, were not limited to, Parkinson's Disease, major depressive disorder, and anxiety disorder. The current Quarterly MDS (Minimum Data Set) assessment, dated 3/4/24, indicated Resident 25 was cognitively intact and did not receive an antipsychotic medication during the seven day look back period. The current Physician Orders included but were not limited to: Aripiprazole (antipsychotic medication) 2 mg (Milligrams), give 2 mg by mouth at bedtime related to unspecified mood disorder, dated 12/6/23. On 5/3/24 at 2:58 P.M., the Social Worker indicated there was a mistake on the MDS assessment. Resident 25 was on an antipsychotic for seven days during the assessment and was coded as not taking the medication. She indicated that was a mistake and needed to be recoded. 2. On 5/1/24 at 8:34 A.M., Resident 55's clinical record was reviewed. Resident 55's diagnoses included, but were not limited to, Alzheimer's disease, Parkinson's disease, and low back pain. Resident 55's most recent Quarterly MDS (Minimum Data Set) assessment, dated 3/7/24, indicated severe cognitive impairment, required moderate assistance with eating, required substantial assistance with bathing and transfers, was receiving a mechanically altered diet, and did not have significant weight loss of 5% in the last 30 days or 10% in the last 180 days.		modified with accurate information. Resident discharged from the facility on 5/28/24. Resident 55 MDS reviewed and modified with accurate information. **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;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. All residents with MDS in the last 30 days were assessed to ensure appropriate oral assessments and coding by the MDS/Designee on 5/28/2024. All residents on an antipsychotic medication with an MDS in the last 30 days were assessed to ensure accurate coding on the MDS according to the MAR by the MDS/Designee on 5/28/2024. All residents with an MDS in the last 30 days were audited for weight loss coding accuracy by the DNS/Designee on 5/28/2024. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing staff was educated on Assessment Accuracy by the IPSDC/Designee on 5/28/2024. Education is ongoing for all licensed and certified staff. All new nurses and qualified medication	

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	The clinical record included, but was limited to, the following dates and weights: 3/7/24- 98.0 Lbs (pounds) 3/4/24- 98.5 Lbs 2/23/24- 116.0 Lbs 1/11/24- 119.0 Lbs 1/3/24- 122.6 Lbs 11/9/23- 125.0 Lbs 10/5/23- 125.0 Lbs 8/22/23- 128.0 Lbs 8/12/23- 141.0 Lbs Weights recorded, in the previous 180 days of the 3/7/24 MDS Assessment, showed a weight loss of 18.37% within 30 days, and 27.55% within 180 days. During an interview on 11:43 A.M., the MDS Coordinator indicated she was unsure why the MDS assessment indicated Resident 55 did not have significant weight loss because the Registered Dietician completed that portion of the assessment. During an interview on 5/9/24 at 12:10 P.M., the Registered Dietician indicated she was unsure why the MDS assessment indicated Resident 55 did not have significant weight loss; Resident 55 was reviewed for significant weight loss in the NAR (nutrition at risk) meeting during that time.3. On 4/30/24 at 10:00 A.M., a family member indicated Resident 246 had no natural teeth and had a full set of dentures. On 5/2/24 at 9:35 A.M., Resident 246's clinical record was reviewed. The diagnoses included, but were not limited to, intestinal malabsorption, major depressive disorder, and generalized anxiety disorder.		aides hired or assigned through agency will be educated prior to start of next shift. **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;** QAPI tool MDS Accuracy will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee 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.	

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	The most recent Admission MDS assessment, dated 9/6/23, indicated Resident 246 was cognitively intact, was not edentulous (without teeth), and had no broken teeth. An Admission Nursing Assessment, dated 9/1/23, indicated Resident 246 had his own natural teeth that were broken. An Admission Nutrition Assessment, dated 9/19/24, indicated Resident 246 had no teeth. A care plan, initiated 9/4/23, indicated Resident 246 had full upper and lower dentures. On 5/6/24 at 2:40 P.M., the MDS Coordinator indicated she had not observed the resident's mouth and was unsure whether he had teeth or not. She indicated she coded the MDS based on word of mouth from other staff, and the Admission MDS Assessment could have been wrong. On 5/8/24 at 10:53 A.M., the Infection Preventionist (IP) provided a current "Resident Assessment - RAI" policy, dated 2023, that indicated "the current version of the RAI [Resident Assessment Instrument] (MDS 3.0) will be utilized when conducting a comprehensive assessment of each resident in accordance with the instructions found in the RAI Manual". 3.1-31(d)			
F 0656 SS=D 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			

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	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 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			

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	arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review, and interview the facility, failed to ensure care plan interventions were implemented for 1 of 2 residents reviewed for falls. The call light was not within reach. (Resident 26) Findings include On 5/1/24 at 8:50 A.M., Resident 26 was observed sitting in a chair with the call light wrapped around the call light monitor and not within reach of the resident. On 5/6/24 at 10:05 A.M., Resident 26 was observed sitting in a recliner with the call light lying across the bed not within reach of the resident. On 5/6/24 at 9:00 A.M., Resident 26's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's Disease with late onset, dementia, and generalized anxiety disorder. The current Quarterly MDS (Minimum Data Set) assessment, dated 3/6/24, indicated Resident 26 was moderately cognitively impaired, needed substantial to maximum assistance for mobility, transfer, and eating, and was a fall risk. Care plan interventions for fall risk included but were not limited to call light and personal items within reach, assisting with toileting, bilateral fall mats to both sides of the bed. On 5/8/24 at 10:53 A.M., the Infection Preventionist (IP) provided a current "Fall	F 0656	**F656 Develop/Implement Comprehensive Care Plan** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 26 fall interventions, including call light in reach, in place per the plan of care. Resident 26 was assessed with no negative outcome. **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;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. All residents identified as a fall risk audited for fall interventions per plan of care by the DNS/Designee on 5/28/2024. All residents audited to ensure call light in place by DNS/Designee on 5/29/2024. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing staff was educated on following fall interventions and plans of care by the	05/31/2024

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	Management" policy, revised June 2023, that indicated "All falls will be discussed by the interdisciplinary team...to determine root cause and other possible intervention to prevent future falls ... " 3.1-35(g)(2)		DNS/Designee on 5/28/2024. Education is ongoing for all licensed and certified staff. All new nurses and qualified medication aides hired or assigned through agency will be educated prior to start of next shift. **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;** QAPI tool Fall Prevention Care Audit Tool will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee 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.	
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.			

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	(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 observation, record review, and interview the facility, failed to ensure that documentation of interventions were not revised for 1 of 2 residents reviewed for falls. (Resident 56) Findings include: On 4/29/24 at 11:05 A.M., Resident 56 was observed wearing a cast on her left arm. On 5/3/24 at 1:55 P.M., Resident 56's clinical record was reviewed. The diagnoses included, but were not limited to, vascular dementia, aphasia following cerebral infarction, unspecified fracture of the lower end of right radius, and nondisplaced fracture of right ulna styloid process. The most current Quarterly MDS assessment, dated 4/17/24, indicated Resident 56 had moderate cognitive impairment, was independent in sit to stand transfers and toileting, did not use any mobility devices, and had 1 fall with major injury since the prior assessment on 2/16/24.	F 0657	**F657 Care Plan Timing and Revision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 56 fall interventions reviewed. Resident 56 was assessed with no negative outcome. **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;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. All residents identified as a fall risk audited for new fall intervention updates per plan of care by the DNS/Designee on 5/28/2024.	05/31/2024

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	A current falls care plan, revised 2/4/23, indicated Resident 56 was at risk for falls or fall related injury due to a history of CVA (cerebrovascular accident), diabetes, decreased vision, and neuropathy. An Event Note, dated 4/12/24 at 11:25 A.M., indicated Resident 56 had an unwitnessed fall in the activity room. The resident complained of pain to the right wrist. An x-ray revealed two fractures to the resident's right wrist. An Interdisciplinary Team (IDT) note, dated 4/16/24 at 9:40 P.M., indicated the resident had decreased safety awareness, communication deficits, and ambulated "independently aimlessly" about the facility. "Continue with current interventions on keeping [name of resident] safe and free from injury as resident will not allow staff to assist with transfers and ambulation" was added to the care plan on 4/17/24. On 5/6/24 at 9:15 A.M., the Director of Nursing (DON) indicated that after a resident fell, the IDT met, and determined a root cause and reviewed the care plan to place a new intervention to prevent falls. She further indicated "continue with current interventions" was not a typical or appropriate intervention. On 5/8/24 at 10:53 A.M., the Infection Preventionist (IP) provided a current "Fall Management" policy, revised June 2023, that indicated "All falls will be discussed by the interdisciplinary team...to determine root cause and other possible intervention to prevent future falls ... The care plan will be reviewed and updated". 3.1-35(d)(2)(B)		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing staff was educated on updating fall interventions and following plans of care by the DNS/Designee on 5/28/2024. Education is ongoing for all licensed and certified staff. All new nurses and qualified medication aides hired or assigned through agency will be educated prior to start of next shift. **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;** QAPI tool Fall Prevention Care Audit Tool will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee 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	

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	155670	A. BUILDING 00 B. WING	05/09/2024

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F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on interview and record review, the facility failed to ensure medication was given according to physician orders for 1 of 5 residents reviewed for unnecessary medications. A blood pressure medication was given outside of parameters and glucagon was administered without an order. (Resident 246) Finding includes: On 5/2/24 at 9:35 A.M., Resident 246's clinical record was reviewed. Diagnoses included, but were not limited to, hypotension, type 1 diabetes mellitus, and disease of the pancreas. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 2/29/24, indicated Resident 246 was cognitively intact, required setup assistance for eating, and received a hypoglycemic medication during the 7-day look back period. Physician orders included, but were not limited to: Midodrine (a medication to treat low pressure) HCl Oral Tablet 5 MG (milligrams) - Give 3 tablets by mouth three times a day for hypotension hold if SBP (systolic blood pressure) more than 110, dated 4/24/24. Baqsimi (a medication used to treat low blood sugar) One Pack 3 MG/DOSE (milligrams per dose) Powder - 1 dose in nostril every 15 minutes as needed for hypoglycemia, dated 4/5/2024.	F 0658	**F658 Services Provided Meet Professional Standards** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 246 discharged from the facility on 5/28/2024. **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;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. All resident orders audited for parameter medications and discontinued orders by the DNS/Designee on 5/28/2024. All medication carts audited for discontinued medications by DNS/Designee on 5/29/2024. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing staff was educated on following physician orders by the	05/31/2024

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	Discontinued physician orders included, but were not limited to: Glucagon (a medication used to treat low blood sugar) Emergency Injection Kit 1 MG (milligram) - Inject 1 mg intramuscularly every 15 hours as needed for hypoglycemia, dated 4/5/24 and discontinued 4/5/24 for a therapeutic exchange. The April 2024 Medication Administration Record (MAR) indicated midodrine was given on the following days that Resident 246's SBP was greater than 110: 4/26/24 at 6:30 A.M. - blood pressure was 119/72 mm/Hg (millimeters of Mercury) 4/27/24 at 6:30 A.M. - blood pressure was 119/68 mm/Hg 4/28/24 at 6:30 A.M. - blood pressure was 142/102 mm/Hg A Nursing Progress Note, dated 5/1/24 at 2:31 A.M., indicated Resident 246 was found non-responsive with a blood sugar level of 32. IM glucagon was given in the right leg. Blood sugar was taken again 10 minutes later with a result of 33. IM glucagon was given in the left leg. Blood sugar was taken again 10 minutes later with a result of 44. The resident remained non-responsive. Emergency Medical Services (EMS) were called and the resident was transported to the hospital for evaluation and treatment. The Medical Doctor was notified of the resident's condition. A SBAR (Situation, Background, Appearance, Review and Notify) Communication Form, dated 5/1/24 at 2:00 A.M., indicated the primary care clinician was notified and orders were given to send the resident to the Emergency Room (ER). The form lacked documentation of an order for IM		IPSDC/Designee on 5/28/2024. All nursing staff was educated on removing medications from the medication carts when orders are discontinued by IPSDC/Designee on 5/29/2024. Education is ongoing for all licensed and certified staff. All new nurses and qualified medication aides hired or assigned through agency will be educated prior to start of next shift. **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;** QAPI tool Physician's Orders will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee 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.	

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	glucagon. An Interdisciplinary Team (IDT) Note, dated 5/2/24 at 11:08 A.M., indicated the resident had a hypoglycemic episode and IM glucagon was administered twice before sending the resident to the ER for evaluation and treatment. The clinical record lacked an active order for IM glucagon on 5/1/24. The clinical record lacked documentation that the primary care clinician verbally gave an order for IM glucagon to be administered or the intranasal Baqsimi that the resident had ordered was to be held. On 5/6/24 at 9:15 A.M., the Director of Nursing (DON) indicated that midodrine was given outside of parameters on 4/26, 4/27, and 4/28 and the medication should not have been given on those days. The DON indicated all diabetic residents had IM glucagon ordered and that the doctor set the parameters of that administration as part of the emergency hypoglycemic protocol. She indicated that pharmacy sometimes had to substitute intranasal Baqsimi for IM glucagon because there was frequently a back order of IM glucagon. On 5/6/24 at 1:32 P.M., the DON indicated the IM glucagon order on 4/5/24 was therapeutically exchanged for nasal administration because the pharmacy said the IM glucagon was on back order. LPN 15 was on duty 5/1/24 and saw the resident previously had glucagon IM ordered and called the doctor who gave the order to administer IM glucagon. She indicated it was too busy that night to document or put in an order. She was unsure if the IM glucagon was pulled from the EDK (emergency drug kit) or if it was a dose the			

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	facility had on hand and would have to check where the nurse got the medication. On 5/6/24 at 2:17 P.M., the DON indicated the IM glucagon administered to Resident 246 on 5/1/24 was in the top drawer of the medicine cart with the resident's name on it. It was from a past order they had on hand that was never returned to the pharmacy. She was unsure how long the medication had been in the medicine cart. She indicated that because the resident had a history of hypoglycemia and pharmacy frequently had glucagon on back order, the facility just kept the medication instead of returning it to the pharmacy. At that time, she indicated medications that had been discontinued should be sent back to the pharmacy. On 5/8/24 at 10:53 A.M., the Infection Preventionist (IP) provided a current "Unnecessary Drugs - Without Adequate Indication for Use" policy, dated 2024, that indicated "The indications for initiating, withdrawing, or withholding medications, as well as the use of non-pharmacological approaches, will be determined by assessing the resident's underlying condition...". On 5/8/24 at 10:53 A.M., the Infection Preventionist (IP) provided a current "Medication and Treatment Orders" policy, revised July 2016, that indicated "Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state ... Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order".			

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	3.1-35(g)(2)			
F 0690 SS=G Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the failed	F 0690	**F690 Bowel/Bladder**	05/31/2024

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	to ensure a resident who entered the facility with an indwelling urinary catheter was effectively assessed for adverse outcomes of an indwelling urinary catheter, received treatment and services to prevent infection in accordance with the physician orders and the plan of care, or was effectively monitored for complications of bloody urine after the catheter was suspected to be pulled for 1 of 4 residents reviewed for urinary catheters. This deficient practice resulted in Resident 35 being hospitalized for the treatment of urethral obstruction and sepsis. (Resident 35) Finding includes: On 5/2/24 at 9:30 A.M., a family member indicated Resident 35 had been admitted to the hospital with sepsis due to a UTI (urinary tract infection). The family member indicated she told the facility there was blood in the tubing and bag on 4/17/24 and staff told her they did not change catheters anymore. On 5/3/24 at 8:44 A.M., Resident 35's clinical record was reviewed. The resident was admitted to the facility on 6/29/23 with an indwelling Foley (urinary) catheter and a history of UTIs, chronic kidney disease, and dementia. The most current Annual Minimum Data Set (MDS) Assessment, dated 4/23/24, indicated that Resident 35 had severe cognitive impairment, had no behaviors, required substantial/maximal assistance with toileting (helper does more than half), had an indwelling catheter, and did not have a UTI in the last 30 days. A current indwelling catheter care plan, initiated 6/30/23, indicated that Resident 35 was at risk for infections and complications related to indwelling		**Incontinence, Catheter, UTI** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 35 discharged from the facility on 5/6/2024. **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;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. All residents with catheters audited for continence/indwelling catheter assessment completion by DNS/Designee on 5/28/2024. All residents with catheters audited for appropriate orders for catheter care by DNS/Designee on 5/28/2024. All residents with catheters audited and orders updated to include monitoring for complications by the DNS/Designee on 5/29/2024. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All staff were educated on catheter care on 5/28/2024 by IPSDC/Designee. Education is ongoing for all licensed and certified staff. All new nurses and	

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	catheter use. The interventions included, but were not limited to: Assess quarterly and as needed for appropriateness of continued use of catheter, catheter/peri care at least every shift and as needed, encourage fluids, keep drainage bag and tubing below level of the bladder, notify MD (medical doctor) of abnormal findings, observe for signs of pain or discomfort related to catheter, observe for symptoms of urinary tract infection: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Physician orders related to the indwelling catheter included, but were not limited to: Foley catheter care every shift - every shift document mL (milliliters) output in POC (point of care, a certified nursing aide charting system), dated 6/30/23. Change Indwelling Catheter/Tubing/Bag every month on the first day of month every night shift starting on the 1st and ending on the 1st every month, dated 8/1/23. May change Foley catheter PRN (as needed) for dislodgement/occlusion, dated 4/19/24. May irrigate Foley Catheter with 10 mL sterile H2O (water) or normal saline as needed for maintenance, dated 4/19/24. An Admission Nursing Assessment, dated 6/29/23, indicated Resident 35 had a chronic indwelling Foley catheter, urine that was cloudy and white, and a UTI within the last 30 days. The assessment indicated Resident 35 required an indwelling urinary catheter due to a history of urinary retention with greater than 200 ml (milliliters) of residual urine.		qualified medication aides hired or assigned through agency will be educated prior to start of next shift. **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;** QAPI tool Catheter Care will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee 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.	

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	The resident's medical record did not include any other nursing assessments or assessments for appropriateness of continued use of catheter. A Nursing Progress Note, dated 1/2/24, indicated the indwelling Foley catheter was changed on 1/2/24 with a return of "pink tinged urine". The Treatment Administration Record (TAR) indicated Resident 35's indwelling Foley catheter was changed on 2/1/24 and 3/1/24. The progress notes, weekly nursing summaries, focused charting, or evaluations from 1/3/24 to 3/31/24 did not include documentation to specifically determine the characteristics of the procedure or to show the resident was effectively monitored for signs/symptoms of adverse outcome of indwelling urinary catheter placement. An Orders-Administration note, dated 3/2/24 at 3:08 A.M., indicated the indwelling Foley catheter was changed. The note did not include documentation to specifically determine the characteristics of the procedure or to show the resident was effectively monitored for signs/symptoms of adverse outcome of indwelling urinary catheter placement. Foley catheter care and catheter output was not documented on the TAR on the following days: January Day Shift - 1/16/24, 1/17/24, 1/18/24 January Night Shift - 1/5/24, 1/13/24, 1/14/24, 1/16/24, 1/19/24, 1/25/24, 1/30/24, 1/31/24 February Day Shift - 2/8/24 February Night Shift - 2/1/24, 2/10/24, 2/18/24, 2/21/24, 2/23/24, 2/24/24, 2/26/24 March Day Shift - 3/2/24, 3/4/24, 3/8/24, 3/13/24, 3/24/24, 3/26/24 March Night Shift - 3/2/24, 3/5/24, 3/8/24, 3/14/24, 3/15/24, 3/17/24, 3/18/24, 3/19/24, 3/21/24, 3/23/24,			

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	3/25/24, 3/26/24, 3/27/24, 3/29/24, 3/30/24 April Day Shift - 4/3/24, 4/7/24, 4/18/24 April Night Shift - 4/1/24, 4/5/24, 4/9/24, 4/13/24, 4/18/24, 4/22/24, 4/25/24, 4/26/24, 4/29/24 The January through March 2024 TARs indicated indwelling urinary catheter care was not provided every shift in accordance with the physician orders and the plan of care. The TAR, progress notes, weekly nursing summaries, focused charting, or evaluations from 1/3/24 to 3/31/24 did not include documentation to show the resident was effectively monitored for signs/symptoms of adverse outcomes of indwelling urinary catheter placement or a UTI. The April 2024 TAR indicated the indwelling urinary catheter was changed on 4/1/24. The progress notes, weekly nursing summaries, focused charting, or evaluations from 4/1/24 to 4/29/24 did not include documentation to specifically determine the characteristics of the procedure, to show the resident was effectively monitored for signs/symptoms of adverse outcomes, or for indwelling urinary catheter placement. The nursing progress notes and TAR, dated 4/30/24 through 5/1/24 at 12:44 P.M., did not include documentation to show Resident 35 experienced bloody urine or had potentially pulled on the catheter tubing. The records did not include sufficient documentation to determine Resident 35 was effectively monitored for bloody urine, catheter placement, or urine output. A Change in Condition Evaluation, dated 4/30/24, indicated the primary care physician (PCP) was			

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	notified on, 4/30/24 at 12:45 P.M., due to the resident having increased sweat, generalized weakness, generalized pain, and a fever of 100.0 Fahrenheit (F). 650 mg (milligrams) of Tylenol were given. The PCP ordered a chest x-ray, complete blood count (Complete Blood Count), and basic metabolic panel (Basic Metabolic Panel). A nursing progress note, dated 4/30/24, indicated "Pulled up completed labs and WBC [white blood count] was 20.8 [elevated level indicating infection] and Lymphs [lymphocytes, a type of white blood cell] 4.8 [elevated level indicating infection], resident restless, skin warm and dry, B/P [blood pressure] -94/57,P [pulse] -101 at 22:00 [11:00 P.M.] now B/P-89/55, P-97, respiration even and nonlabored, color satis [sic], urine dark yellow. Will continue to monitor". A Physician Telehealth note, dated 5/1/24 at 12:24 A.M., indicated the resident had some mental status change, fever, and appeared to be uncomfortable. Blood pressure was 89/50, oxygen saturation was closer to 90 percent on room air, and the resident was tachycardic (increased heart rate) and mildly tachypneic (increased rate of breathing). The chest x-ray did not show any acute changes. Creatinine (used to measure kidney function) and WBC were elevated. An order was given to send the resident to the Emergency Room (ER) for treatment and evaluation. An ER Admission Note, dated 5/1/24, indicated Resident 35 was admitted to the hospital to be treated for obstructive uropathy, sepsis secondary to UTI, and acute kidney injury. A CT (computed tomography) scan indicated the Foley catheter balloon was inflated in the urethra. Hospital staff changed the Foley catheter and had			

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	"quite a bit of purulent [thick, milky] drainage come out". The resident was started on IV (intravenous) Vancomycin (antibiotic medication) and IV ertapenem (antibiotic medication). On 5/2/24 at 12:58 P.M., Registered Nurse (RN) 5 indicated that the facility policy changed on or around 4/19/24 to reflect the Center for Disease Control and Prevention (CDC) guidance to only change out indwelling foley catheters as needed unless the doctor orders say otherwise. The nurses did change catheters if required. On 5/3/24 at 10:55 A.M., a family member indicated Resident 35 was in the hospital for treatment of a UTI and sepsis. She indicated that she observed blood in the resident's urine in both the catheter tubing and bag on multiple occasions and that the resident had less urine output than normal over the past two weeks. She indicated that she told staff about her concerns and requested for the catheter to be changed but was told that staff don't change the catheters anymore. On 5/3/24 at 12:00 P.M., Licensed Practical Nurse (LPN) 8 indicated she was working the day Resident 35 was sent to the hospital. She indicated Resident 35 had a fever of 100 F that morning, was sweaty, and not acting like himself so she called the Nurse Practitioner (NP) who ordered a CBC, BMP, and chest x-ray. She indicated the resident had blood in his urine the day before, but they thought he had pulled on the tube and irritated his urethra because it "cleared up". She indicated the resident had no obvious signs of UTI and his baseline urine was cloudy. At that time, she indicated there was no place to document a catheter assessment. The TAR was marked complete when Foley catheter care was completed and any abnormalities would get			

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	reported to the nurse, assessed, and documented in a progress note. On 5/6/24 at 9:15 A.M., the Director of Nursing (DON) indicated catheter assessments were charted as a general progress note or in a change of condition form. If the assessment was normal nothing would be documented. At that time, she indicated that if tasks were not initiated on the TAR, the task was not completed. She indicated that Foley catheter care and output from the catheter was not completed, assessed, or documented on the days missing a signature or appropriate charting code. On 5/8/24 at 8:45 A.M., all documentation related to Resident 35's indwelling Foley catheter including, but not limited to, assessments, monitoring, progress notes, Interdisciplinary Team (IDT) notes, evaluations, provider notes, change of condition forms, and TAR notes was requested. On 5/8/24 at 10:53 A.M., the Infection Preventionist (IP) indicated all applicable documentation had been provided. On 5/8/24 at 12:42 P.M., the IP indicated that she tracked CAUTI (catheter associated urinary tract infections) using a form and looked at all residents who had a catheter or received peri care. The IP indicated the current CAUTI tracking form did not include documentation related to Resident 35. On 5/8/24 at 1:04 P.M., the IP provided a CAUTI tracker form that indicated Resident 35 had not been tracked for UTI or related urinary symptoms since 9/22/23. On 5/6/24 at 1:58 P.M., the Administrator provided an "Indwelling Catheter Use and Removal" policy, dated 2023, that indicated "The facility will			

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	conduct ongoing assessments for ...residents with indwelling catheters to determine if the catheter needs to be continued or removed if the catheter is no longer necessary. If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include but are not limited to: ...timely and appropriate assessments related to the indication for use of an indwelling catheter; ... insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures; response of the resident during the use of the catheter; and ongoing monitoring for changes in condition related to potential catheter-associated urinary tract infections, recognizing, reporting and addressing such changes". On 5/8/24 at 10:53 A.M., the IP provided a current "Catheter Care, Urinary" policy, revised September 2014, that indicated "Observe the resident for complications associated with urinary catheters. ... Check the urine for unusual appearance (i.e., color, blood, etc.). Notify the physician of supervisor in the event of bleeding ... Observe for other signs and symptoms of urinary tract infection or urinary retention. Report findings to the physician or supervisor immediately. ... The following information should be recorded in the resident's medical record: 3. All assessment data obtained when giving catheter care. 4. Character of urine such as color (straw-colored, dark, or red), clarity (cloudy, solid particles, or blood), and odor. 5. Any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain. 6. Any problems or complaints made by the resident related to the			

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	procedure. 7. How the resident tolerated the procedure". 3.1-41(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 observation, interview, and record review, the facility failed to provide nutritional care and services including the failure to obtain weekly weights, failure to provide assistance with meals and alternative food/supplement choices, and failure to notify the physician and address the resident's refusal of nutritional supplements and poor intakes resulting in a significant weight loss of 18.37% in less than 30 days 1 of 3 residents reviewed for significant weight loss and ensure a resident was receiving adequate fluids resulting in	F 0692	**F692 Nutrition/Hydration Status Maintenance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 55's MD and the Registered Dietitian was notified of weight loss on 5/28/2024. Resident 75's MD and the	05/31/2024

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	dehydration and a urinary tract infection 1 of 1 residents reviewed for dehydration. (Resident 55 and Resident 75) Findings include: 1. During an interview on 5/1/24 at 8:25 A.M., a family member expressed concern Resident 55 was not receiving all of her meals, that staff would sometimes bring Resident 55's tray in to her room and place it on her bedside table and come back and collect the tray without assisting her to eat, and that family would travel from hours away to come sit with her multiple days in a row each week to ensure she was receiving meals. On 5/1/24 at 8:34 A.M., Resident 55's clinical record was reviewed. Resident 55's diagnoses included, but were not limited to, Alzheimer's disease, Parkinson's disease, and low back pain. Resident 55's most recent Quarterly MDS (Minimum Data Set) assessment, dated 3/7/24, indicated severe cognitive impairment, required moderate assistance with eating, and was receiving a mechanically altered diet. Current physician orders included, but were not limited to: Regular diet puree texture regular consistency, started on 9/18/23. Frozen nutrition treat two times a day for weight loss, started on 2/29/24. Nutritional shake with meals for supplement, start 2/29/24. Weekly weights every day shift every Tuesday		Registered Dietitian was notified of fluid intake on 5/28/2024. **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;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. All residents were audited to ensure weights were obtained and the MD/NP was notified of any significant change by DNS/Designee on 5/28/2024. All residents that require assistance with eating were reviewed to ensure the proper level of assistance is provided. All residents were audited to ensure fluid intakes were accurate according to the plan of care by DNS/Designee on 5/28/2024. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All licensed nurses were educated on notifying the MD/NP/RD of significant weight changes on 5/28/2024 by the IPSDC/Designee. Education is ongoing for all licensed and certified staff. All new nurses and qualified medication aides hired or assigned through agency will be educated prior to start of next shift.	

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	Notify physician of weight gain 5 pounds or greater, started on 7/4/23. The clinical record included, but was limited to, the following dates and weights: 4/5/24- 104.0 Lbs (pounds) 3/7/24- 98.0 Lbs 3/4/24- 98.5 Lbs 2/23/24- 116.0 Lbs 1/11/24- 119.0 Lbs 1/3/24- 122.6 Lbs 11/9/23- 125.0 Lbs 10/5/23- 125.0 Lbs 8/22/23- 128.0 Lbs 8/12/23- 141.0 Lbs Weights recorded, in the previous 180 days of the 3/7/24 MDS Assessment, showed a weight loss of 18.37% within 30 days, and 27.55% within 180 days. Care plans included, but were not limited to: Resident requires adequate nutrition to promote overall good health, strength and stamina. Resident is at risk. Resident will consume at least 50-75% of planned meals. Notify of any weight changes less than five percent thru next review, revision on 7/3/23. Provide assistance with meals and hydration, date initiated 6/22/23. Monitor/document/report as needed any signs/symptoms of refusing to eat, date initiated 3/12/24. Registered Dietician to review weights, by mouth intake, nutritional labs as needed. Will adjust dietary interventions as needed, date initiated 6/30/23. Weigh as directed, date initiated 6/22/23.		All nursing staff was educated on providing assistance at meals when applicable on 5/28/2024 by IPSDC/Designee. Education is ongoing for all licensed and certified staff. All new nurses and qualified medication aides hired or assigned through agency will be educated prior to start of next shift. All staff was educated on accurate documentation of meal and fluid intakes on 5/28/2024 by IPSDC/Designee. Education is ongoing for all licensed and certified staff. All new nurses and qualified medication aides hired or assigned through agency will be educated prior to start of next shift. All nursing staff was educated on obtaining and documenting weekly weights on 5/30/2024 by IPSDC/Designee. Education is ongoing for all licensed and certified staff. All new nurses and qualified medication aides hired or assigned through agency will be educated prior to start of next shift. All nursing staff was educated on assessing hydration status on 5/30/2024 by IPSDC/Designee. Education is ongoing for all licensed and certified staff. All new nurses and qualified medication aides hired or assigned through agency will be educated prior to start of next shift. **How the corrective action(s)**	

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	The clinical record, during the time of significant weight loss from 2/23/24 to 4/4/24, showed the following meal times Resident 55 consumed 0% or less than 50% nutrition, and was not offered an alternative meal: 2/23/24 breakfast, lunch, dinner 2/24/24 breakfast 2/26/24 breakfast, dinner 2/27/24 dinner 2/28/24 breakfast, lunch, dinner 3/1/24 dinner 3/2/24 breakfast, lunch, dinner 3/3/24 breakfast, dinner 3/4/24 dinner 3/6/24 lunch, dinner 3/7/24 dinner 3/8/24 dinner (breakfast, lunch not documented) 3/9/24 lunch, dinner 3/10/24 dinner 3/11/24 breakfast, lunch, dinner 3/12/24 breakfast, lunch, dinner 3/13/24 breakfast, lunch, dinner 3/14/24 breakfast, dinner 3/15/24 breakfast, lunch 3/16/24 breakfast, lunch 3/17/24 breakfast, lunch, dinner 3/18/24 dinner (breakfast, lunch not documented) 3/19/24 dinner (breakfast, lunch not documented) 3/20/24 breakfast, lunch 3/21/24 breakfast, lunch, dinner 3/23/24 breakfast, lunch, dinner 3/24/24 breakfast, lunch, dinner 3/25/24 lunch, dinner 3/26/24 dinner (breakfast, lunch not documented) 3/27/24 breakfast, lunch, dinner 3/28/24 dinner 3/29/24 dinner 3/31/24 lunch (dinner not documented) 4/1/24 dinner 4/2/24 dinner		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** QAPI tool nutrition/weights will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee 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.	

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	4/3/24 breakfast, lunch, dinner 4/4/24 dinner During an observation on 5/2/24 at 8:23 A.M., Resident 55 was observed lying in bed with no breakfast tray in the room. At 8:25 A.M., CNA 16 delivered Resident 55's breakfast tray to her room. At 8:51 A.M. Resident 55's tray was observed on the food cart going back to the kitchen. 12.5% of the meal was gone and the nutritional shake on the tray was unopened. On 5/3/24 at 8:30 a.m., Resident 55's clinical record indicated CNA 16 documented a meal consumption for Resident 55 on 5/2/24 for the breakfast meal of 26-50%. During an interview on 5/2/24 at 8:51 A.M., LPN 12 indicated staff never really feed Resident 55 breakfast because it was in her care plan to not eat breakfast. During an interview on 5/9/24 at 11:41 A.M., the DON indicated Resident 55 should be offered all meals, was not care planned to not receive meals, and could not find or provide documentation of physician ordered weekly weights being completed for Resident 55. The DON stated staff did not always document correctly and it was an ongoing issue. On 5/6/24 at 2:17 P.M., the MDS Coordinator provided a current policy titled "Charting and Documentation", dated 7/2017, that indicated documentation in the medical record will be objective, complete, and accurate. 2. On 5/1/24 at 2:06 P.M., Resident 75's clinical record was reviewed. The diagnoses included, but were not limited to, failure to thrive, severe			

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	protein-calorie malnutrition, and type 2 diabetes mellitus with CKD (chronic kidney disease). The most recent Quarterly MDS (Minimum Data Set) assessment, dated 3/25/24, indicated Resident 75 had moderate cognitive impairment and dehydration. Current care plans included, but were not limited to: Resident is at risk for fluid imbalance due to decreased cognition, cancer diagnosis with recent chemotherapy regimen, CKD, revised on 3/25/24. Resident will be free of symptoms of dehydration, revised on 12/4/23. Document intake, date initiated 11/21/22. Encourage and assist with fluids, date initiated 11/21/22. Observe for signs of dehydration: decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting/standing, increased pulse, headache, fatigue/weakness, dizziness, fever, thirst, recent/sudden weight loss, dry/sunken eyes. Document and notify physician of abnormal findings, date initiated 11/21/22. The most current Dietician Review, dated 11/22/23, indicated Resident 75 had an estimated daily fluid need of approximately 1636 to 1964 cc (milliliter equivalent) per day. Documentation of fluids consumed during the month of March 2024 were provided on 5/9/24 at 11:28 A.M. by the MDS Coordinator. The following days the resident was provided less that the minimum daily needed fluid amount required to maintain hydration: 3/1/24 - 260 mL (milliliter) 3/2/24 - 740 mL			

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	3/3/24 - 1120 mL 3/5/24 - 1280 mL 3/6/24 - 1220 mL 3/7/24 - 980 mL 3/8/24 - 240 mL 3/9/24 - 1100 mL 3/10/24 - 840 mL 3/11/24 - 600 mL 3/12/24 - 1570 mL 3/13/24 - 600 mL 3/14/24 - 272 mL 3/15/24 - 480 mL 3/16/24 - 1440 mL 3/17/24 - 840 mL 3/18/24 - 560 mL 3/19/24 - 260 mL The clinical record lacked any fluids offered by staff or refused by Resident 75 from 3/1/24 through 3/19/24. A Nursing Progress Note, dated 3/17/24 at 3:06 P.M., indicated Resident 75 presented to the nurses station expressing concern about urinating a lot and having excessive thirst. A Hospital Assessment Note, dated 3/19/24 at 1:48 A.M., indicated lab called on 3/18/24 with a critical blood sugar of 735 at 9:30 A.M. At 9:45 P.M., facility gave resident 15 units of Humalog (fast acting insulin) along with 15 units of Lantus (long acting insulin). At 11:30 P.M rechecked blood sugar and machine read high. Resident states he has been extremely thirsting and peeing a lot. A Nursing Progress Note, dated 3/19/24 at 5:41 A.M., indicated Resident 75 had been transferred to the hospital; the hospital called the facility to give notification Resident 75 had a UTI (urinary			

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	tract infection), had a blood sugar in the 200's, and was receiving fluids. An IDT (interdisciplinary team) Progress Note, dated 3/25/24 at 2:36 P.M., indicated Resident 75 was sent to the ER (emergency room) on 3/19/24 and received IV (intravenous) hydration related to lab work collected on 3/18/24 that showed dehydration including, but not limited to, Creatinine of 1.6 (normal range 0.6-1.2) and BUN (blood urea nitrogen) of 36 (normal range 8-23). Physical signs and symptoms also noted including increased thirst and increased fatigue requiring increase in assistance with ADLs (activities of daily living). During an interview on 5/9/24 at 12:20 P.M., the Administrator stated lack of follow through from staff was a problem with the documentation. On 5/6/24 at 2:17 P.M., the MDS Coordinator provided a current, undated policy titled "Resident Hydration and Prevention of Dehydration" that indicated, minimum fluid needs will be calculated and documented on initial, annual, and significant change assessments, using current Standards of Practice. Nurses' Aides will provide and encourage intake of bedside, snack, and meal fluids, on a daily and routine basis as part of daily care. Intake will be documented in the medical records. Aides will report intake of less than 1200 mL/day to nursing staff. If potential inadequate intake and/or signs and symptoms of dehydration are observed, intake and output monitoring will be initiated and incorporated into the care plan. The physician will be notified. Nursing will monitor and document fluid intake and the dietician will be kept informed of the status. The IDT will update the care plan and document resident response to interventions..			

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	3.1-46(a)(1) 3.1-46(b)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, interview, and record review, the facility failed to ensure oxygen equipment was labeled and oxygen administration signs were in place for 3 of 3 residents reviewed for oxygen administration. (Resident 24, Resident 73, Resident 88) Findings include: 1. On 4/30/24 at 9:05 A.M., Resident 24's was observed wearing O2 (oxygen) via a cannula in bed alongside of a CPAP (Continuous Positive Airway Pressure) machine at the bedside with tubing that lacked a date and initials when changed. There were no oxygen administration warning signs on the outside door frame. On 5/3/24 at 1:28 P.M., Resident 24 was observed wearing O2 via cannula while sitting in a chair and the CPAP machine sitting on a bedside table, the tubing lacked a date and initials when changed. There were no oxygen administration warning signs on the outside door frame.	F 0695	**F695 Respiratory/Tracheostomy Care and Suctioning** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 24 assessed with no negative outcome. Resident 73 assessed with no negative outcome. Resident 88 assessed with no negative outcome. **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;** All residents have the potential to be affected by the alleged deficient practice. All residents with O2 orders audited for appropriate signage by	05/31/2024

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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
	On 5/3/24 at 12:08 P.M., Resident 24's clinical record was reviewed. The diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), heart failure, and anxiety. The current Admission MDS (Minimum Data Set) assessment, dated 4/8/24, indicated Resident 24 was mildly cognitively impaired and utlitized supplemental oxygen. Physician's ordered included, but were not limited to: Oxygen AT 3 L/M (Liters per Minute) per NC (Nasal Cannula) continuously every shift for COPD, dated 5/8/24. Oxygen tubing change weekly label each component with date and initials every night shift every Sunday for maintenance, dated 4/7/24. The current care plan included interventions that included but were not limited to oxygen and CPAP as ordered. During an interview on 5/3/24 at 1:31 P.M., CNA 16 indicated rooms should have a sign on the outside door indicating the resident is on O2 and the tubing would be changed weekly by a nurse. 2. On 4/30/24 at 10:52 A.M., Resident 73's O2 tubing was observed draped across the concentrator. A sign for oxygen administration was not observed on the outside door frame. On 5/3/24 at 3:06 P.M., Resident 73's clinical record was reviewed. The diagnoses included, but were not limited to, COPD and dementia. The current Quarterly MDS assessment, dated 2/27/24, indicated Resident 73 was severely		DNS/Designee on 5/28/2024. All residents with O2 orders, Nebulizer orders, CPAP/BiPAP orders audited for labeled, dated, and properly stored tubing by DNS/Designee of 5/28/2024. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All staff was educated on oxygen concentrators, labeling/dating and storage, nebulizer therapy by IPSDC/Designee on 5/28/2024. Education is ongoing for all licensed and certified staff. All new nurses and qualified medication aides hired or assigned through agency will be educated prior to start of next shift. **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;** QAPI tool O2 labeling/dating will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee 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.	

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	155670	A. BUILDING 00 B. WING	05/09/2024

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	cognitively impaired and utlized supplemental oxygen. Current physician orders included but were not limited to: Administer O2 as needed to keep oxygen saturation greater than 88% for comfort every day and night shift, dated 4/10/24. Current care plan interventions for respiratory distress include but were not limited to oxygen as ordered dated 4/10/24.3. During an observation on 4/30/24 at 9:37 A.M., Resident 88's oxygen concentrator was on and against the foot of the bed, blocking air flow to the air intake. The bag and tubing attached was not dated. During an observation on 5/2/24 at 12:50 P.M., Resident 88's oxygen bag and tubing attached was not dated. On 5/3/24 at 10:15 A.M., Resident 88's clinical record was reviewed. The diagnoses included, but were not limited to, respiratory failure, Chronic Obstructive Pulmonary Disorder (COPD), and type 2 diabetes mellitus. The most recent Significant Change MDS (Minimum Data Set) assessment, dated 2/29/24, indicated Resident 88 was moderately cognitively impaired and used supplemental oxygen. Current physician orders included, but were not limited to: Oxygen at 3 liters per nasal cannula every shift, start date 1/24/24. On 5/9/24 at 11:41 A.M., a policy relating to oxygen equipment dating and labeling was requested but not provided.			

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	On 5/8/24 at 10:53 A.M., RN 15 produced a current policy "Oxygen Administration" revised October 2010. The policy indicated " the purpose of this procedure is to provide guidelines for safe oxygen administration... equipment needed is no smoking/oxygen in use sign... place an "Oxygen in Use" sign in a designated place..." 3.1-47(a)(6)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to provide pain assessments and provide pain management in accordance with the resident's comprehensive care plan for 1 of 1 residents reviewed pain. (Resident 55) Findings include: During an observation on 4/30/24 at 3:50 P.M., Resident 55 was observed in bed and appeared to be restless, moaning, and crying out in pain. On 5/1/24 at 8:34 A.M., Resident 55's clinical record was reviewed. Resident 55's diagnoses included, but were not limited to, Alzheimer's disease, Parkinson's disease, and low back pain. Resident 55's most recent Quarterly MDS (Minimum Data Set) assessment, dated 3/7/24,	F 0697	**F697 Pain Management** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 55 pain assessed with no negative outcomes. Monthly pain in advanced dementia assessment completed. **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;** All residents have the potential to be affected by the alleged deficient practice. All residents utilizing pain medications were reviewed by the	05/31/2024

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	indicated severe cognitive impairment and was not experiencing pain during the pain assessment. Current physician orders included, but were not limited to: Tylenol (acetaminophen pain relief) extra strength oral tablet 500 MG (milligrams). Give two tablet by mouth, two times a day for pain, start date 12/29/23 Celecoxib (anti-inflammatory medication) oral capsule 200 MG. Give one capsule by mouth one time a day for pain, start date 10/7/23 Ketorolac Tromethamine (anti-inflammatory medication) oral tablet 10 MG. Give one tablet every six hours as needed for pain, start date 6/21/23 Morphine Sulfate (opioid pain medication) concentrate solution Give 0.5 mL (milliliters) sublingually every 15 minutes as needed for pain/dyspnea, start date 4/27/24 Administration records for March, April, and May 2024 showed a single as needed administration of Ketorolac Tromethamine, for treatment of pain, on 3/17/24 at 10:16 P.M. Care plans included, but were not limited to: Resident is at risk for pain due to Parkinson's, low back pain, migraines, and recent left hip fracture with surgical intervention, revision on 12/1/23. The interventions included, but were not limited to: Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM (range of motion), withdrawal or resistance to care, initiated 6/23/23.		DNS/Designee on 5/29/24. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing staff were educated on the pain medication policy and pain assessment policy by the IPSDC/Designee on 5/29/24. Education is ongoing for all licensed and certified staff. All new nurses and qualified medication aides hired or assigned through agency will be educated prior to start of next shift. **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;** QAPI tool Pain Assessments will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee 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.	

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	Observe for symptoms of non-verbal pain: changes in breathing, vocalizations (grunting, moans, yelling out, silence), mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion), initiated 6/23/23 Offer non-pharmacological interventions such as position change, relaxation, quiet environment, back rub, diversional activity, initiated 6/23/23 A document titled "Pain Interview", dated 5/3/24, indicated complete verbal pain assessment interview if resident is able to communicate appropriately. If the resident is rarely or never understood, then complete the Pain in Advanced Dementia (assessment) instead. The verbal pain assessment was completed by LPN 12 at that time. During an interview on 5/9/24 at 9:36 A.M., LPN 12 stated Resident 55 would often climb out of bed due to pain. LPN 12 indicated Resident 55 moaned and was agitated often, staff was unable to differentiate if it was pain or just her usual restlessness, and stated some days the resident could answer yes/no questions and some days she could not due to her dementia level. A policy titled "Pain Assessment and Management", revised 3/2020, was provided by the Administrator on 5/9/24 at 9:56 A.M., and indicated observe the resident for physiological and behavioral signs of pain. Possible behavioral signs of pain, including groaning, crying, grimacing, resisting care, irritability, limitations in activity level, difficulty eating or loss of appetite. Assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognition level. 3.1-37(a)			

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F 0729 SS=D Bldg. 00	483.35(d)(4)-(6) Nurse Aide Registry Verification, Retraining §483.35(d)(4) Registry verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless- (i) The individual is a full-time employee in a training and competency evaluation program approved by the State; or (ii)The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. §483.35(d)(5) Multi-State registry verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual. §483.35(d)(6) Required retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. Based on record review and interview, the facility failed to ensure CNA's had a current and valid	F 0729	**F729 Nurse Aide Registry Verification, Retraining**	05/31/2024

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	certificate to work in the facility for 1 of 27 CNA's reviewed. (CNA 2) Finding includes: On 5/6/24 at 2:09 P.M., the employee records were reviewed. CNA 2's CNA certificate expired on 4/17/24. On 5/6/24 at 3:25 P.M., the Administrator indicated Human Resources (HR) was responsible for making sure licenses stayed current and that they were working to get CNA 2's certificate renewed. On 5/8/24 at 12:23 P.M., the dates CNA 2 worked as a CNA were provided by the Infection Preventionist (IP). CNA 2 worked as a CNA on 10 shifts from 4/17/24 to 5/6/24. On 5/8/24 at 11:07 A.M., the IP provided a current "Licensed Health Professional Check" policy, revised November 2020, that indicated "If an existing Care Member's license is not renewed prior to the expiration date, the licensed Care Team Member will be placed in a non-certified position or removed from the schedule until the license has been renewed and the Human Resources Director or Designee has verified renewed/active licensure via the state portal". 3.1-14(e)		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were affected by the alleged deficient practice. The nurse registry will be checked weekly to ensure compliance with licensure and certification requirements. **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;** All residents have the potential to be affected by the alleged deficient practice. The nurse registry will be checked weekly to ensure compliance with licensure and certification requirements. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing staff files audited for appropriate license/certification by the HR/Designee on 5/29/24. **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;** QAPI tool File Audits will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4	

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			months by DNS/Designee 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.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, interview, and record review, the facility failed to ensure it was free from a medication error rate greater than 5% for 2 of 26 opportunities observed to administer medications, resulting in an error rate of 7.7%. (Residents 7, Resident 15) Findings include: 1. During a medication administration observation on 5/2/24 at 7:09 A.M., QMA 9 prepared medications for Resident 15. QMA 9 measured 17g (Grams) of Miralax powder and mixed it in water, and prepared the following oral medications: Furosemide (high blood pressure medication) 40mg (milligrams) Potassium chloride (potassium supplement) 10 mEq (milliequivelant) Sodium chloride (sodium supplement) 1gm (Gram) Thiamine (Vitamin) 100 mg Galantimine (dementia medication) 8 mg Senna (constipation medication) 8.6-50 mg Carbidopa-Levodopa (Parkinson's Medication) 25-100 mg	F 0759	**F759 Free of Medication Error Rts 5% of More** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 15 assessed with no adverse negative outcomes related to the alleged deficient practice. Resident 7 assessed with no adverse negative outcomes related to the alleged deficient practice. **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;** All residents have the potential to be affected by the alleged deficient practice. Medication Administrations audited by the DNS/Designee on 5/29/24. **What measures will be put into place and what systemic**	05/31/2024

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	Depakote (Seizure Medication) Sprinkles 125 mg capsules Levetiracetam (Seizure medication) 5 ml (milliliter) solution into a separate medication cup. QMA 9 then crushed all pills together, opened four Depakote capsules and emptied the sprinkles inside into the crushed medications, and mixed the medications with applesauce. QMA 9 entered Resident 15's room, and offered the resident a drink of the Miralax mixture; Resident 15 refused the Miralax mixture. QMA 9 offered Resident 15 spoonful of the medication in applesauce until gone. Resident 15's clinical record was reviewed on 5/2/24 at 10:15 A.M. Current medication orders included, but were not limited to, Losartan (blood pressure medication) 50 mg give one tablet by mouth one time a day, hold for systolic blood pressure less than 100 or pulse less than 50. The administration record on 5/2/24 at 7:18 A.M., indicated Losartan 50 mg was not available, and lacked a blood pressure obtained. During the medication administration observation, a blood pressure reading was not obtained from Resident 15, and QMA 9 did not check the EDK (Emergency Drug Kit) machine for Losartan. 2. During a medication administration observation on 5/2/24 at 7:34 A.M., RN 6 prepared insulin for Resident 7. RN 6 used an alcohol pad to clean the vial of Novolin insulin (short acting) and used an insulin syringe to draw 16 U (units) of medication from the vial. RN 6 then attached an insulin pen needle to a Lispro (short acting) insulin pen and turned the dial to 4. RN 6 entered Resident 7's room, placed the insulin syringe and insulin pen in		**changes will be made to ensure that the deficient practice does not recur;** All licensed nurses and qualified medication aides were educated on the medication error prevention policy by the IPSDC/Designee on 5/29/24. Education is ongoing for all licensed and certified staff. All new nurses and qualified medication aides hired or assigned through agency will be educated prior to start of next shift. **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;** QAPI tool Medication Administration will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee 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.	

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	Resident 7's bed, and began wiping Resident 7's right upper arm with an alcohol pad. RN 6 then administered the Novolin insulin and Lispro insulin in Resident 7's right upper arm. During the medication administration observation, the Lispro insulin pen needle was not primed prior to administration. Resident 7's clinical record was reviewed on 5/2/24 at 10:26 A.M. Current medication orders included, but were not limited to, Humulin (Novolin) R 18 units subcutaneously (into the fatty layer of the skin) before meals, and Humalog (Lispro) Pen sliding scale (amount given based on blood sugar readings); Resident 7's recorded blood sugar was 210 which indicated a dose of 4 units to be administered. During an interview on 5/6/24 at 12:11 A.M., the DON (Director of Nursing) stated medications should be documented if they are given and if a medication is not available in the medication cart, staff should check for availability in the EDK machine. The DON then provided a list of all medications available in the EDK machine and included, but was not limited to, Losartan. On 5/9/24 at 9:56 A.M. a current policy titled "Insulin Preparation and Administration", dated effective 2/1/18, was provided by the Administrator and indicated "Insulin pen procedure..attach a needle to the insulin pen..Remove air from the insulin pen, Turn the dial to two units, Hold pen and point needle up, Gently tap pen to move air bubbles to top of pen, Press the inject button, There should be a drop of insulin on the tip of the pen, If no drop is seen, change the needle and repeat the step."			

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	3.1-48(c)(1)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure deteriorated medications were discarded for 1 of 3 medication carts observed. (100 Hall Cart 1) Findings include: During a medication storage observation, of the 100 Hall Cart 1 on 5/8/24 at 9:05 A.M., the	F 0761	**F761 Label/Store Drugs and Biologicals** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were identified or affected by the alleged deficient	05/31/2024

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	following loose and unlabeled medications were observed: one tan round pill with no imprints one light blue round pill with imprints SG 45 three white round pills with imprints C 73 two white oval pills with imprints ZF 41 one pink round pill with imprints lupin 10 one half semi-round white pill with no imprints one white round pill with imprints SC one pink round pill with imprints 201 LS one green round pill with imprints HH 974 one clear capsule filled with tan powder one red round pill with no imprints one white oval pill with imprints 11 A one white round pill with imprints GG 26 During an interview on 5/8/24 at 9:12 A.M., LPN 8 stated loose pills in the medication cart should be disposed of, then disposed of all 16 medications into the sharps container on the side of the medication cart. On 5/9/24 at 9:56 A.M. a policy titled "Labeling of Medication", dated 2/1/18, was provided by the Administrator and indicated Medication labeling must be typed or printed and clearly indicate Resident/patient full name, patient location within the facility, prescription number, brand name/generic name, strength of drug, prescribed dose of drug/medication, route of administration, time of administration, quantity of drug/medication dispensed, date dispensed, expiration date, prescriber/physician name/ name/address/telephone number of dispensing pharmacy." 3.1-25(o)		practice. **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;** No residents have the potential to be affected by the alleged deficient practice. All medication carts audited for loose medications by DNS/Designee on 5/28/2024. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All staff was educated on proper disposal of medications and cart organization by IPSDC/Designee on 5/29/2024. Education is ongoing for all licensed and certified staff. All new nurses and qualified medication aides hired or assigned through agency will be educated prior to start of next shift. **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;** QAPI tool Med Cart Audits will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee If 100% threshold is not achieved an action plan will be developed. This information will be presented to	

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	155670	A. BUILDING 00 B. WING	05/09/2024

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MAJESTIC CARE OF NEWBURGH	5233 ROSEBUD LANE NEWBURGH, IN 47630

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			the QAPI committee during the monthly meeting.	
F 0804 SS=E 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- §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 that food was served at an appetizing temperature for 1 of 1 trays tested for temperature. (Resident 21, Resident 246, Resident 74, Resident 73, Resident 87, Resident 4, Resident 24, Resident 55, Resident 25) Finding includes: On 4/30/24 at 9:33 A.M., Resident 21 indicated the food was cold. On 4/30/24 at 9:59 A.M., Resident 246 indicated the food was cold. On 4/30/24 at 10:10 A.M., Resident 74 indicated the food was tough, overcooked, and cold. On 4/30/24 at 10:44 A.M., Resident 73 indicated the food was cold. On 4/30/24 at 12:40 P.M., Resident 87 indicated the	F 0804	**F804 Palatable Food** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 21 suffered no adverse reaction from the alleged deficient practice. Resident 246 suffered no adverse reaction from the alleged deficient practice. Resident 74 suffered no adverse reaction from the alleged deficient practice. Resident 73 suffered no adverse reaction from the alleged deficient practice. Resident 87 suffered no adverse reaction from the alleged deficient practice. Resident 4 suffered no adverse reaction from the alleged deficient	05/31/2024

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	food tasted cold. On 4/30/24 at 12:58 P.M., Resident 4 indicated the food was hard and cold. On 4/30/24 at 1:23 P.M., Resident 24 indicated the food was warm or cold. On 5/1/24 at 8:35 A.M., Resident 55 indicated the food was always cold. On 5/1/24 at 8:46 A.M., Resident 25 indicated the food was burnt and cold. On 5/2/24 at 1:06 P.M., a test tray was obtained. Food temperatures for that meal were: - Baked chicken 100 degrees F (Fahrenheit) - Mac and cheese 92 degrees F - Carrots 88 degrees F - Pumpkin pie 76 degrees F On 5/2/24 at 1:16 P.M., the Dietary Manager indicated foods should be no more than 10 degrees less than what it was prior to serving. He indicated he expected meat to be served at 155 F and vegetables at 140 F. On 5/8/24 at 10:53 A.M., the Infection Preventionist (IP) provided a current "Food: Preparation" policy, revised 2/2024, that indicated "...minimize the time that food items are exposed to temperatures greater than 41 degrees F and/or less than 135 degrees F". 3.1-21(a)(2)		practice. Resident 24 suffered no adverse reaction from the alleged deficient practice. Resident 55 suffered no adverse reaction from the alleged deficient practice. Resident 25 suffered no adverse reaction from the alleged deficient practice. **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;** All residents have the potential to be affected by the alleged deficient practice. All hot food cooking temperature will be monitored to ensure at least 155 degrees and holding temperature is at least 135 degrees. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Educational inservice on correct use of Camduction components provided to all dietary staff by Executive Director/Designee on 5/28/2024. Camduction system components will be utilized for all hot foods for all meal service trays. Trays will be delivered in a timely manner with overhead pages when carts are leaving the dietary department to alert floor staff of upcoming	

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			meal deliveries. The first tray put onto each meal cart will be delivered timely and temped at service and recorded. This will be monitored for each meal service cart sent out for one meal per day, three days per week. DM/Designee to monitor. Education is ongoing. All new hires will be educated prior to start of first shift. **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;** QAPI tool Nutrition will be completed 4 times per week X 6 weeks, 2 times per week x 6 weeks, and 1 time per week x 6 weeks by DNS/Designee. 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.	
F 0806 SS=D Bldg. 00	483.60(d)(4)(5) Resident Allergies, Preferences, Substitutes §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to			

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	eat food that is initially served or who request a different meal choice; Based on observation, interview, and record review, the facility failed to provide food to accommodate a resident's food allergy for 1 of 7 residents reviewed for nutrition. Milk was given with a meal to a resident who had a lactose allergy. (Resident 246) Finding includes: On 4/20/24 at 9:59 A.M., a family member indicated Resident 246 got milk on his meal trays and he was lactose intolerant. At that time, milk in an unopened carton was observed on the resident's breakfast tray. On 5/2/24 at 9:35 A.M., Resident 246's clinical record was reviewed. Diagnoses included, but were not limited to, intestinal malabsorption and gastroparesis. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 2/29/24, indicated Resident 246 was cognitively intact and required setup assistance for eating. An allergy list included lactose intolerance (gastrointestinal issues), dated 10/5/23. An Admission Nutrition Assessment, dated 9/19/23, indicated Resident 246 had a food allergy to milk and cheese which resulted in an upset stomach. A nutrition care plan, initiated 9/5/23, included an intervention "diet as ordered provide PO [by mouth] supplement if ordered. Honor food/beverage preferences as much as possible. Has known lactose intolerance".	F 0806	**F806 Resident Allergies, Preferences, Substitutes** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 246 discharged from facility on 5/28/2024. **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;** All residents have the potential to be affected by the alleged deficient practice. All residents with a listed food allergy were audited with the meal tray tickets by the DNS/Designee on 5/29/24. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All staff were educated on resident allergies and food preferences by the IPSDC/Designee on 5/29/24. Education is ongoing. All new hires and agency staff will be educated prior to the start of their first shift. **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**	05/31/2024

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	On 5/2/24 at 11:37 A.M., a sign was observed posted in the kitchen that indicated Resident 246 had a dairy allergy. On 5/6/24 at 9:15 A.M., the Director of Nursing (DON) indicated allergies were listed on the resident's dietary card and Resident 246 should not be receiving milk from the facility. On 5/8/24 at 10:53 A.M., the Infection Preventionist (IP) provided a current "Dining and Food Preferences" policy, revised 10/2022, that indicated "upon meal service, any resident/patient with expressed or observed refusal of food and/or beverage will be offered an alternate selection of comparable nutrition value". 3.1-21(a)(3)		**into place;** QAPI tool Food Allergies will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee 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.	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the			

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	facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to store and prepare food under sanitary conditions during 4 of 4 kitchen observations and 1 of 1 nutrition pantry observation. Food was not labeled, left open to air, and expired food was not disposed of from the refrigerator, hair nets were not worn, and hand hygiene was not completed. (Kitchen, 100 hall nutrition pantry, Dietary Aide 3, Dietary Aide 21, Dietary Manager) Findings include: 1. On 4/29/24 at 8:29 A.M., during the full kitchen tour with Dietary Aide 3 the following was: - Dirt, food debris, a rag, and an ice scoop were on the floor under the dishwasher. Food debris was on the clean side of the dishwasher. - Liquid was on the floor by the juice cart. - In the freezer, Marzetti frozen pasta and beef patties were open to air. - In the walk-in refrigerator, the following items were observed: shredded mozzarella cheese - no label/date small cup white liquid - no label/date bologna - no label/date yogurt - lid not closed and no label/date square tin of yellow substance - no label/date onion, sliced - no label/date cucumber, sliced - no label/date tomato sliced - no label/date green salad - no label/date	F 0812	**F812 Food Procurement, Store/Prepare/Serve Sanitary** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No residents were identified as being affected by the alleged deficient practice. **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;** All residents have the potential to be affected by the alleged deficient practice. All food will be procured, stored, prepared and served in a safe and sanitary manner/environment. A full deep clean of the kitchen was completed on 5/29/2024 under systemic changes. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All staff educated on the following: 1. Safe food storage, preparation, and meal service. 2. Use of hair restraints in the dietary department. 3. Policy and procedure on labeling and dating	05/31/2024

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	- In the reach-in refrigerator, the following items were observed: ravioli - dated 4/21, use by 4/23 eggs for puree - dated 4/26, use by 4/28 gravy - use by 4/27 beef base - use by 4/28 diced chicken - dated 4/23, used by 4/28 salad - dated 4/24, used by 4/27 - In the dry pantry, the floor was observed to be sticky and a brown liquid was observed on the floor. Two tomato soup cans were stored on floor under a shelf. A Clean Sign was observed hanging between the walk-in refrigerator and freezer that indicated "always clean up any spills immediately". On 5/1/24 at 8:26 A.M., during a follow up walk through of the kitchen the following was observed: - Dirt, food debris, a rag, and an ice scoop were on the floor under the dishwasher. Food debris was on the clean side of the dishwasher. - In the freezer, beef patties were observed to be open to air - In the walk-in refrigerator, the following items were observed: Shredded cheddar cheese - no date parmesan cheese - open to air, no date lemonade - no label/date hard boiled eggs - open to air, no label/date lettuce, wrapped - no label/date - In the reach-in refrigerator, beef base was observed with a use by date of 4/28.		of food. 4. Cleaning log with tasks for each position/shift. 5. Hand hygiene by ED/Designee on 5/28/2024. Education is ongoing with each new hire prior to the start of their first shift. **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;** QAPI tool will be completed 4 times per week x 6 weeks, 2 times per week x 6 weeks, and weekly x 6 weeks by ED/Designee. 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.	

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	- In the dry pantry, the floor was observed to by sticky and a brown liquid was observed on the floor. One can of tomato soup was stored on floor under shelf. Dirt was observed under the shelves. A can of blackeyed peas and bartlett pears were observed to be dented. During an interview at that time, the Dietary Manager indicated the dented cans were set aside and returned. He indicated the can of blackeyed peas and bartlett pears should have been set aside. 2. On 4/29/24 at 8:29 A.M., Dietary Aide 3 had loose hair coming out of the back of her hair net. Dietary Aide 21 had loose hair coming out of the back of her hair net. On 4/29/24 at 10:27 A.M., the Dietary Manager had his beard net on backwards. On 5/1/24 at 8:47 A.M., the Dietary Manager was not wearing a beard cover. On 5/2/24 at 11:37 A.M., the Dietary Manager was observed in the kitchen without wearing a beard net. 3. On 5/1/24 at 11:00 A.M., Dietary Aide 3 was observed preparing the puree meal items. During that time, Dietary Aide 3 was observed performing hand hygiene on 5 separate occasions during the food preparation process. On the first occasion she lathered her hands for 10 seconds. On the second occasion she lathered her hands for 7 seconds. On the third occasion she lathered her hands for 4 seconds. On the fourth occasion she lathered her hands for 2 seconds. On the fifth occasion she lathered her hands for 2 seconds.			

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	4. On 5/3/24 at 1:46 P.M., the following items were observed in the nutrition pantry on the 100 hall: lemonade in a container with a blue lid - dated 4/29 - 5/1 lemonade in a container with a red lid - dated 4/29 - 5/1 milk - dated 4/15/24 bag of Little Debbie snacks in a clear bag - not dated On 5/8/24 at 12:42 P.M., the Infection Preventionist (IP) indicated that staff should lather their hands with soap for 40 seconds while performing hand hygiene. She further indicated kitchen staff should wear hair and beard nets when they were past the door of the kitchen and no hair should be sticking out of them. On 5/8/24 at 10:53 A.M., the IP provided a current "Staff Attire" policy, revised 9/2017, that indicated "All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained". On 5/8/24 at 10:53 A.M., the IP provided a current "Handwashing/Hand Hygiene" policy, revised 2/2018, that indicated "employees must wash their hands for twenty (20) seconds using antimicrobial or non-antimicrobial soap and water...". On 5/8/24 at 10:53 A.M., the IP provided a current "Food Storage: Dry Goods" policy, revised 2/2023, that indicated "all packaged and canned food items will be kept clean, dry, and properly sealed". On 5/8/24 at 10:53 A.M., the IP provided a current "Food Storage: Cold Foods" policy, revised 2/2023, that indicated "all foods will be stored wrapped or in covered containers, labeled and			

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	dated, and arranged in a manner to prevent cross contamination". 3.1-21(i)(2) 3.1-21(i)(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;			

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	(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based observation, interview, and record review, the facility failed to ensure resident records were complete and accurate for 1 of 5 residents reviewed for unnecessary medications, 1 of 3	F 0842	**F842 Resident Records – Identifiable Information** **What corrective action(s) will be accomplished for those**	05/31/2024

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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
	residents observed for medication administration, and 1 of 2 residents reviewed falls. (Resident 246, Resident 15, Resident 26) Finding includes: 1. On 4/30/24 at 10:00 A.M., a family member indicated Resident 246 received insulin. On 5/2/24 at 9:35 A.M., Resident 246's clinical record was reviewed. Diagnoses included, but were not limited to, type 1 diabetes mellitus, intestinal malabsorption, and generalized anxiety disorder. The most recent Quarterly Minimum Data Set (MDS) assessment, dated 2/29/24, indicated Resident 246 was cognitively intact and received insulin 7 days during the 7-day lookback period. Physician orders included, but were not limited to: Insulin Lispro Injection Solution (a fast-acting hypoglycemic medication) 100 UNIT/ML (units per milliliter) - Inject as per sliding scale: if 0 - 150 = 0 units; 210 - 265 = 1 units; 266 - 320 = 2 units; 321 - 375 = 3 units; 376 - 430 = 4 units, subcutaneously before meals and at bedtime related to type 1 diabetes mellitus, dated 4/25/24. On 5/2/24 at 3:21 P.M., Licensed Practical Nurse (LPN) 8 indicated that if Resident 246's blood sugar was between 151-209, he did not receive insulin. On 5/6/24 at 9:15 A.M., the Director of Nursing (DON) indicated she was not sure if Resident 246 was supposed to receive insulin or not if his blood sugar was between 151 and 209 and would have to call the Nurse Practitioner (NP) to clarify the order.		**residents found to have been affected by the deficient practice;** Resident 246 reviewed for unnecessary medication with no adverse reaction to the alleged deficient practice. Resident 246 discharged from the facility on 5/28/2024. Resident 15 medication administration observed for accuracy with no adverse reaction to the alleged deficient practice. Resident 26 reviewed for fall interventions with no adverse reaction to the alleged deficient practice. **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;** All residents have the potential to be affected by the alleged deficient practice. All residents with insulin scale orders audited by the DNS/Designee on 5/29/2024. All residents identified as a fall risk; interventions audited by DNS/Designee on 5/29/2024. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All nursing staff were educated on following physician orders by the IPSDC/Designee on 5/29/24. All licensed nurses and qualified	

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	155670	A. BUILDING 00 B. WING	05/09/2024

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	On 5/6/24 at 12:12 P.M., the DON indicated she called the NP to clarify the sliding scale order, and insulin shouldn't be given below 210. The order should have indicated 0 - 209 = 0 units and 210 - 265 = 1 unit. She indicated the previous order was confusing and she was not sure how an agency nurse would have known how much insulin to give. On 5/8/24 at 10:53 A.M., the Infection Preventionist (IP) provided a current "Charting and Documentation" policy, revised July 2017, that indicated "Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate". 2. During a medication administration observation on 5/2/24 at 7:09 A.M., QMA 9 measured 17 g (Grams) of Miralax powder and mixed it in water. QMA 9 prepared oral medications. QMA 9 then crushed all the pills together, and mixed the medications with applesauce. QMA 9 entered Resident 15's room, and offered the resident a drink of the Miralax mixture. Resident 15 refused the Miralax mixture. Resident 15's clinical record was reviewed on 5/2/24 at 10:15 A.M. Current medication orders included, but were not limited to, Miralax 17 g give by mouth once a day The administration record on 5/2/24 at 7:18 A.M., indicated Miralax 17 g was administered to Resident 15. During the medication administration observation, Miralax 17 g was not administered to Resident 15 due to resident refusal.		medication aides were educated on medication administration on 5/29/2024. All staff was educated on following fall interventions by the IPSDC/Designee on 5/29/2024. Education is ongoing for all licensed and certified staff. All newly nurses and qualified medication aides hired or assigned through agency will be educated prior to start of next shift. **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;** QAPI tool will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee 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.	

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	On 5/9/24 at 9:56 A.M., a current policy titled "Medication Administration General Guidelines", dated effective 2/1/18, was provided by the Administrator and indicated "If resident refuses or ingests only a partial dose, this must be documented on MAR/eMAR." 3. On 5/1/24 at 8:50 A.M., Resident 26 was observed sitting in a chair with the call light wrapped around the call light monitor and not within reach of the resident. On 5/6/24 at 9:00 A.M., Resident 26's clinical record was reviewed. The diagnoses included, but were not limited to, Alzheimer's Disease with late onset, dementia, and generalized anxiety disorder. The current Quarterly MDS (Minimum Data Set) assessment, dated 3/6/24, indicated Resident 26 was moderately cognitively impaired, needed substantial to maximum assistance for mobility, transfer, and eating, and was a fall risk. A Nursing Progress Note, dated 4/18/24, indicated Resident 26 had called out for help after being found on the fall floor mat. The resident had recently been toileted and was apparently trying to get more comfortable in bed. The nurse who found the resident initiated the documentation of neurological checks. On 5/6/24 at 1:15 P.M., the DON (Director of Nursing) presented The Neurological Evaluation Flow Sheet the facility used for Resident 26. The flowsheet lacked documentation of the vital signs at 6:30 A.M., 7:00 A.M., 7:30 A.M., 8:30 A.M., 9:30 A.M., and 10:30 A.M. During an interview on 5/6/24 at 11:54 A.M., RN 5 indicated all information should be filled out on			

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	the neurological check flow sheet including the vital signs. 3.1-50(a)(1) 3.1-50(a)(2)			
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 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;			

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	(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. 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, record review, and interview, the facility failed to ensure infection	F 0880	**F880 Infection Control** **What corrective action(s) will**	05/31/2024

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	control practices were implemented for 2 of 2 residents observed for wound care. Hand hygiene and glove changes were not completed. (Resident 12, Resident 11, LPN 8, CNA 7, RN 7, Nurse Practitioner 19) Findings include: 1. On 5/3/24 at 9:19 A.M., wound care was observed on Resident 12 by LPN 8 and CNA 7. During wound care the resident was observed to have a bowel movement. LPN 8 had gloves on, turned the resident on left side, cleaned buttocks with wipes, and proceeded to touch the resident without changing gloves or performing hand hygiene. The resident was then turned to the right side by gloved CNA 7, soiled dressing removed, peri care completed, and dirty linen was removed. CNA removed gloves but did not perform hand hygiene before placing new gloves on. The resident again turned to the left side so that LPN 7 could complete wound care to the sacral wound. LPN 7 proceeded to touch clean linen with the same gloved hands without changing gloves or performing hand hygiene. 2. On 5/2/24 at 10:42 A.M., RN 5 and NP (Nurse Practitioner) 19 were observed performing wound care treatments for Resident 11. Resident 11 had a sign on the door indicating enhanced barrier precautions were required for staff performing high-contact resident care activities including, but not limited to, wound care. RN 5 and NP 19 entered Resident 11's room, performed hand hygiene, and put on gowns and gloves. NP 19 began spraying wound cleanser on gauze, then cleansed wound to the residents abdomen. NP 19 then used her gloved hand to manipulate Resident 11's abdomen to take measurements with a disposable measuring ruler. NP 19 then used her gloved hand to manipulate Resident 11's abdomen to take photos on a phone		**be accomplished for those residents found to have been affected by the deficient practice;** Resident 12 assessed with no adverse reactions to the alleged deficient practice. Resident 11 assessed with no adverse reactions to the alleged deficient practice. **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;** All residents that reside in the facility have the potential to be affected by the alleged deficient practice. LPN 8, CNA 7, RN 7, Nurse Practitioner 19 were all educated on changing gloves from dirty to clean tasks and hand hygiene with glove changes on 5/ 28/2024 by the IPSDC/Designee. A complete LTC Infection Control facility self-assessment was completed on 5/29/2024 by the IPSDC/Designee. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All staff were educated on proper PPE and hand hygiene with return demonstration on 5/28/2024 by the IPSDC/Designee. The Executive Director/Designee will audit daily to ensure hand	

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	for documentation of the wounds. NP 19 removed the soiled gloves, used hand sanitizer, and put on new gloves. NP 19 applied calcium alginate rope and dressing pads over the abdominal wounds. NP 19 removed the gloves and applied new gloves. No hand hygiene was observed. NP 19 used wound cleanser on gauze to clean Resident 11's penile wound, then placed a dressing pad over the penile wound. NP 19 removed the soiled gloves, used hand sanitizer, and put on new gloves. NP 19 observed lacerations on the residents right upper thigh that were exposing dermis (middle layer of skin). Resident 11 indicated these were due to scratching dry skin. RN 5 assisted turning Resident 11 to his left side and NP 19 cleansed the wounds on the buttock and right thigh. Drainage from the buttock and thigh wounds were noted to be draining serosanguineous (blood and clear fluid) drainage into Resident 11's incontinence brief. NP 19 took photos on a phone of the wounds for documentation. NP 19 then applied collagen and dressing pads over the wounds. NP 19 removed her soiled gloves and placed the phone used to take photos in the pants pocket. NP 19 opened a dressing pad, RN 5 then placed the dressing pad under Resident 11's right armpit. NP 19 removed her gown, applied hand sanitizer, and exited the room. RN 5 gathered trashed and called for another nurse to assist in changing Resident 11's soiled brief. On 5/8/24 at 10:53 A.M., RN 11 provided a current policy "Handwashing/Hand Hygiene" revised 2/2018. The policy indicated "the facility considers hand hygiene the primary means to prevent the spread of infections...in most situations, the preferred method of hand hygiene is the with an alcohol- based hand rub... the following situations are considered: before		hygiene items, including soap and ABHS are always available. All staff were educated to notify the Executive Director immediately if these items are unavailable. All new hires and assigned agency staff will be educated on Infection Control policy, hand hygiene, and proper PPE prior to the first shift worked by IPSDC/Designee. **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 Root Cause Analysis was conducted with input from the facility Medical Director/IPSDC/DNS. Solutions and systemic changes were identified. The LTC infection control self-assessment was reviewed and updated as necessary. QAPI tool Infection Control will be completed weekly X 4 weeks, bi-monthly X 2 and monthly X 4 months by DNS/Designee 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. DNS/IPSDC/ED/Designee will monitor each area daily for a minimum of 6 weeks or until compliance is reached. DNS/IPSDC/ED/Designee will	

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	handling ...soiled dressings, before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, after handling used dressing, after contact with objects, and after removing gloves." During an interview on 5/9/24 at 8:36 A.M., RN (Registered Nurse) 11 indicated gloves should be changed after use and if visibly soiled RN 11 also indicated if a staff member performed peri care the gloves should be changed and hand hygiene should be conducted before and after each use of the gloves. On 5/9/24 at 8:46 A.M., RN 11 provided a current policy "Personal Protective Equipment-Gloves" revised on 2/2018. The policy indicated " gloves must be worn when handling blood, body fluids, secretions, excretions, mucus membranes and/or non-intact skin... The use of gloves will vary according to the procedure: if the employee's hand will come in contact with blood, body fluids, and/or non-intact skin while performing procedure such as ... handling soiled linens or items that may be contaminated... or during cleaning of blood or body fluids..." 3.1-18(b)(1)		complete daily visual rounds throughout the facility to ensure staff are practicing appropriate infection control techniques and complying with the solutions identified for a minimum of 6 weeks or until compliance is maintained. The facility through the QAPI program will review, update and makes changes to POC as needed for sustaining substantial compliance for no less than 6 months.	